



AcademyHealth

**The AcademyHealth Listening Project:  
Improving the Evidence Base for Safety Net Health Care Delivery**



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# Table of Contents

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<b>Executive Summary</b>	<b>1</b>
<b>Introduction</b>	<b>10</b>
<b>Methods</b>	<b>11</b>
<b>Sample Population</b>	<b>11</b>
<b>Instrument and Interviews</b>	<b>12</b>
<b>Qualitative Analysis</b>	<b>12</b>
<b>Results</b>	<b>13</b>
<b>Understanding Safety Net Care in the United States</b>	<b>13</b>
<b>Evidence Needs</b>	<b>17</b>
<b>Data, Quality Improvement, and Research</b>	<b>32</b>
<b>Advice for Researchers</b>	<b>37</b>
<b>Discussion and Next Steps</b>	<b>39</b>
<b>Appendix A: Instrument Used for Semi-Structured Interviews</b>	<b>42</b>
<b>Appendix B: Final Codebook Used to Analyze Interviews</b>	<b>43</b>

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# Executive Summary

*AcademyHealth is a leading national organization serving the fields of health services and policy research and the professionals who produce and use this important work. Together with our members, we offer programs and services that support the development and use of rigorous, relevant, and timely evidence to increase the quality, accessibility, and value of health care, to reduce disparities, and to improve health. Launched in 2013, AcademyHealth's Translation and Dissemination Institute helps move health services research into policy and practice more effectively. It undertakes activities that help research producers better understand the needs of research users, and serves as an incubator for new and innovative approaches to moving knowledge into action. This report is the [third in a series](#) focusing on the short- and long-term research needs of policymakers and leaders in health care delivery systems.*

The Listening Project, a signature activity of AcademyHealth's Translation and Dissemination Institute, seeks to identify the most pressing research needs of leaders in health policy and health care delivery for the next three to five years. The goal of the project is to foster greater interaction among the producers, funders, and users of health services and policy research (HSR) and to spur the production and use of timely, relevant evidence to improve health and health care. This report explores the stated evidence and data needs of leaders in safety net provider organizations.

## Sample

In 2014 and 2015, AcademyHealth staff conducted semi-structured key informant interviews with 43 individuals with extensive experience and/or expertise in the delivery and financing of safety net care. The individuals interviewed represent diversity along several dimensions, including their position and employer type, geographic location, and area of expertise within safety net care. To maintain the anonymity of our respondents and in keeping with our Institutional Review Board exemption,<sup>1</sup> we do not provide more specific information about the individuals included in the interviews.

## Methods

Staff used qualitative data analysis techniques to identify and synthesize major themes, which were validated by an external review committee comprised of interviewees and other content experts. The full report draws heavily on the use of verbatim quotes to illustrate each finding and in some cases, quotes were edited for grammar and length. While we do not identify interviewees by name or organization, we precede the verbatim quotes with information about the respondent's role relative to safety net care, for example, as a leader of a community health center, physician at a safety net hospital, or researcher with safety net expertise. The report includes results presented in four sections: (1) background on safety net health care in the United States; (2) interviewees' stated evidence needs; (3) interviewees' experiences with data, quality improvement, and research activities; and (4) interviewees' advice for researchers.

## Understanding Safety Net Care in the United States

The safety net health care system in the United States is not the uniform system that the name might imply, but instead a diverse set of institutions, clinics, and individual providers that serve some of the nation's most vulnerable individuals, regardless of their ability to pay. These organizations vary widely in how they are structured, financed and operated. The differences between organizations are largely shaped by factors at the state and local levels, particularly the health care needs of the local patient population. In this section, we provide a brief overview of safety net provider organizations, the patients they serve, and relevant financial and policy issues they face. In doing so, we highlight comments from interviewees that, while not necessarily evidence needs, provide important contextual information for understanding the project findings that follow.



