

# Clinic-Medical Center Partnership Project

Findings from Interviews of Clinic Executive Directors in  
California Hospital Medical Center's Service Area

by



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## **Introduction**

When California Hospital Medical Center (CHMC) increased the number of primary care clinics it operates in its service area, many of the existing community clinics were angered by the competitive nature of these actions. Unless it opened its clinics to increase revenues, the existing community clinics believed CHMC could have achieved its aim (of reducing Emergency Department demand) and could have helped create a nascent system of care by working with them. The resulting tensions between the medical center and the clinics could, ultimately, negatively affect patients. In an attempt to reduce these tensions, LA Care [via the Community Clinic Association of Los Angeles County (CCALAC)], Catholic Healthcare West and the National Health Foundation (NHF) funded the Clinic-Medical Center Partnership Project. The first research phase of this two phase project included interviewing the Executive Directors of primary care clinics in California Hospital Medical Center's service area.

After briefly setting the context (past and present), this report presents the findings from those interviews under: Method and Findings. The Findings section includes four components: a description of the clinics, a discussion of clinic-CHMC interactions, a review of clinic perceptions of CHMC, and clinics' suggestions for how they and CHMC could work together. The report ends with a brief conclusion.

## **Historical background**

- 1990-1991 UniHealth and CHMC together start a community-based IPA. Five clinics were involved, two for profit, two not-for-profit and one CHMC clinic.
- 1992 Hope Street was an early project in CHMC's Community Benefits program beginning when Dr. Lynn Yonekura brought a grant shared with UCLA to CHMC. Over time Hope Street became CHMC's main access to the community i.e., to all the agencies and organizations, including clinics, working with the families using Hope Street.
- 1995 CHMC opened a licensed community clinic which along with another not-for-profit community clinic joined the IPA.
- 1999 The IPA became a safety net IPA called the Health Care LA IPA, and clinic participation increased.
- 1999 Catholic Healthcare West bought UniHealth Hospital System.
- 2000 CHMC hired the current Director of its California Family Care clinics when it wanted its clinics to become FQHC look-alikes.
- 2002-03 CHMC's main expansion plan centers on opening several (3) primary care clinics. These were built in areas where pregnant patients were delivering at hospitals other than CHMC.
- 2004-05 CHMC is facing a huge operating loss. Clinics understand that this makes it hard for the hospital to work with them and that it may explain CHMC's aggressive marketing efforts.

## Method

Building on the study of clinic-hospital relationships by CCALAC and Kaiser Permanente of Southern California,<sup>1</sup> NHF developed a semi-structured interview instrument that was designed to encourage 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. Using Office of State Health Planning and Development (OSPHD) 2002 data and applying a five mile radius from CHMC, 67 primary care clinics, administered by 43 Executive Directors were identified. Of these Executive Directors, 24 were interviewed over a six week period (December 2004-January 2005). Reasons for not interviewing the others (19) included refusal to participate (4), being part of the Skid Row project (4)<sup>2</sup>, providing substance abuse, mental health, counseling or only surgical services (8), or clinic closure (3).

Of the 24 clinic Executive Directors involved in this study, 13 administered clinics that are Health Care LA IPA<sup>3</sup> (IPA) and CCALAC members, 3 administered clinics that are IPA members only (1 is associated with a university and 2 are for-profit), 3 administered clinics that are CCALAC members only, and 5 administered clinics that do not belong to either. Interview times ranged from 30 to 75 minutes.

## Findings

Findings from these interviews are presented in four distinct components: 1) Descriptions of clinics, 2) Clinic-CHMC interactions, 3) Perceptions of CHMC, and 4) Potential partnerships.

**1) *Description of Clinics.*** The Executive Directors participating in this study ranged from some who administer single clinics to others who administer “clinic clusters” of up to eight clinics. A dichotomy between clinic clusters and single clinics is exemplified by membership in different organizations and participation in specific programs. For example, clinics in clusters tend to be members of both CCALAC and the IPA; while single clinics tend to belong to either one of these organizations or neither. Also, more than half of the clinics in clusters and fewer than half of the single clinics are Federally Qualified Health Centers (FQHC), or FQHC “look alikes,” and have Public Private Partnership contracts from the Los Angeles County Department of Health Services.

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<sup>1</sup> “Growing Resources for HealthCare in Our Community: Hospital-Community Clinic Partnership Project,” a collaborative project of Kaiser Permanente Southern California Region, Community Clinic Association of Los Angeles County and UniHealth Foundation, 2004.

<sup>2</sup> The Skid Row project, administered by CCALAC, includes various service providers including CHMC. It was agreed that these agencies are already working to establish partnerships with CHMC.

<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.

