



*Clinic-Medical Center Partnership Project*  
*Final Report*

*By*

*National Health Foundation*

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# Clinic-Medical Center Partnership Project Final Report

## **Introduction**

The National Health Foundation (NHF) set out to develop at least 10 clinic-California Hospital Medical Center (CHMC) partnerships through which access to healthcare for patients in CHMC's service area would be enhanced. While NHF cannot point to 10 distinct partnerships resulting from this project, it can claim several successes, not least of which is beginning to change CHMC's culture. As a result of this project, five partnerships between CHMC and community clinics are either being planned or implemented. In addition, CHMC is in the process of adopting or exploring ways to adopt, all 13 of the recommendations generated through NHF's interviews with executive directors of clinics in CHMC's service area.

Rather than following the Scope of Work's reporting format used to this point, this final report will be structured to summarize what has been accomplished and to propose at least one "next step," in the process. It begins by explaining why NHF changed its originally proposed approach, describing successes to date and discussing some of the lessons learned. This discussion is followed by a brief discussion on next steps. The report ends with delineating the original goals and proposed activities and reviewing the findings from clinic interviews.

## **Current Partnership Building**

At the time NHF completed its Interview Findings Report, CHMC was assessing whether to close some or all of its clinics. CHMC's Senior Vice President of Business Development has told NHF that having this report by an independent organization considerably helped her make the case for closing or transferring all but two of CHMC's clinics (Woman's Health Center and California Family Care West).

Thus, eight<sup>1</sup> of CHMC clinics have now been closed or transferred (to another operating clinic) and CHMC has begun to look at strategic ways to collaborate with the community clinics even as it has responded to clinic recommendations. At least four collaborations are underway, they include:

1. A collaboration between CHMC and T.H.E. (To Help Everyone) Clinic to improve Obstetrics (OB) delivery care in which CHMC plans to hand over the facilities of one of its clinics to T.H.E. The objectives of this partnership are to a) focus on

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<sup>1</sup> CHMC clinic transferred: California Family Care (CFC) , Foshay, VernBro, Camino Nuevo  
Clinic closure: King Center Clinic (MLK), Seavue, Primeros Pasitos, Long Beach Family Clinic

the continuity of care issues for OB patients in the hospital and clinic settings, b) provide opportunity for Cedars-Sinai Medical Center residents to care for prenatal patients and c) ensure a financially sustainable and productive clinic operation. This collaboration benefits each of the three organizations involved. T.H.E. clinic will benefit by addressing its issue of insufficient OB staff, CHMC will benefit by having a continued affiliation with Cedars' residency program and Cedars will benefit by preserving its residency program and teaching reputation.

To assist CHMC in its decision to continue providing prenatal care in collaboration with T.H.E. clinic, NHF helped the process by identifying and introducing to CHMC a student group from the Coro Health Leadership Program. (This program provides a premier leadership training experience for multi-cultural, professionally diverse individuals who are dedicated to improving opportunities for Los Angeles' medically underserved communities). This group has met with the participating organizations and is currently determining what factors are needed to make this clinic-hospital partnership successful (the final report is due November 2005).

In the interim, as an indirect response to T.H.E. clinic's shortage of OB physicians, CHMC has placed an OB physician at the clinic site. This physician will see T.H.E. clinic prenatal patients at 36 weeks and will be the physician who delivers at CHMC.

2. The clinic interviews findings report produced through this project helped inform a Healthy Communities Access Program (HCAP) proposal submitted by CHMC to the United States Department of Health and Human Services, Health Resources and Services Administration. This proposal outlines the first steps in creating a collaborative network of community clinics in SPA 4 to provide primary and preventive care linked to the LAC+USC's Healthcare Network for specialty care, radiology and laboratory services, supported by a case and disease management system and community-based health education. Initially CHMC was only working with its own clinics for this proposal, but a phone call from the NHF Chief Executive Officer/President, resulted in the Eisner Family and Pediatric Clinic being included in it. To date, this proposal has not been funded.
3. CHMC is planning to collaborate with St. John's Well Child clinic to develop a patient education program through a Best Babies Collaborative designed to improve delivery outcomes. The Best Babies Collaborative is supported by the Healthy Births Initiative (of First 5 LA) and seeks to increase capacity and coordinate services in the community, enabling the provision of comprehensive, integrated continuous care that will improve birth and pregnancy outcomes.

4. South Central Clinic is partnering with CHMC by hosting monthly baby showers at the hospital. Through these events, South Central's new mothers will be introduced to CHMC's facilities and its prenatal program, thereby making the women and their families' more comfortable using the hospital and improving their experiences.

