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Innovation and Transformation in California's Safety-net Healthcare Settings: An Inside Perspective

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Abstract

Background—Health reform requires safety-net settings to transform care delivery, but how they will innovate in order to achieve this transformation is unknown.

Methods—We conducted two series of key informant interviews (N= 28) in 2012 with leadership from both California's public hospital systems and community health centers. Interviews focused on how innovation was conceptualized and solicited examples of successful innovations.

Results—In contrast to disruptive innovation, interviewees often defined innovation as improving implementation, making incremental changes, and promoting integration. Many leaders gave examples of existing innovative practices such as patient-centered approaches to meeting their diverse patient needs. Participants expressed challenges to adapting quickly, but a desire to partner together.

Conclusions—Safety-net systems have already begun implementing innovative practices supporting their key priority areas. However, more support is needed, specifically to accelerate the change needed to succeed under health reform.

There will be a myriad of major changes to the U.S. healthcare system with the full implementation of the Affordable Care Act (ACA) in 2014.¹ This law requires that legal US citizens be covered by a health insurance plan or be subject to a financial penalty. Additional insurance will be obtained through 1) an expansion of Medicaid for individuals up to 133% of the federal poverty level, 2) broader coverage among small employers, and 3) individual purchasing through newly created Health Insurance Exchanges. This increase in insurance is likely to generate an increased demand for care; in California alone, more than 3 million individuals (more than 40% of those who are currently uninsured) are expected to obtain

Conflicts of Interest

The authors have no conflicts of interest to report.

health insurance in 2014.^{2,3} Moreover, as individuals obtain coverage and choose amongst multiple health systems, all healthcare systems will face more competition. In order to retain and attract newly insured patients, competition will require providing higher quality care and improving patient experience through more efficient and coordinated care. The ACA reinforces this trend toward higher value care by outlining new payment models. Many systems will be facing value-rather than volume-based reimbursement models for the first time – striving for population health improvements while lowering overall costs.⁴

Because safety-net systems provide care for the majority of Medicaid and uninsured patients (i.e., populations expected to represent a large proportion of the insurance expansion), the impact of health reform on access in these settings will be considerable. Public hospitals and community health centers are the core of the safety net in California, with public hospitals providing 69% and community health centers providing 45% of all their care to those who are uninsured or on Medicaid. These systems will need to have sufficient capacity to serve the newly insured, and will need to retain patients who have new access to other systems. In addition to insurance expansion among patients in the safety net, it is important to note that an additional 3-4 million Californians² (up to 55% of those currently uninsured) will likely remain uninsured post-reform, such as undocumented immigrants. Safety-net systems will continue to provide access to those without insurance, which may present further challenges in maintaining adequate access to care.

California's public hospital systems and community health centers have recently begun preparations for the changes in reimbursement under health reform, which provide some early insight into how these settings will operate in 2014.⁵ For example, the California 1115 Medicaid Waiver represents a large-scale federal pay-for-performance initiative, with each public hospital system working to achieve 217 improvement milestones (on average) over five years.⁶ Similarly, for community health centers, the federal patient-centered medical home (PCMH) certification process, along with potential enhanced Medi-Cal reimbursement for "health homes" for patients with chronic conditions, have been driving clinics to change care delivery. In addition, some California public hospitals and clinics have worked with their local Medi-Cal managed care plans to develop tailored pay-for-performance programs. Finally, Meaningful Use incentives for electronic health records (EHRs) have accelerated health information technology uptake nationwide.⁷

The transformative climate of health reform demands an unprecedented pace of change, and innovation will therefore be a means to infuse new ideas and accelerate improvements. Previous studies have defined innovation as "the implementation of a new or significantly improved product (good or service), or process, a new marketing method, or a new organizational method in business practices, workplace organization, or external relations,"⁸ often in a disruptive way to replace older processes altogether.⁹ However, innovation has not often been conceptualized within safety-net settings, and the social and medical complexities of the diverse patient populations served in these settings may pose both unique opportunities and challenges for innovation.¹⁰ Therefore, we conducted key interviews with safety-net leaders to understand their perspectives at this crucial transition.

