Community Health Center Integration: Experience in the State of Ohio

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Abstract: In the face of severe financial challenges and demands to improve quality and service to patients, many community health centers (CHCs) have aligned or integrated with other CHCs, physician groups, or hospitals. Yet the nature of and rationale for these organizational decisions are not well understood. Our research applied an organizational theoretical framework to test whether strategic adaptation theory or institutional theory best describes the integration activity of CHCs in Ohio. We collected primary data from case studies of seven CHCs selected for geographic representation and studied December 2000–January 2001. Semi-structured interviews and a case study database supported our chain of evidence. We found that CHC integration activity was substantial (five of seven CHCs integrated) and extremely varied. Consistent with strategic adaptation theory, we determined that CHC integration actions were predominantly center-specific, rational responses to environmental challenges and were initiated to improve operations or financial performance. Rarely did CHCs initiate major organizational change merely to mimic other CHC actions, as might have been expected of highly institutionalized organizations. Understanding the basis for CHCs' strategic decisions while monitoring financial health will remain critical as lawmakers and administrators work to develop policies that both maintain progress made and improve primary care access for the poor, the uninsured, and those with special health care needs served by these important safety net providers.

Key words: Community health centers, organizational models, health services accessibility, medically underserved area, medically uninsured, organizational objectives, organizational case studies.

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Community health centers (CHCs) and other core safety net providers are struggling to survive in an increasingly hostile health care environment.[1] Established to provide services to anyone seeking care, regardless of insurance status or ability to pay, CHCs are required by law to locate in medically underserved areas and their patient populations tend to be extremely vulnerable. National data on CHC and migrant health center patients indicate that over 40% of those who receive care at centers are uninsured, over 85% have incomes below 200% of the federal

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poverty level,[2] and a disproportionate share also have special health care needs such as substance abuse (11%), homelessness (5%), and HIV positive status (3%).[3] Recent health care trends have contributed to CHCs' challenges, and the Institute of Medicine (IOM) has reported that three factors are particularly troublesome to CHCs: the growing number of uninsured people, the proliferation of Medicaid managed care, and changes in subsidies that are used to cover the cost of providing charity care. As a result, CHCs' financial viability has been severely threatened, provoking responses from both the federal government (to increase financial support)[4] and from individual CHCs (to adapt within their individual markets).

In response to similarly problematic environmental threats, such as cost containment pressures and demands for improving quality and service to patients, many U.S. health care organizations have integrated or formed cooperative alliances with other organizations to jointly provide services, share information systems, or negotiate purchasing arrangements.[5–6] Community health centers have been encouraged to consider integration alternatives such as mergers, consolidations, or alliances with other entities in the hope that integration will be helpful in CHCs' efforts to maximize service value and reduce costs, consistent with the benefits of integration found in other areas of the health care industry.[7–12]

The Bureau of Primary Health Care (BPHC), which administers the CHC program, has specifically encouraged CHC integration activity,[2] providing funding and technical assistance to support the creation of integrated delivery systems and practice management networks through its Integrated Services Development Initiative. Although there are reports that CHCs have been involved in integration activities with other CHCs, hospitals, and physician groups,[2,13–14] scant research exists showing how CHCs have responded to these initiatives,[15] and no studies have assessed whether CHC integration activities are consistent and consonant with organizational theory. The primary reason for this is that data on CHCs are limited, and the data that do exist do not permit examination of CHC organizational behavior. As a result, it is not known how often integration activity occurs, nor what reasons drive these behaviors. Better knowledge of CHC organizational behavior can help researchers, regulators, and policymakers to anticipate the effects of future market and policy changes, such as have occurred with study of other areas of health care (e.g., hospital restructuring,[12,16–19] health care industry transformations,[20–22] and hospital adoption of services[23–24]).

This paper uses information from organizational case studies in Ohio to examine recent CHC integration activity. Community health centers have a long history of operating in Ohio. Ohio's 15 CHCs serve both the large urban population centers of the state and outlying rural areas. In rural locations, including Appalachian southern Ohio, CHCs provide health services to migrant workers and are sometimes the only source of primary care in the county for all residents, including those with private insurance. Overall, Ohio's CHCs serve many diverse populations who are in need of access to primary care services and they experience many of the same operational and financial challenges experienced by CHCs in other states.