There are two primary reasons why NHF was unable to facilitate ten new partnerships. First, we underestimated the animosity between the clinics and CHMC and second, we had little power over them. NHF was an outsider that was not bringing money to the table and this combined with the extreme level of animosity meant that clinics were not as willing to participate in this project as we had anticipated. Due to these circumstances, NHF changed its proposed direction. Rather than trying to promote partnerships, we focused on helping CHMC implement as many of the activities clinics wanted CHMC to undertake as was possible given NHF's and CHMC's limitation of staff time and funding.

The following table outlines activities clinics recommended CHMC take in order to build trust between them and discusses how CHMC has responded to them. Of the 13 clinic recommendations (9 under Patient Services and 4 under Administrative and Planning Support), six have been successfully adopted, five are being tested, and ways to implement two of them are being explored. This information is summarized in the following table.

*CHMC Responses to Clinics' Recommendations*

Patient Services	
<i>Potential partnership/collaboration</i>	<i>CHMC's response</i>
1) Clinic patients to access CHMC's health education programs	CHMC has created a calendar flyer of available health education classes and will regularly mail this to the clinics. Clinics' patients can register for these classes by calling the CHMC call center.
2) Better CHMC patient education about its programs and services	CHMC has addressed this in several ways. For example, through their calendar of available health education classes, hosting a monthly baby shower in collaboration with South Central Clinic (see Current Partnerships Building), and educating internal staff on how to communicate CHMC programs/services to clinic patients (e.g., giving patient information about CHMC programs).
3) CHMC outreach workers to refer	CHMC gave a presentation to the

patients to all community clinics	Southside Coalition of Community Clinics Association <sup>2</sup> on the Para Su Salud program, a group that enrolls eligible patients into public programs (e.g., Healthy Families, Medi-Cal). Para Su Salud staff initially referred patients only to CHMC clinics but has now been instructed to refer them to all community clinics.
4) Access to limited services and resources, especially for uninsured patients	CHMC is looking into whether its foundation can purchase a block of services that can be access by community clinics for their uninsured patients.
5) Improved communications about ED patients	CHMC has looked at ways to create a communication link and is testing a Services Needed/Wanted Checklist for CHMC staff to complete (it also includes information about the referencing clinic). From these check lists, CHMC staff get information back to the referring clinics.
6) CHMC physicians to provide medical care and program support	CHMC is investigating ways to broker relationship between physicians and clinics.
7) Educate clinic staff about available specialty services	CHMC is currently educating the community clinics about hospital services on a one-to-one basis.
8) Develop cooperative medication sharing scheme	CHMC is uncertain if it can donate/share close to expiration medications to clinics. Instead, it is exploring the ideas of co-op buying.
9) Provide access to specialty care for clinics' uninsured patients	CHMC continues to explore ways to address the issue of getting care to the clinics' uninsured patients.

Administrative and Planning Support	
<i>Potential partnership/collaboration</i>	<i>CHMC's Response</i>
10) Share CHMC community needs assessment	CHMC's Community Benefits Report has been shared/mailed to the community clinics whose Executive Directors were interviewed for this project.
11) Reinstate clinic-CHMC liaison	CHMC has hired a staff person, Rick

<sup>2</sup> Southside Coalition is comprised of seven community clinics serving in Spa 6. The group's objective is to look at ways to address issues such as limited resources and lack of funding coming into or by passing the South Central area.

	Jacob, Director of Business Development, to be the liaison between the clinics and CHMC. This staff person will be responsible for communicating and facilitating partnering opportunities.
12) Make building partnerships with clinics a priority	The Senior Vice President of Business Development is responsible for the CHMC-clinic partnership work. To date, the CHMC's 2006 Community Benefits Plan and 2010 Strategic Plan includes ways to collaborate with the community clinics.
13) Could clinic-CHMC partnerships help access new funding for community clinics? Could CHMC's Foundation provide grants for collaboration?	CHMC indicated that clinics could apply for small grants from their foundation; however, the clinics were not satisfied with this response. They would like to partners with CHMC to access funds they otherwise could not. This discussion will continue.