METHODS

We recruited participants from two statewide membership organizations. First, we recruited leaders from the California Association of Public Hospitals and Health Systems (CAPH) and its quality improvement affiliate, the California Healthcare Safety Net Institute (SNI) – representing 16 county-owned and -operated and 3 University of California healthcare systems. Members of CAPH/SNI provide services in 15 counties where more than 81% of Californians reside, delivering care to 2.5 million Californians and providing over one-third of the hospital care to the state’s 6.7 million uninsured. In addition to hospital care, California’s public hospital systems provide over 10 million outpatient visits each year in hundreds of primary and specialty care clinics. Second, we recruited leaders from the Center for Care Innovations (CCI), a nonprofit organization that provides support to the majority of the 480 community health centers and their regional consortia in California. These health centers collectively provide primary care services to over 4 million Californians, generating over 15 million encounters a year. They also provide outpatient dental and mental health services in counties across the state.¹¹

Interviews and Analysis

From these organizations’ memberships, we used purposive sampling to recruit leaders for the interviews. Using professional knowledge about key executive and clinical leadership, we began outreach for the study separately for the public hospital systems and the community clinics. During initial interviews, we also implemented snowball sampling techniques to explore if there were additional relevant participants to include.

The semi-structured interview guide was developed and subsequently edited and adapted after the first 5 interviews. The interview process was informed by grounded theory without specified *a priori* hypotheses.¹² The final 15 questions (available in the Appendix) focused on system-wide transformation and innovation, such as “What are the top 3 important strategic challenges your organization is facing?” and “What does innovation mean to you in the context of your organization?” Interviews were conducted by two team members (CL and VA) from January to April 2012, ranging 30-60 minutes.

All interviews were recorded and transcribed for analysis. We then conducted qualitative content analysis of the transcripts: first coding two interviews for major thematic content areas, then meeting to develop a coding framework before completing the analysis across all transcripts. We completed simultaneous data analysis and interviewing to complete additional iterations of the codebook as needed, and held regular meetings to achieve consensus on the themes. We received human subjects approval from the UCSF Committee on Human Research.

RESULTS

Among public hospitals, there were 13 interviewees, with leadership roles ranging from Chief Executive, Medical, Quality, or Nursing Officers to Innovation/Transformation and Ambulatory Care Directors.¹ There were 15 interviewees from the clinics, ranging from Medical Directors, Chief Executive Officers, Chief Operations Officers, and Quality

Managers.ⁱⁱ As the vast majority of the themes were similar for both public hospital and clinic interviewees, they are summarized together below.

Strategic Challenges

The interviews started with a discussion about system-wide challenges that drive a need for rapid innovation (Table 1). Most of comments from both sets of interviewees centered around the need for *transformation and change under health reform* – such as new financial models that require forging new partnerships and becoming a “provider of choice” by increasing access, providing high-quality care, and improving patient and staff experience. Specifically, many comments about strategic challenges centered around the need for a culture shift. For safety-net systems in particular, whose mission has often been to serve uninsured patients without a choice in their care, the idea of operating where a large proportion of patients will now be insured requires a new organizational outlook, as expressed by this statement:

Because of [health reform], we need to become a system of choice and not just the place where people go because they have no choices... We need to become a system that provides high-value care. That means excellent quality at the lowest cost possible. Then, linked to that as well is that we need to be a place where staff are really delighted to be there every day and are committed to and engaged in creative and high-quality work. (Public Hospital CEO)

Underscoring this transformational process was the recognition of the importance of new payment structures that will be the key external drivers in facilitating change. That is, new federal dollars (such as those through Medicaid expansion) will no longer be delivered in a strictly fee-for-service environment, as all payers are looking to compensate systems for more comprehensive and coordinated care. Though some new payment models are in place, safety-net systems are challenged to provide high-quality care to complex patients while their payment structures are not yet fully aligned. For example, one participant commented:

There is tension between our [existing] reimbursement methodology and the whole PCMH and patient experience [model]... The way that we want to put the patient first isn't always in sync with how we're getting paid. (Clinic CEO)

Definition of Innovation

Next, we assessed how interviewees conceptualized innovation, as this is critical for understanding how they are incorporating innovative practices within their organizations. Most often, the interviewees defined innovation as being open to new ideas by adapting and implementing solutions that already have been shown to work in other healthcare settings. There appeared to be a consensus that innovation did not generally mean inventing new

ⁱParticipating public hospital systems included: Alameda County Medical Center (2 interviews), Contra Costa Regional Medical Center, Los Angeles Department of Health Services, Rancho Los Amigos National Rehabilitation Center, San Joaquin General Hospital, San Mateo Medical Center, Santa Clara Valley Medical Center, San Francisco General Hospital (2 interviews), University of California Davis Medical Center