All clinics provide care to low-income and ethnically diverse populations. Those whose missions are to serve the homeless tend to provide more than just medical care and to be linked to a broad array of social service organizations and different funding streams. While there is variation, most clinics provide similar onsite diagnostic services and most use external labs and imaging services. None of the non-IPA or for-profit IPA members have dispensaries or pharmacies. A few of the IPA members communicate with CHMC using the Internet; most clinics use the Internet for billing and establishing eligibility. None uses it to communicate with patients.

**2) Clinic-CHMC Interactions.** Clinic Executive Directors reported more bad experiences and negative feelings about working with CHMC than good. Bad experiences occurred with units/departments throughout CHMC whereas the good experiences occurred primarily in one area.

While one clinic spoke positively about its relationship with CHMC's Hope Street, many reported good experiences in working with Health Care LA IPA<sup>4</sup>. For example, clinics commented that this IPA is supportive and works with clinics to get them access to the specialty care their patients need, going so far as to ask clinics to identify the specialty groups with whom they should contract.<sup>5</sup> Also, the IPA meetings hosted at CHMC are reported as providing good information to the participating clinic representatives.

The bad experiences revolve around two main areas: communications and program issues. The communications problems reported by Executive Directors centered on clinic-CHMC staff interactions in the course of getting information about clinic patients that have received services from CHMC. Program problems are more likely to be brought to a clinic's attention by its patients.

Executive Directors report that it is extremely difficult to get information about clinic patients who use CHMC's Emergency Department (ED) or who receive specialty or diagnostic services. This information void severely hampers a clinic's ability to provide the proper follow up care. Specific examples include CHMC ED clerks (who must call to get clinic approval before a patient is seen) not being trained on how to talk to clinic staff about patients' conditions (describing something as a "cough" when they should, for example, be talking about the patient having "a headache, a hoarse cough and bringing up mucus"), and specialists who complete and report on some tests, require additional tests

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<sup>4</sup> The one complaint about MedPoint was that it did not inform a clinic when a physician's credentialing was completed. This complicated service provision and required considerable clinic follow up to determine when the process was complete and the physician could be used to treat IPA patients.

<sup>5</sup> Health plan administrators' knowledge about and relationships with specialists in different geographic areas can vary enormously, i.e., because MedPoint does a good job of administering the Health Care LA IPA in CHMC's service area, it does not follow that it does an equivalent job in other geographic areas.

but do not specify them. In both cases, patients do not receive appropriate and timely follow up care.

Clinic Executive Directors also report being without access to any major decision-makers at CHMC. At one time, there was a CHMC staff person who reported directly to CHMC's President/CEO and who acted as a clinic-CHMC liaison, thereby being the "first stop" for resolving clinics' problems. The clinics really appreciated having such a person available to them. However, the liaison left. Clinics were never notified of her leaving, and she was not replaced. Therefore, this single, somewhat formalized clinic-CHMC relationship was lost.

The inconsistency and inadequacy of clinic-CHMC communications also directly affects clinics' abilities to care for their patients. Different clinics have relationships with different units and departments within CHMC through a framework of personal relationships. Some clinics have, or have had, informal verbal agreements with specific CHMC staff through which they can access care for their patients (e.g., one sonar gram/month for uninsured patients). However, when clinic or CHMC staff leave and the personal relationships are broken, these arrangements also end, typically without notification or discussion. When such relationships have existed over several years they can appear institutionalized even though they are not. Their disappearance not only affects patient care, it can also widen the perceived gulf between a clinic and CHMC.

While these communication difficulties are at the provider level, clinic Executive Directors typically hear about programmatic problems from their patients. In the past, CHMC tried to ameliorate pregnant patients' fears of having to go to a "strange" place for their deliveries by providing prenatal patients with delivery facilities' tours. However, these activities were not conducted in ways that assuage patients' fears or made them want to deliver at CHMC. Also, these patients express frustration with how front line CHMC staff respond to them once they identify themselves as coming from the clinic.

Pregnant patients that do not want to deliver at CHMC may need to be disenrolled and re-enrolled in health plans that will allow them to attend the hospitals of their choice. This takes considerable clinic time and effort and when clinics cannot support them in their choices, patients go to other providers. Community clinics cannot afford to lose any covered patients.

**3) *Clinic Perceptions of CHMC.*** Clinics generally have extremely negative attitudes toward CHMC and view it as the least collaborative of all hospitals. They recognize CHMC does a lot of work with its "community," and, because they see themselves as part of that community, they are frustrated that CHMC chooses to compete and not to collaborate with them. Most of the clinics' negative perceptions of the hospital fall into three areas: CHMC is perceived to

be a) competitive, b) untrustworthy and c) disrespectful to clinic providers and their patients.