## Defining Safety Net Providers

For the purposes of this report, we define safety net provider organizations using the definition of “core safety net providers” articulated by the National Academy of Medicine in a 2000 report. This definition describes core safety net providers as those organizations that (1) either by legal mandate or adopted mission offer care to patients regardless of their ability to pay for those services; and (2) have a substantial portion of their patient mix that is comprised of uninsured, Medicaid, and other vulnerable patients.<sup>2</sup>

Safety net provider organizations, such as public hospitals, community health centers, and local health departments, serve a diverse patient population that includes the uninsured, underinsured, Medicaid beneficiaries, and dual eligibles, among others. Safety net patient populations are often low income and may have complex medical needs, which may be exacerbated by significant non-medical needs such as inadequate housing, lack of transportation, poor access to healthy food, or weak familial or social networks. However, in the interviews, a few respondents cautioned against confusing patients’ medical or economic vulnerability with a lack of determination or resolve.

*“This is quite a resilient population. I would like to know how many of us would be able to navigate four buses to get to work every day. [These] are some of the things that I think the population that we serve is doing every day that would really take most of us out.”*

*-Interviewee*



In talking about the characteristics of safety net patients, many respondents raised the topic of provider payment and other policy issues related to safety net health systems’ financial viability. The Patient Protection and Affordable Care Act (ACA), a major health reform law passed in 2010, broadened access to health insurance coverage through expansions in Medicaid eligibility and the creation of health insurance exchanges where qualifying low-income individuals and families can use subsidies to purchase private health care coverage. While aspects of the ACA stand to benefit safety net provider organizations – namely, greater insurance coverage among previously uninsured safety net patients – other provisions carry financial uncertainties, such as cuts to Medicaid Disproportionate Share Hospital payments and penalties for excess 30-day hospital readmissions. Moreover, providers’ experiences are expected to vary greatly depending on whether or not they are located in a state that has chosen to expand Medicaid and whether their patients qualify for expanded coverage.

Beyond the ACA, safety net provider organizations continue to grapple with risk adjustment, the issue of whether and how health care providers serving large numbers of high-need patients should be compensated differently for the services they provide. Risk adjustment – an issue that was raised frequently in the interviews – has been the topic of



continued debate between safety net providers, who feel they are not adequately compensated given the needs of their patients, and payers, who seek to keep costs down and incentivize high quality health care. Other financial challenges facing some safety net provider organizations include pressure to compete with other provider organizations in a region for Medicare and private pay patients.

Given the complex needs of safety net patient populations and the financial challenges described above, safety net providers frequently collaborate with community organizations such as schools, churches, social service agencies, and homeless shelters to deliver services and help improve the health of their patients. One respondent, an executive in a public health care system, alluded to these partnerships as an important first step in addressing the health of populations.

*“At the population level, we have to begin to think outside of ourselves and in a more regional manner, and I think that is a unique challenge given our government structure. It’s certainly not something only our public system is dealing with. I think private systems also have to deal with this, it’s just a different set of issues...All of us need to figure out how do we come to the table as partners and how do we bring our government structures into that conversation and not use them as leverage or barriers. That’s one challenge or one opportunity.”*

-Interviewee

## Evidence Needs

The primary purpose of this project was to help health services and policy researchers direct their efforts toward issues that are relevant and timely for safety net delivery system leaders and their staffs. Respondents identified eight areas where they believe new or better research is needed to help inform the delivery of care in safety net settings. With the exception of payment and delivery system reform, a topic cited across the interviews, the research areas that follow are not listed in priority order.



## Payment and Delivery System Reform

Respondents expressed significant interest in evidence that helps safety net provider organizations navigate and respond to changes in health care service delivery and payment. For example, respondents cited the need for information that helps provider organizations understand the true cost of delivering services. Without such information, providers may find it difficult to assess their readiness to participate in accountable care organizations and other payment models with risk-sharing components. As safety net providers experiment with new ways of delivering care, respondents emphasized the need for information that helps providers understand which innovations work, for which patients, and why.