ⁱⁱParticipating community health centers included: Alameda Health Consortium, Asian Health Services (2 interviews), CommuniCare Health Center, Golden Valley Health Center, Hill Country Health & Wellness Center, La Clinica de la Raza, Neighborhood HealthCare, Open Door Health Center, San Ysidro Health Center, St. Johns Wells Child and Family Center, Shasta Community Health Center, Valley Health Care Center, Venice Family Clinic, West County Health Center

solutions or using new technologies to address challenges. Innovation was also framed as *embracing continual change toward improvement* by taking incremental steps to gain better results, rather than focusing on “disruptive” innovations. These themes were echoed across several comments:

To me, innovation means: what are we doing differently or what can we be doing differently to answer some of those challenges? We’re an organization that says ‘Let’s not be first on the block on everything.’ We don’t need to be. Our egos don’t need that. Let’s let some other people die on the sword and learn from that and then do what makes sense for us. (Clinic CEO)

That’s the difference between innovation in an academic setting, where it’s invention. In a hospital healthcare setting, it doesn’t have to be the invention. It’s the implementation. (Public Hospital CMO)

Existing Innovations

When discussing factors that have facilitated successful innovations, several interviewees mentioned the existing *creativity in safety-net settings* to generate innovations that meet their patients’ needs. In line with their conceptualizations of innovation, the innovations discussed were often adapted or improved from other healthcare settings. Overall, safety-net systems have made improvements in delivering patient-centered care given their populations’ complex medical and social needs. In addition, caring for the uninsured within fixed payment structures has often encouraged coordinated care and team models of care delivery in order to maximize existing staff time and resources – which will only continue to unfold under new payment models under health reform. One participant specifically commented:

Maybe [the financial constraint in the safety net] enhances it. If you know this is what you have to work with, then maybe you get creative about the ways that you work with it. (County Assistant Director of Healthcare)

Safety-net systems have been successful in designing programs to meet patient needs, largely due to their place in their communities. One leader commented about this unique relationship:

We have these opportunities to get into the community a lot more to know what’s going on, and we have outreach. It’s just more comprehensive [than other systems], and I think that helps us sort of know what’s going on a bit more and see where there’s some opportunity. (Clinic CEO)

Drawing upon this creativity within the safety net, participants mentioned several specific innovative approaches that were adopted early in California’s safety net (Table 2). Most often, these examples of existing innovations reflected the patient-centered approach that was closely tied to the missions of these organizations. Some examples included new care delivery models (such as adapting team-based care from patient-centered medical home models), telemedicine, and electronic systems for increasing linkages between specialty and primary care – all of which addressed patient needs for access.

Finally, underlying the success of these innovative practices were comments centered around workforce development issues – particularly leadership to align innovation within

organizational priority areas and *staff engagement* in generating and implementing newer, better practices. Beyond generating bottom-up, creative approaches that meet patient needs, these innovations could not succeed without top-down leadership to inspire and help facilitate innovation or improvement in a systematic way toward that system mission:

You need to make sure you are asking the right questions. Innovate for those things that matter... Try to understand the perspective of the medical staff. (Clinic CEO)

[We need to] redirect people's efforts to a shared vision and a common goal which is not what we have right now... Can we come up with a singular vision or set of goals?" (Public Hospital Director of Integration)

Innovation Barriers

Participants also mentioned specific barriers to innovation. The first roadblock cited was culture – specifically, being unaccustomed to the scale and speed of change necessitated by health reform:

The frequency of evolution I think is a barrier...but people need to feel okay with some uncertainty for a while for us to learn whether this is actually going to be good or not. (Public Hospital CEO)

Interviewees also noted that there were barriers in moving from piloting to fully implementing practices. This theme directly related to the interviewees' definition of innovation that stressed the need to embed and sustain changes into ongoing work processes. Several leaders made comments related to these large-scale implementation barriers that are common across many healthcare settings:

The hard part about all of these kinds of things is not getting them kick started. I mean, the world is full of great ideas. The harder part is how do you make it work once the grant is gone? (Clinic CEO)

It's hard enough to work on implementing, even if it's best practices. (Public Hospital CMO)

Linked to the strategic challenges mentioned above, the clinic interviewees also felt that the reimbursement system often was a barrier to innovation and prevented them from being able to move in a direction that was patient-centered and/or supported more efficient and effective care. For example, although they had a wealth of new ideas for increasing access to care outside of traditional office visits, the payment structures to support such new modes of care delivery were not fully developed::

We have been talking about engaging patients through other means of communication, like e-mail and text messaging and phone conferencing. If we do that and keep our patients out of our clinic, we actually lose money. (Clinic COO)