### Lessons Learned

NHF's roles in this project were 1) to facilitate communication and collaboration between the community clinics and CHMC and 2) to identify and promote potential partnerships that would enhance access to care for their patient populations. Each of the three participants in this project (community clinics, CHMC and NHF) experienced different challenges. Descriptions of these challenges and the lessons learned from them can be summarized as follows:

#### Community Clinics

- Although the community clinics had similar needs for administrative and financial support (e.g., more staff, specialty care), other needs varied depending on the clinics' funding streams (e.g., whether they were FQHCs or had PPP contracts) and the populations they served (e.g., homeless populations require different services than young families). This made it almost impossible to group clinics by need thereby making it difficult to identify partnering projects that would work for all or groups of clinics. CHMC ideally would have to understand the complex nature of each clinic and work with them individually.
- The clinics' negative perceptions of trying to work with CHMC stems from years of working with this hospital. NHF learned that because of this long standing animosity, collaboration was difficult and unwelcome; therefore redirecting the project's proposed process. Changing such feelings and perceptions would take more time and resources than this project allowed.

### California Hospital Medical Center

- CHMC has been under pressure to meet its financial obligations for some time. Because of this, there was a sense of being in “survival mode”, which meant administrative staff were primarily oriented towards the Corporate office of Catholic Healthcare West (CHW) of which they are part. With the exception of the Senior Vice President of Business Development, senior staff were not thinking about reaching out to clinics. Although this VP is committed to improving the hospital’s relationships with community clinics, she has been unable, to date, to completely change the culture of her organization to one that embraces partnerships with community clinics. Despite these constraints, she continues to direct her own and her staffs’ efforts to improving relationships with community clinics.
- The Senior Vice President of Business Development has been in that position for approximately two years and has only recently focused on partnership building with community clinics. The Senior VP’s decision to outreach to clinics was strongly influenced by NHF’s interviews findings report and although this VP has some staff, not enough of them have, to date, fully adopted her approach to community clinics to assure effective responses to all partnerships opportunities.

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- Although CHMC’s Senior VP was doing most of the work—encouraged and supported by NHF’s president—it was extremely difficult to fully monitor what was happening between CHMC and the clinics. NHF underestimated the time and resources required to create an appropriate communication and tracking mechanism to monitor partnerships development progress and its documentation.
- Because the project did not include any immediate incentives for developing relationships with CHMC, clinics did not want to put much energy into this project.

Despite the challenges faced by all three participants in this project, lasting changes have been achieved. To see the outcomes NHF hoped for (increased access to specialty care and reductions in the inappropriate use of the emergency department) CHMC’s Senior VP of Business Development must continue her current work and incrementally add new partnership projects to the foundation that has been laid.

### **Next Steps**

NHF is hopeful that CHMC will build on the four collaborations and the seven recommendations that have been addressed by continuing to seek ways to

respond to the six outstanding recommendations and other partnership opportunities. CHMC's Senior VP of Business Development says she is committed to improving clinics' perceptions of the hospital and wants the hospital to become a valued partner.

To this end, she is currently exploring the feasibility of collaborating with the community clinics that have Public Private Partnership contracts with Los Angeles County Department of Health Services. The proposed project would create medical homes for the self-pay patients that frequently visit CHMC's emergency room (ER) for non-emergency care. By creating medical homes, CHMC anticipates that inappropriate use of its ER would significantly decrease. As part of its feasibility assessment, CHMC has annualized the number of self-pay visits to its ER and NHF has identified clinics with PPP contracts. NHF will continue to work with CHMC to identify and secure funding to support the creation of medical homes for frequent self-pay ER patients and to facilitate partnerships between CHMC and community clinics with PPP contracts.

Thus despite the many challenges to this project—clinics' varying needs and negative perceptions of CHMC, CHMC's financial obligations and lack of staff oriented to working with clinics, barriers to NHF closely monitoring CHMC-clinic partnership progress and a lack of incentives built into the project—its legacy remains as CHMC, some clinics and NHF continue to consolidate existing relationships and to build new ones.

### **Summary of Previous Progress Reports**

#### Outline of objectives from original proposal

This project was intended to create a health care services network to improve access to high quality health care for the population living in California Hospital Medical Center's service area. Network creation would be accomplished by solidifying and expanding at least 10 partnerships between the hospital and the community clinics in this service area. The National Health Foundation was to facilitate the partnership development process through the following activities:

1. defining the community clinics in CHMC's service area that would be part of the network
2. interviewing the interested clinics to learn about their current relationships, or lack thereof, with CHMC
3. identifying the population service needs in the service area
4. identifying other possible health care providers to add to the network
5. convening a meeting with interviewed clinics to present findings, prioritize potential partnerships and identify possible barriers
6. presenting potential partnering projects to CHMC
7. continually facilitating and monitoring partnership projects via CHMC-clinic meetings and documentation