## Coverage Expansion under Health Reform

Interviewees raised several research questions about the impact of health care reform on safety net provider organizations and their patients, particularly the implications of increased coverage for providers' finances and patients' access to care. For example, respondents raised questions about the positioning of safety net provider organizations in health plans offered on insurance exchanges and the ability of safety net patients to access care with their usual provider. Interviewees also described the need for further evidence on topics such as provider choice among newly-insured safety net patients; the capacity of safety net delivery systems to care for the newly insured, including strategies for promoting greater access to care; and the ability of safety net providers to compete with other providers on patient satisfaction and quality of care.



## Care Coordination

Respondents raised several evidence needs related to the coordination of care for complex, high-need patients. Of particular interest was research that helps safety net providers 1) identify the appropriate level of care coordination for patients of varying needs, and 2) determine which among many, sometimes simultaneous care coordination efforts are actually making a difference. In addition, some respondents cited the need for strategies that help improve data sharing and other forms of communication among providers, with the ultimate goal of improving patients' transitions in care.

## Patient Behavior and Engagement

Noting the significant economic, social, and environmental challenges often faced by safety net patient populations, respondents expressed interest in understanding the variety of factors that influence patients' attitudes about health care and their health care-seeking behaviors. In particular, respondents pointed to the need for more information on the impact of factors such as culture, language, and immigration status on a patient's health care-seeking behavior. Strategies for promoting behavior change – particularly through improvements in health literacy and the adoption of culturally sensitive practices – also emerged as an area of interest.



## Non-medical Services and Supports

Many respondents raised questions about the role of safety net delivery systems in addressing patients' social determinants of health—factors outside the health care system such as access to healthy food, transportation, and housing that may affect a person's health. In one line of comments, several interviewees described the need for evidence that helps safety net providers parse out the most effective components of interventions aimed at addressing patients' non-medical needs. Others pointed to the need for research that goes beyond documenting the link between patient health and various social determinants of health to actually evaluating the effectiveness of health system and community-level interventions.

## Organizational Management

Several interviewees described the need for evidence on the effective organization and management of safety net provider organizations. For example, respondents raised questions about strategies for identifying good managers, providing leadership training to physicians, and identifying leadership traits of top-performing organizations that might be emulated elsewhere. In addition, some respondents saw a role for the research community in helping identify effective strategies for promoting behavior change among leadership and staff within safety net provider organizations, perhaps by drawing on relevant insights from the business and management literature.



## Behavioral Health

Behavioral health, including the prevention and treatment of mental illness and substance use disorders, was another high-priority research area raised in the interviews. In particular, several respondents described the need for additional evidence on models for effectively integrating physical health and behavioral health services, including research that calls out the most important elements for success. In another line of comments, several respondents cited the need for evidence on effective strategies for identifying, managing, and even preventing behavioral health issues before they reach crisis levels that are costly for both patients and providers.

## Implementation of Research

Several respondents emphasized the need for evidence that helps safety net delivery system leaders implement existing evidence-based practices in their unique settings. In particular, interviewees cited the need for evidence on the implementation, scale, and spread of promising innovations in care, including those developed at other organizations. Respondents indicated that a central challenge is determining whether a promising intervention from a peer organization is the right fit for another provider's setting, and if so, how the intervention should be implemented most effectively.

## Data, Quality Improvement, and Research

In addition to asking about high-priority evidence needs, we asked interviewees to comment on the availability and use of data in safety net provider organizations; approaches to quality improvement in these organizations; and the extent to which safety net provider organizations are interested and able to conduct research or evaluation projects for both internal use and external dissemination.

## Data Challenges

Interviewees indicated that data is used in safety net delivery systems for a variety of purposes: to comply with reporting requirements, for quality improvement projects, to inform broader decisions around care delivery, and to a lesser extent, to engage in research for dissemination in peer-reviewed publications. While the interviews suggest there is variation among safety net provider organizations in their ability to collect and analyze

data, respondents identified a number of shared challenges associated with accessing data, translating it into meaningful information, and using that information to address the types of evidence needs described above.