The need for meaningful data was also cited as an essential barrier for some settings. Data to drive improvement was seen as a necessary precursor to be able to both prioritize issues within the organization and to gauge success of new practices. Although many systems have implemented electronic records to help to improve their quality and performance improvement programs and metrics, there was a desire to improve the collection of more

timely and actionable data as well as to increase their internal capability for more sophisticated data interpretation, since many of the systems have not lived up to the expectations related to data reporting and analysis. Several interviewees' comments reflected the need for both improved and ongoing data and evaluation:

Having measurable data that you're constantly looking at and using that data to make change is important...To do this well, you need electronic systems in place; you need good ways of explaining data for everyone in the organization. (Public Hospital CEO)

Supporting Future Innovation

Finally, our interviews covered what participants needed to support future innovation within their systems. First, the leaders discussed additional learning opportunities, specifically to improve their internal capability to develop and implement innovations. This included developing new skillsets as well as a more complete understanding of what specific innovations and practices are working within other healthcare settings that might be able to be adapted to their settings:

Help public hospitals improve the capacity and capability for improvement and for innovation. (Public Hospital Medical Director)

You need people who are scanning the landscape to really see what's out there that really fits our needs – to identify the big buckets of problems and the promising solutions. (Public Hospital Director of Integration)

Many of the leaders also expressed a desire for assistance with establishing and/or strengthening healthcare partnerships. Because of the growing need for accountability under health reform – including managing care for patients regardless of where they seek care in the community – many interviewees in both settings stressed the need for expanded local relationships between the hospital systems and the clinics themselves. For example:

Locally we also work with our...community clinic network...and we are doing more and more work with them – a lot of work around integration of behavioral health in primary care and in case management and in panel management. (Public Hospital Medical Director)

I think it's going to take new partnerships and the integration between the primary, specialty and tertiary levels of care. How do you integrate and coordinate services and incentivize services in such a way that you're rewarding prevention and providing care at the least expensive level and dis-incentivizing [emergency room] use, hospital readmissions. You can't do that if you don't have all the players at the table. (Clinic CEO)

DISCUSSION

In our interviews with safety-net leadership in California, we found the external drivers of federal and state health reform are beginning to promote large-scale improvement and innovation in safety-net settings. As other systems have noted,¹³ interviewees' confirmed that financial incentives and coordinated electronic systems are critical for innovation.

Finally, the limited resources and complex patient populations within safety-net settings have historically necessitated creative innovations (not limited to those mentioned during the interviews¹⁴) – but many of these solutions need support for broader dissemination and implementation to become transformational.

The leaders recognized that these changes in the external environment, including competition for newly insured patients, provide a major impetus for adopting new ideas and innovations. These leaders also defined innovation as an ongoing and often incremental process, rather than a disruptive process in which a new technology would drive transformation. This is in contrast to literature from other industries that strongly emphasizes disruptive innovations, perhaps because healthcare settings have often been less able to implement business-model innovation strategies⁹ – particularly public service organizations.¹⁵ Furthermore, the interviewees emphasized the importance of building an organizational culture to support innovation and risk-taking, also consistent with previous literature.^{16,17}

Moving forward, it is clear that leaders are interested in safety-net-wide partnerships to support innovation and integration, as mentioned in their comments about future innovation work. This is consistent with previous findings, especially in light of recent studies that document both the progress as well as barriers toward such safety-net-wide integration.^{18,19} In order to establish such partnerships and implement such care coordination across systems, safety-net leaders need assistance with 1) sharing of best practices and effective innovations, 2) spreading existing successful innovations, and 3) skill-building to support improvement and innovation. Safety-net health systems need support and resources to acquire these skills – particularly to work together at the speed that is necessary to meet the challenges ahead. This includes improved electronic data infrastructures to collect meaningful data, as well as staff training to gain expertise in improvement, innovation, and implementation methodologies.²⁰ Furthermore, safety-net leaders expressed a need for reimbursement structures that support their current and future innovation work. This includes aligning payment with efforts to coordinate care within and across healthcare settings, to move more toward holistic payments that support improving the health of patients rather than remaining tied to volume-based financial incentives. In addition, payment reform should be flexible enough to support new modes of care delivery, such as telemedicine and virtual visits, to encourage increased access based on patient needs and preferences.

There are a few limitations to note. We conducted interviews within several safety-net systems throughout California. These leaders may hold a shared perspective about innovation, and this may limit the generalizability of our findings. However, these are the relevant decision-makers, and the similarity of comments across both community clinic and public hospital settings suggests that these perspectives may be independently emerging. Furthermore, since safety-net systems have long dealt with managing patients within limited budgets, our results are likely generalizable to other systems as well – as all systems will be facing similar cost pressures after health reform implementation. Similarly, because health reform emphasizes patient-centeredness and experience, current safety-net systems may be innovative leaders in areas of cultural competency, linkages with community-based organizations, and geographic proximity to patient populations.