Six of these activities were completed, but the individual products from them were not used or not used in the way NHF originally anticipated. Defining the clinics in the service areas (#1) was challenging because some Executive Directors (ED) administer several clinics, some in CHMC's service area and others not. NHF decided to switch our interview universe from clinics to EDs (#2). Identifying population service needs (#3) was achieved by combining findings from the Department of Health Services health survey and CHMC's community benefits (SB697) needs assessment. Other health providers (#4) were identified by both a windshield survey and a computer search. However, as we could not determine which would serve Medi-Cal or uninsured patients, this proved not to be useful. NHF obtained information about the most important partnership needs (#5) during our interviews and a meeting was convened with clinics that focused on the accuracy of how we had presented their thoughts and views. The findings report was presented to CHMC (#6) and NHF worked with CHMC to respond to the clinics' concerns (#7). The clinics were upset with CHMC; they did not want to partner with the hospital. Instead, they wanted to see actions that indicated a change of CHMC's attitude towards them and their work. Thus, rather than facilitating CHMC-clinic interaction, NHF focused on helping CHMC begin the process of building trust with community clinics.

#### Summary of Clinics' views of CHMC – Interview Findings

The interviews were designed to encourage clinic Executive Directors to describe their current relationships with CHMC and to discuss actions CHMC and the clinics themselves could take to expand and improve these relations. It was anticipated that the findings would help facilitate discussions about potential actions for both CHMC and the clinics. The findings were presented under four headings: a) a description of the clinics, b) a discussion of clinic-CHMC interactions, c) a review of clinic perceptions of CHMC, and d) the clinics' suggestions for how they and CHMC could work together. They can be summarized as follows:

a) While all clinics provide care to low-income and ethnically diverse populations, some of them are administered as single clinics and others as groups. The latter we describe as "clinic clusters". The difference is that clinics in the clusters are more likely to i) belong to member organizations (e.g., Health Care LA IPA<sup>3</sup>, Community Clinic Association of Los Angeles County); ii) have broader funding streams (i.e., have funding from Public Private Partnerships<sup>4</sup>, as Federally Qualified Health Centers<sup>5</sup>,

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<sup>3</sup> HealthCare LA IPA is a contract administered by MedPoint that allows clinics to refer Medi-Cal patients to CHMC for specialty care. That is, IPA members have formal relationships with CHMC via MedPoint.

<sup>4</sup> The Public-Private Partnership (PPP) Program is a collaborative effort between the Los Angeles County Department of Health Services (DHS) and private, community-based providers (Partners) who are committed to providing quality health services in a culturally and linguistically appropriate environment to low income and uninsured communities.

<sup>5</sup>FQHCs are recipients of federal grants under section 330 of the Public Health Services (PHS) Act. FQHC look-alikes meet all requirements to receive PHS 330 grants but do not receive funding.

and from General Relief); and iii) participate in specific programs that can also provide a source of funding (e.g., reproductive health, chronic disease).

b) Clinics had more bad experiences in interacting with CHMC than good. The good experiences came from working with the Health Care LA IPA and the bad primarily fall into two areas: communications and program issues. The communication issue centered on the flow of information about clinic patients that have received services at CHMC. Clinics were not getting information about the services/tests patients received at CHMC; this prevented them from providing appropriate and timely follow up care. Communications were further compromised because clinics often depended on the personal relationships they had with CHMC units/departments to get services for their patients. These relationships appeared to clinic staff to be institutionalized but actually were not and were often lost when individual CHMC staff left the hospital.

The program issues are reported to the clinics by their patients and center on patients feeling disrespected and unsure of where to go for their care. Clinic patients are unfamiliar with CHMC's programs; they do not know where to go, whom to talk to, etc. In addition, clinic patients reported that once CHMC staff learn they are from a clinic, staff treat them differently.

c) The clinics generally have extremely negative perceptions of CHMC and view it as the least collaborative of all hospitals. These attitudes fall into three areas: viewing CHMC as competitive, untrustworthy, and disrespectful to clinic providers and their patients. CHMC's creation of its own clinics is viewed as being extremely competitive. Because CHMC staff have been seen outside clinics, recruiting/stealing patients, CHMC as an institution is believed to be untrustworthy. Lastly, CHMC's unwillingness to collaborate with clinics in ways that would support them and help their patients are viewed as being tremendously disrespectful, revealing that CHMC does not value the clinics and the work they do.

d) The clinics provided recommendations on potential partnering opportunities with CHMC that fall into two areas: patient services and administrative and planning support.

Patient services focus around patient education, access to specialty care, and improved communications. Administrative services center around partnership building and funding strategies.

For more detail on clinic interviews, refer to Attachment I, Interview Findings Report.