For example, interviewees noted that many provider organizations are inundated with patient data following the implementation of electronic health records (EHRs) and other data collection and integration efforts. Respondents from both hospitals and community health centers suggested that this influx of data, combined with lack of staff time, capacity, and barriers to data sharing across organizations, limits the ability of many provider organizations to take available data and convert it into actionable information. One interviewee, an expert with experience working with safety net health systems, described the challenge of using a variety of data sources to inform improvements in care delivery.

*“How do we take advantage of the fact that we have all this new data from EHRs? There are great geographic information system (GIS) data, community level data, so how do we start using that to manage patients differently and improve the health of the community?”*

-Interviewee

## Quality Improvement

The interviews suggest that safety net provider organizations engage in a number of quality improvement activities aimed at improving the quality and efficiency of care for their patients. Respondents noted that the type, size, and duration of these activities is often dependent on a variety of factors, including the type of provider organization, available funding, staff capacity, and the organization’s current priorities.

*“Nobody’s going to tell you that a lot of these things aren’t worth doing. The question that comes up over and over again is how do you afford to do this given all the various constraints? We can think of 25 things to do. We have one resource to devote.”*

-Interviewee

Given these resource constraints, respondents noted that many safety net provider organizations seek to learn from the experiences of peer organizations. To a lesser extent, providers may partner with external researchers to implement and evaluate an innovation in care. During the interviews, respondents generally did not articulate the difference between a quality improvement project and a research project, though most seemed to associate “research” with rigorous methods, long timeframes, and publishable findings. Defined this way, some interviewees noted that their organizations simply do not engage in this type of activity.

*“We found out that for our health center physicians, if they wanted to do research they would have stayed in academia... Our physicians don’t have the time or necessarily the interest and motivation to pursue what’s really required for research.”*

-Interviewee



Safety net providers who do participate in more formal research activities cited a number of challenges in doing this work, described further in the box below.



### Safety Net Providers' Participation in Research

Safety net provider organizations that engage in more formal research activities do so either through the use of staff to evaluate and publish on a particular project, or by partnering with external researchers to plan, implement, and evaluate an intervention. Interviewees noted that providers may face several challenges in carrying out this work, such as navigating the grant application process, gaining Institutional Review Board (IRB) approval, collecting and managing data, and mitigating the burden on patients and staff.

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*“Everyone thinks it’s so easy to get this consent or do this for the IRB or just add this to your workflow. We’re already stretched thin, so any change to workflow is really hard.”*

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Other respondents, including a community health center leader, described the challenge of keeping up with required grant deliverables and renewal processes without staff trained in grants management.

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*“There has been a lot of conflict in terms of meeting deadlines for projects that we just can’t meet because we just don’t have the infrastructure for it. We don’t have a dedicated grant research department or a research grant specialist that understands the nuances and the differences between an operational grant and a research grant.”*

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Several interviewees noted that their organizations rely on internal committees to review proposals from external researchers seeking to conduct a study with their patients, staff, or data. These committees are meant to ensure that study objectives align with the organization’s priorities and that the study design is not onerous for patients or staff.

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*“It is important that [the project] could be done in such a way that confidentiality is key, consent is clearly not connected to patient care, it doesn’t disrupt workflows, and it’s not going to be a demand on the organization which we can’t provide.”*

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## Advice

During the interviews, respondents were asked whether they had advice for health services and policy researchers seeking to produce useful work for safety net delivery systems. In response, interviewees offered suggestions for how researchers might partner with providers to “co-produce” research that meets the needs of both parties. Interviewees advised that successful co-production of research is facilitated when the researcher:

- actively consults with the provider organization in shaping the goals and activities of the research project;



- considers the feasibility and potential burden of different research designs and activities given the financial, staffing, and other resource constraints facing the provider organization;
- offers the provider organization compensation for its role in the project;
- includes a staff member from the provider organization as co-principal investigator on the project; and
- produces findings that can help inform decision-making by the provider organization beyond the life of a single grant.