There is new movement in California to develop a Safety Net Innovation Network to support safety-net setting providers to adopt and scale innovations, especially since shared learning and support through peer networks can be a driver of large-scale change.²¹ The Network was launched in 2012 with innovative leaders from public hospital systems, community health centers, Medi-Cal managed care plans, start-up companies, commercial investors, and other stakeholders. While this Network is a starting point to help safety-net providers expand skills, identify and adopt innovations, and foster critical partnerships, there is a need for more focused attention and resources for the implementation and spread of these practices and approaches.

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Appendix: Interview Guide

Context

1. What are the top 3 important strategic challenges your organization is facing?
2. What will it take for you to successfully meet those challenges?

Innovation within your organization

3. What does innovation mean to you in the context of your organization?
4. Can you talk about an example of innovation currently used in your health care system?
5. Please discuss the process for learning about and/or selecting this innovation.
6. How does the unique structure and patient population of safety-net systems influence innovation?
7. What is the process for evaluating and reporting results?
8. You gave me this example of an innovation in your organization [insert answer to 4]. How have you/do you plan to spread and sustain this innovation?
9. In your experience, what are the key elements to a successful innovation? Are there certain areas where innovations have been most successful?

External Resources

10. What types of resources help you initiate innovations?

11. Where else do you look to find examples of innovative practice?
12. Who do you see as particularly innovative in the safety net?
13. What other mechanisms or organizations exist to promote innovation in the safety net? How useful are they?

Future Work

14. What are the areas in greatest need for additional information/resources to support innovation:
 - a. Innovations from another health system that could be translated to your organization
 - b. Innovations developed by outside vendors that could be applied in your organization
 - c. Capacity and/or skill-building around innovation
 - d. Collaboration with other public hospitals for designing and testing innovations
 - e. Access to innovation leaders
15. What focus areas would be of most interest to you to learn about innovations and new services?

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Table 1

Major Strategic Challenges

| | # of public hospital respondents | # of community clinic respondents |
|--|----------------------------------|-----------------------------------|
| Transition to new financial/reimbursement structures and payment reform | 5 | 4 |
| Becoming a provider of choice under health reform | 5 | 2 |
| Improving access, quality, value | 4 | 2 |
| Infrastructure development (including EMR implementation) | 3 | 4 |
| External contracting/partnerships to create Accountable Care Organizations | 3 | 5 |
| Improving patient/staff experience | 2 | 3 |
| Maintaining an appropriately skilled workforce | 1 | 4 |
| Patient centered medical home certification/implementation | 0 | 3 |

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Table 2

Key examples of safety-net innovations

| Innovation Area | Specific program | Example quote |
|---|--|---|
| Designing and implementing new care delivery models | Homeless healthcare clinic, designed to provide comprehensive care to this hard-to-reach population | Physicians who had the ability to think non-traditionally...put together a clinic for homeless people that was situated in the right areas, making it easily accessible to those patient populations...[They were] designing a clinic that made sense, specific to their needs...[It was] just the opportunity to completely think from a patient standpoint or a unique population standpoint. (Public Hospital System Director of Delivery System Reform) |
| Expanding primary care teams | Incorporating in-home support services workers into the care team, outside of the medical setting | [Expand] the role of home health workers – IHSS workers – as part of the medical team that provides care, particularly for patients with chronic disease or disabilities so they have the support they need. [So] that the clinic is their medical home, but not only in the four walls of the clinic...We help to include the [home health workers] as part of the medical team and trained [them] up so they could help with medication management and reconciliation, and they can accompany that patient to the doctor. (Clinic CEO) |
| Electronic referrals | Electronic system to send referrals to specialists, both to determine if a visit is needed or provide a consultation virtually | [eReferral was] a transactional need done between primary care and specialty care...Then all of these great innovations spawned from that – which was relationship building, connectivity, learning on both parts.” (Public Hospital System Chief Quality Officer) |
| Telemedicine | Remote visits with a variety of healthcare providers, often occurring through video conferencing or other electronic media | We started telepsychiatry because...we have sometimes as much as 45 miles between our sites. We can't afford to have psychiatrists there. We can't afford to be having him drive all over the place. (Clinic CEO) Getting to specialty care can be such a struggle in LA, the time and the money for parking and all these kinds of things. So [a provider] will actually be in the room with the patient. On the other side of the camera, there will be a psychologist, a dietician. Rather than the patients having to make an extra trip, she'll do the visit via telemedicine to help them get their weight under control. (Clinic COO) |