As already mentioned, many clinics' view CHMC's creation of clinics as a business strategy to make money. This means CHMC is in competition with clinics for patients, particularly Medi-Cal patients. As one Executive Director commented CHMC wants to "compete with us for Medi-Cal patients and to 'dump' its uninsured patients on us." Lack of collaboration exacerbates, by increasing, the perceived level of competition. There has been some collaboration around marketing, but the clinics report having "to fight to get a meeting to discuss this and then to remain involved in it." It is clear to clinics that CHMC will not partner with them unless it financially benefits from the partnership.

Many clinics do not trust CHMC at all. They do not trust the hospital to tell the truth and they firmly believe it will steal their patients whenever it can. When asked directly, CHMC denied its intent to build one of its clinics near an existing community clinic, and then it did. Unsurprisingly therefore, some Executive Directors describe CHMC as a "big time liar." As far as the clinics are concerned there is considerable evidence that CHMC will steal their patients. For example, some clinics report having CHMC staff recruiting pregnant patients outside clinic doors, others report CHMC entering into an agreement with another IPA to recruit patients from clinic waiting rooms, and one clinic arranged to send its 7-month pregnant patients to CHMC with the understanding that after delivery they and their child would be returned to the clinic. They were not.<sup>6</sup>

Finally the perception that CHMC respects neither the community clinics as health care providers nor their patients stems from less tangible factors than the view that it is competitive and untrustworthy. Perceptions that its administration is "impenetrable," affect clinics' attitudes towards and expectations for CHMC. It has a reputation for being the least accessible hospital to community clinics in LA County and many examples of other, more accessible and supportive hospitals were provided. These examples varied from collaborations on single projects to hospitals seen to have, and to act upon, an ethos of hospital-clinic collaboration.<sup>7</sup> Because it is unwilling to collaborate with clinics in ways that help patients and clinics, community clinics also believe that CHMC does not care about and is not interested in them. These perceptions, attitudes, expectations and beliefs are compounded when, for example, clinics' prenatal patients report they are not respected by CHMC staff, and by the fact that other hospitals clearly value clinics more than CHMC does. How providers and clinic staff feel about CHMC filters down to their patients. With the perceptions discussed here, clinic staff will not

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<sup>6</sup> At a recent meeting where clinic EDs reviewed the accuracy of this report, NHF was told that CHMC is now assuring clinics that it is not marketing to their families and not "keeping our babies."

<sup>7</sup> Kaiser Permanente is perceived to have a corporate culture that values community clinics and what they do. Other hospitals were reported to have good relationships with individual clinics but these were generally based on informal relationships between physicians.

extol the benefits of using CHMC to their patients. Thus, such perceptions can directly affect CHMC's bottom line.

**4. Potential Partnerships.** The single most challenging issue faced by community clinics is access to specialty care for the uninsured. While many acknowledge that the public hospitals provide excellent specialty care, clinic providers are worried by the long time their uninsured patients must wait to access it. As already mentioned many clinics have or had informal agreements with specific CHMC staff to provide limited uncompensated care. However, once the involved CHMC staff left the hospital, these agreements ended.

Clinics would very much like to look at ways collaboration can be formalized and thus how they can work with CHMC to create a network of care and thereby permanently benefit the community served by CHMC and clinics. Potential ways of working together are summarized below under Patient Services and Administrative & Planning Support.

#### **Patient Services**

- 1) Now that CHMC has a trauma center, could it leverage this relationship to negotiate some access to specialty care for uninsured patients with LA County Department of Health Services? A new program for uninsured patients has recently been negotiated between a clinic and another hospital in CHMC's service area. Could CHMC tie into this program by providing it with physicians? Also, clinics do think that CHMC's becoming a trauma center may help their patients because more specialists might become available.
- 2) Could CHMC make spaces in its patient education classes available to clinic patients? CHMC is recognized for providing extensive and high quality patient education, and it should assure that its patient education information and classes meet the cultural needs of all the cultural groups in its service area. Clinics cannot as easily provide such information and classes. Therefore, when CHMC's classes are not full, it would considerably help the clinics if their patients could participate instead. Many different kinds of patient education were mentioned: diabetes and other chronic disease management, obesity prevention, nutrition and exercise.
- 3) Could CHMC improve the way it tries to make clinic patients feel less inhibited about going there? Examples suggested include a tour of radiology for women needing mammographies, CHMC OB/GYNs going to clinics to see pregnant patients at 7 months, and having appropriate language capabilities and providing transportation.
- 4) Could CHMC's outreach workers more thoroughly review patients' service histories and home addresses and refer them to the most convenient/preferred clinic rather than only referring them to CHMC's clinics?