Methods

Conceptual framework. Our study of CHC integration used a conceptual framework similar to that used in studies that have examined hospital organizational behavior and have been used to guide policy development.[25-27] Two theoretical perspectives were used to classify CHC integration activities: strategic adaptation theory and institutional theory. Strategic adaptation theory contends that a firm's management will modify organizational strategy to improve performance when confronted by external or internal environmental changes.[28] In contrast, institutional theory maintains that organizations are driven by the need for legitimacy and support.[29-32] Institutional theory contends organizations will make decisions in an effort to conform to external norms, rules, and requirements rather than for reasons of efficiency and improved organizational performance.[33] In practice, many organizations dependent on government founding have been found to be highly institutionalized,[34] but it is not clear how CHC behavior should be characterized.

Study sample. Community health center sites were selected from those operating in the state of Ohio as of December 2000. Of the 15 CHCs in operation, 7 were urban and 8 were rural. We selected 7 sites throughout the state to ensure geographic and site diversity. The 7 selected CHCs included 2 urban and 5 rural sites; all selected CHCs agreed to participate. Urban CHCs selected had the largest number of associated Federally Qualified Health Center (FQHC) sites, maximizing geographic representation.

Case studies. Our research design followed the standards of rigorous case study methodology[35] and consisted of a combination of interviews and analyses of available CHC financial and demographic data. We developed a semi-structured interview guide for our interviews, including multiple open-ended questions. Prior to use, this interview guide was reviewed, pilot tested, and revised to incorporate recommendations from the BPHC and the Ohio Primary Care Association.

Face-to-face interviews were held with the executive director at each CHC's corporate office and lasted one to two hours. Participants understood that data collected during interviews would not be linked to individual CHCs in any published report. One study investigator (JSM) conducted all of the interviews between December 2000 and January 2001.

Interviews asked for center-specific information regarding operations and integration activity from 1998 to 2000. Three main question topics guided the interviews: 1) questions about the CHC's financial health and operating environment (including patient-mix changes, third party insurance payment, managed care penetration, services offered/discontinued, mission); 2) questions about integration activity (past and future); and 3) questions about strategic planning activity. Financial health was assessed by CHC directors on the basis of five possible ratings: strong, fair, tenuous, poor, or extremely poor. The taxonomy used to classify CHC financial health is presented in Table 1.

Analysis. To maintain construct validity, a case study database was created to support a chain of evidence, and multiple sources of evidence were used when available. For example, financial data and other information were extracted from the Uniform Data System (UDS), a database administered by the BPHC that contains

Table 1.

CLASSIFICATION OF FINANCIAL HEALTH OF COMMUNITY HEALTH CENTERS (CHCS)

Financial Health Rating	Description
Strong	CHC is able to continue the present level of operations without curtailment and without fear of operating at a loss for the next five years
Fair	Operating loss is unlikely to develop in the present year; however, strategic steps will need to be taken to maintain this level of financial health in the future
Tenuous	Present level of operations has been altered to reduce the possibility of an operating loss this year
Poor	An operating loss is inevitable this year but the future is uncertain
Extremely poor	An operating loss is inevitable this year and is likely to continue in the foreseeable future

annual information in such areas as revenue, cost, patient demographics, and staffing. Uniform Data System data were used during the interviews to help stimulate discussion about CHC financial health. In addition, the multiple-case study design, by nature, incorporated repetition that served to support external validity. Both the use of a semi-structured interview guide and the development of a case study database helped ensure the reliability of the study.

We used a pattern-matching mode of analysis to address issues of internal validity.[35] Using this technique, we were able to compare patterns in CHC directors' descriptions of their organizations' integration activities with organizational behavior predicted by the two competing theories we tested: strategic adaptation theory and institutional theory. Table 2 presents more detail about the evidence patterns we used to distinguish between the competing theoretical bases for CHC integration.

Results

We found substantial CHC integration activity across our sites, with five of the seven CHC executive directors (71%) describing at least one integration activity initiated over the previous three years that involved his/her CHC (Table 3). Four of the five CHC directors reporting integration activity explained that the primary reason for integrating was to improve the financial performance of his/her centers, leading us to classify this integration behavior as consistent with strategic adaptation theory. Specifically, CHC directors noted that they sought integration opportunities either to enable the center to reduce operating costs or to increase revenues by expanding the CHCs patient base. In the single contrasting case, the CHC had joined a very small,

Table 2.