In another line of comments, participants identified opportunities for researchers to better communicate their findings to safety net delivery system leaders. Citing the technicality of the academic literature, some interviewees encouraged researchers to learn to speak and write using clear language that is meaningful to clinicians, health system executives, and others. Interviewees also suggested tailoring a publication's length and level of detail to the needs of the intended audience. One person noted that when writing for health system leaders, researchers should be brief, practical, and to the point, while clinicians and those who implement interventions would find more detail useful. Several respondents pointed to the usefulness of one-page research briefs or syntheses that describe the problem being examined, the intervention tested, and the outcomes, with links or citations that direct the reader to more information.

One interviewee, an academic with safety net expertise, went on to describe the role of “policy translators” in helping health system leaders interpret and understand findings out of the academic literature.

*“If you’re trying to run a health center or a hospital today, you can’t read this stuff. You’re looking for the Sacagaweas out there whom you’ve developed some relationship with, who are going to do the translating, whose translations you know you can read, and we in turn as the Sacagaweas are looking for the researchers who will work with us by getting [us] something very simple.”*

-Interviewee

It is worth noting that advice around the communication of research findings was also a theme in previous Listening Project interviews with Medicare and Medicaid policymakers, respectively.

## Discussion and Next Steps

Findings from AcademyHealth’s Listening Project provide useful insights into the issues that are top-of-mind for leaders in safety net delivery systems and highlight opportunities for health services researchers to work collaboratively with providers to explore these topics. The interviews conducted for this project suggest that:

- Safety net providers generally see the value of research as a resource for helping inform decision-making.
- Safety net providers particularly value information that helps them implement evidence-based practices in their unique settings.

- Many safety net providers wish to better assess the effectiveness of their quality improvement efforts, which may or may not involve formal research activities.
- Safety net providers wish to be treated as partners in research studies involving their patients, data, or other resources.

We recognize that there were some topics interviewees did not mention or emphasize as much as expected. For example, content experts asked to review an earlier version of this report noted few or no comments about issues such as opiate abuse and substance abuse more generally; veteran's health; rural health; reproductive health services; health insurance literacy; and trauma-informed care and resiliency. A possible explanation is that these issues simply did not rise to the top of the discussion during the approximately 60 minutes we had for each interview.

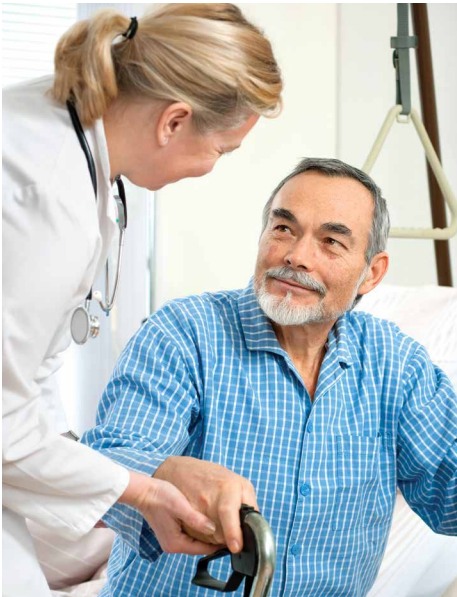
Following the lead of our previous Listening Project reports, AcademyHealth will share findings from the safety net interviews through a variety of channels, including professional meetings. Through these and other activities, we hope to spur discussion among the producers, funders, and users of research about opportunities for strengthening the evidence available to help inform safety net care.