- 5) Could CHMC help clinics access resources which are typically extremely limited for their patients (particularly the uninsured)? For example, could some access be provided to mental health and substance abuse services? Could x-ray and lab services be donated? What about some extra assistance in accessing those specialty services (e.g., pediatric subspecialties) that are difficult even for clinics' IPA patients to obtain.
- 6) How about improving communications between CHMC and clinics by setting up systems and providing ongoing training for CHMC staff about getting accurate and timely information back to clinics about their patients who have been treated in CHMC's ED?<sup>8</sup>
- 7) Is there any way CHMC staff could provide program support, e.g., dietary consultations, mental health assessments, in the clinics?
- 8) Is there a way for CHMC to donate close to expiring medications to clinics?
- 9) Could CHMC provide information /trainings to clinic staff about the specialty services it can provide?

### ***Administrative and Planning support***

- 1) Could CHMC reinstate a clinic-CHMC liaison? Some clinics intimated there is a contract liaison (presumably this is MedPoint), and they would like a services liaison in addition. The clinics made it clear that if they are to establish successful relationships with CHMC, the hospital must be serious in its commitment to the person in the services liaison position, for example, s/he must be able to work through the corporate as well as CHMC's administration. Also, this person must understand and appreciate the clinics' mission, which differs from CHMC/CHW's.<sup>9</sup>
- 2) Would CHMC be willing to share its community needs assessment data with the clinics? They do not have the resources to conduct such extensive assessments, yet clinics know CHMC is required to regularly review the needs of its community. These data could help clinics plan their programs and could, perhaps, form the basis for collaboration between them and CHMC.
- 3) The clinics would like to see CHMC broaden its definition of "community" to include them, to stop building competing clinics, and to make building partnership with clinics an organization-wide priority. Could the clinics work with CHMC's Community Benefits Program to help CHMC meet its community benefits requirements? Clinics believe that CHMC's community benefits strategies would be enhanced if the clinics were included in them, and a dedicated linkage between CHMC and the clinics is a pre-requisite for success.

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<sup>8</sup> Some clinics say the radiology department does a good job of getting information back to them, but generally departments do not.

<sup>9</sup> These are necessary, but not sufficient, pre-conditions to successful hospital-clinic partnerships. See the "Growing Resources for HealthCare in Our Community: Hospital-Community Clinic Partnership Project," a collaborative project of Kaiser Permanente Southern California Region, Community Clinic Association of Los Angeles County and UniHealth Foundation, 2004.

- 4) Several Executive Directors pondered whether partnering with FQHC's would allow CHMC to access other federal funding streams for specialty services.
- 5) Could the CHMC foundation provide grants for special clinic-CHMC projects and technical assistance (e.g., health education support, data analysis)?

## **Conclusions**

CHMC created considerable tension between itself and the community clinics in its service area when it opened its own clinics. As part of a project to reduce this tension by creating clinic/CHMC partnerships, NHF interviewed 24 Executive Directors of clinics in CHMC's service area. These interviews revealed that clinics neither like nor trust CHMC and that from the clinics' point of view; their relationships with CHMC could be much improved.

Negative clinic-CHMC interactions center on extremely poor communications at every level of the hospital – administrative, clinical and support, and clinics perceive CHMC to be competitive, untrustworthy and disrespectful of clinic providers and patients. These attitudes are strongly reinforced when clinic patients do not want to use CHMC.

Despite such negatives perceptions and attitudes, clinics would like to work with CHMC to improve patients' services, particularly for uninsured patients, and to begin to build a comprehensive system of care for all patients. A broad range of potential partnerships are identified from improving clinic-CHMC communication to collaborating on projects that would allow CHMC to access different funding streams.

These interviews showed that clinics and CHMC have different definitions of "community" and, closely linked to this, different ideas about what constitutes community benefits. CHMC is known for its excellent community-based health education programs. These programs hire and train community health workers to encourage health promotion and disease prevention through churches, schools, etc., but not, too date, through the community clinics. Thus, while clinics see themselves as essential members of the health care community, CHMC does not. Similarly because they view themselves as community members, the clinics have a broader vision than CHMC of what constitutes "community benefits," and they would like to help CHMC meet its community benefits requirements.

Finally, providing care to uninsured patients presents the biggest challenge for both clinics and hospital and their relationships are not structured to help address this challenge. Current clinic relationships with CHMC vary considerably and are dependent on many different factors including: the actual distance between a clinic and the medical center, historical relations, personal relationships between

clinic and hospital staff, and clinic payer mix. While today informal relationships help care for these uninsured patients, they also contribute to the inconsistency of care and do not support any long term program planning.