EVIDENCE PATTERNS USED TO DISTINGUISH BETWEEN THEORETICAL BASES FOR COMMUNITY HEALTH CENTER (CHC) INTEGRATION

Strategic Adaptation Theory	Institution Theory
• Integration is a rational response (e.g., financially sound) • Integration designed to improve present or future operations or performance	• Integration manifests mimetic behavior of CHC • Integration pursued to attain legitimacy or support for the organization • Integration activity pursued with little regard to expected individual strategic benefits

regional, physician-hospital organization (PHO) with the primary goal of improving the CHC's political relationship with the local provider community; this alliance was not expected to have a significant short-term financial impact upon that CHC. In the majority of cases, the CHC itself had initiated negotiations. Descriptions of our how our theoretical evidence test matched representative comments from our interviews are included in Table 4.

In the four integration cases where improved financial performance was a primary goal, the CHCs also reported experiencing poor or worsening financial health over the previous three years. In contrast, the two non-integrating CHCs, along with the center that joined the PHO, reported generally strong or strong-to-fair financial health over the same three-year period. Whether the CHC was located in a rural or an urban area did not appear to influence decisions to integrate, even though a rural location might have limited the number of potential partners or integration opportunities. This evidence supports our judgement that CHC integration activities were center-specific, rational responses designed to improve operations or financial performance, and were thus consistent with strategic adaptation theory.

Further, we found that the CHC integration activities described were quite varied. In one instance, a rural CHC formally worked as a partner with a local integrated health system to provide lab and diagnostic services on-site. Separately, two urban CHCs and one rural CHC worked as partners to finance and develop a shared management information system. One of the same urban CHCs also worked as a partner with a local hospital alliance to receive donated physician services at many of its locations. Without this arrangement, the CHC director made it clear that "at least a couple of their sites would be staring Chapter 11 in the face." In another case, a rural CHC's director described the recent formation of a limited liability corporation with area hospitals and a multi-specialty group as "an effort to position ourselves better for the introduction of managed care, particularly Medicaid managed care." Specifically, the corporation's objective was to identify service-specific improvements

Table 3.

INTEGRATION ACTIVITY REPORTED BY COMMUNITY HEALTH CENTERS (CHC) IN OHIO

Case Study Site	Location	Integration	Initiated by	Rationale	Current Financial Health Rating[a]	CHC Users in 1999 (Approx.)	Full-Time Equivalents (FTEs) in 1999 (Approx.)
1	Rural	Yes	CHC	Political	Poor	9,000	50
2	Rural	Yes	CHC	Operational efficiency; economic	Tenuous to Fair	11,000	75
3	Urban	Yes	CHC	Economic	Fair	35,000	150
4	Rural	Yes	CHC and others	Economic	Poor	42,000	250
5	Rural	No	—	—	Strong	9,000	40
6	Rural	No	—	—	Strong to Fair	7,000	40
7	Urban	Yes	CHC and others	Economic; operational efficiency	Fair	15,000	100

[a]Financial Health Rating: CHC executive director was asked to describe the current financial health of the CHC based on explicit criteria. Please see Table 1 for taxonomy.

in efficiency that could help to reduce individual costs. As another example, an urban CHC was created as a result of several individual centers merging two years earlier. According to the CHC's director, "There was no way these centers were going to make it independently," especially give the dual challenges posed by Medicaid managed care and welfare reform in their service area.

For institutional theory to have explained the observed integration behavior, we would have expected much greater similarity in the CHC integration activities taking place. In addition, we would have expected an indication by the center directors that such actions were common practice among all CHCs. However, no executive director reported that integration had occurred just because other centers were integrating; instead, integration activity appeared limited to CHCs that reported poor or worsening financial health in the recent past. Furthermore, center staff knowledge about the specific operations of other CHCs was reportedly very limited.

Discussion

We found CHC integration activity in Ohio to be both prevalent and varied. Such activities were often strategic responses to concerns about current financial

Table 4.

EVIDENCE OF STRATEGIC ADAPTATION THEORY DESCRIBING INTEGRATION ACTIVITY

Evidence Test[a]	Representative Comments
• Community Health Centers (CHCs) engaging in integration activity reported that these actions were undertaken as rational responses (usually economic) designed to improve the individual center's operational efficiency and/or financial performance.	• "Originally there were five health centers (in the community) that decided around the time of Medicaid managed care and welfare reform that there was no way they were going to make it independently and if they joined together under one organization they would be stronger—they would be able to probably negotiate better managed care contracts—they would be a larger voice in the city—there would be economies of scale that they could gain as well." • "We were trying to position ourselves better for managed care—particular Medicaid managed care. When it appeared several years ago, they [Ohio] wanted to do Medicaid managed care [in our catchment area] and we wanted to have a delivery system that would provide more efficiencies and provide more financial benefit to our members." • "Another objective arising from this partnership is the re-engineering of the patient visit in order to get as much productivity as possible out of existing resources."

[a]Contrasting evidence test that would have supported institutional theory:
- If nearly all CHCs interviewed report recent integration activity.
- If integration was found to be widespread, CHCs' directors reported that such actions were common practice among CHCs.

performance, and were consistent with strategic adaptation theory. Although CHCs are subject to substantial government regulation at both the federal and state levels, they do not behave like highly institutionalized organizations. Instead, CHCs appeared to behave independently, and to make decisions based on the internal and external environmental factors relevant to their centers. As one executive director warned, "When you understand one CHC, you understand only one CHC." In practice, it appears that each CHC's profile is a byproduct of its attempt to address the access needs of its particular clients while operating within an individual market that must respond to different provider and community interests. The entrepreneurial spirit that was evident in these CHCs seems to have emerged as a result of centers carrying out their individual missions from the grassroots of the specific communities they serve.

While CHCs may be operationally unique, they can certainly benefit from dissemination of best practices and information about activities and initiatives that have helped other centers. Despite this, however, we found neither sharing of information nor knowledge of BPHC resources among the CHC staff who were interviewed. The Ohio CHCs whose directors we interviewed did not rely on external resources to develop or implement their integration plans. Thus, efforts to increase awareness about available assistance programs such as those offered through the BPHC to provide CHCs with training, technical assistance, and financial support to foster integration activity through their Integrated Services Network initiative may help CHCs to appreciate the potential benefits of integration[15] and to effectively respond to the myriad of challenges they face.

Directors of centers that had made operational changes such as deciding to engage in mergers or alliances did not feel these changes had negatively affected their commitment to serve their target populations. All executive directors interviewed reported that their centers' missions had not been altered over the previous three years. However, given threats to CHC financial viability nationwide,[1–2,15,36–38] one could reasonably foresee possible integration scenarios where this commitment might be compromised. As an example, it may be the case that the voices of local interest groups or of patients with a particular health condition who were once well-represented on the CHC governing board may no longer be heard when integration activities shuffle the board's composition.

When CHCs integrate, fundamental tradeoffs are made. More and more stakeholders become involved in center operations when larger networks are created and integrated delivery systems are formed. New stakeholders may include for-profit firms or other organizations with strategic priorities that differ from CHC priorities, such as was the case for several Ohio CHCs. Integration may help CHCs decrease costs and achieve economies of scale and scope, as predicted by organization theory, but the sense of local ownership and grassroots responsiveness that have contributed to CHCs' historical success may be sacrificed as organizations are combined to jointly serve disparate populations. Both policymakers who encourage integration activity and centers that consider forward-thinking strategic plans must be careful to ensure that efficiency gains do not outweigh the costs of reduced access to care for the vulnerable patient populations who depend on CHCs for their health care.

Over their history, CHCs have adapted to many changes in the health care environment. The findings of this limited but focused study suggest that CHC integration activity represents a response consistent with strategic adaptation theory. Yet, while our findings demonstrate that CHCs have substantial freedom to adapt strategically to the challenges they face, we also found that centers continue to be financially fragile. The integration activities we studied were most often pursued as necessary responses to the centers' financial concerns. Developing and maintaining a clear understanding of CHCs' likely organizational responses while monitoring their financial health is critical as lawmakers and administrators work to develop policies both to maintain progress and to improve primary care access for the poor, the uninsured, and those with special health care needs.

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Notes

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