## Introduction

The Listening Project is an AcademyHealth effort to help health services and policy researchers proactively identify the most pressing research needs of leaders in health policy and health care delivery for the next three to five years. The goal of the project is to foster greater interaction among the producers, funders, and users of health services and policy research (HSR) and to spur the production and use of timely, relevant evidence to improve health and health care.

The Listening Project is a signature activity of AcademyHealth's Translation and Dissemination Institute, an initiative that addresses the challenges of getting the best health services research to the right audiences, at the right time, and in a form useful to decision makers. Launched in 2013, the Institute undertakes activities that help research producers better understand the needs of research users, and serves as an incubator for new and innovative approaches to moving knowledge into action. This work involves testing new technologies, media, and the application of practices from other fields. The Institute released its first Listening Project report in 2014, which focused on research and data needed to support Medicare policymaking. A subsequent report, released in 2015, focused on the research and data needs of state and federal Medicaid policymakers. This report is the third in the Listening Project series and explores the stated evidence and data needs of leaders in safety net provider organizations.



### Defining Safety Net Providers

For the purposes of this report, we define safety net provider organizations using the definition of “core safety net providers” articulated by the National Academy of Medicine in a 2000 report. This definition describes “core safety net providers” as those organizations that (1) either by legal mandate or adopted mission offer care to patients regardless of their ability to pay for those services; and (2) have a substantial portion of their patient mix that is comprised of uninsured, Medicaid, and other vulnerable patients.<sup>3</sup>

While some of the evidence needs raised in the report are not exclusive to safety net settings, findings help illuminate the unique ways in which these issues play out among providers serving some of the most medically and economically fragile Americans. Understanding the experiences and needs of safety net providers is especially important for assessing the implications of health reform and anticipating the needs of an increasingly diverse U.S. population. As with previous Listening Project reports, this document is not intended to be a research agenda or the sole effort of its kind, but rather a starting point for fostering collaborative, productive relationships among the funders, producers, and users of research that help strengthen the delivery of safety net care and improve health.

## Methods

The idea and some of the methods used in the Listening Project are informed by similar efforts to elicit HSR needs in Canada and the United Kingdom as well as prior work undertaken by Evidence-based Practice Centers in the United States.<sup>4</sup> During 2014 and 2015, AcademyHealth staff conducted semi-structured key informant interviews with 43 individuals with extensive experience and/or expertise in the financing and delivery of safety net care.



## Sample Population

In early 2014, AcademyHealth staff developed a list of potential interviewees based on input from senior leadership as well as external partners with expertise in safety net care. That spring, two staff members conducted semi-structured telephone interviews utilizing the interview guide described in the section below. Following a preliminary analysis of interview transcripts and in an effort to include a greater diversity of perspectives, staff conducted a second round of interviews during the summer of 2015.

The 43 individuals interviewed across both rounds bring diverse perspectives based on their role and employer type, geographic location, and area of expertise within safety net care, among other dimensions. As shown in the table below, well over half of interviewees are employed by organizations delivering health care services – primarily safety net hospitals and community health centers, and to a lesser extent, local public health departments and community-based behavioral health providers. The provider organizations represented in the interviews are located across the country and serve a wide range of patient populations, including children, immigrants, individuals with HIV/AIDS, individuals with mental health and substance use disorders, and other diverse groups. In addition to health care providers, interviewees include researchers and other individuals with safety net expertise employed by universities, think tanks, or foundations. The remaining interviewees, listed as “Other” below, are individuals who do not fit squarely into the other categories but whose work with relevant stakeholder groups such as provider associations or health plans equips them with valuable insights into safety net care.



Interviewees by Employer Type	
Employer Type	Number of Interviewees
Hospital	12
Community Health Center	10
Public Health Department	6
Community-based Behavioral Health Provider	2
University/Think Tank/Foundation	6
Other	7
<b>Total</b>	<b>43</b>

To maintain the anonymity of our respondents and in keeping with our Institutional Review Board exemption,<sup>5</sup> we do not provide more specific information about the individuals included in the interviews.

## Instrument and Interviews

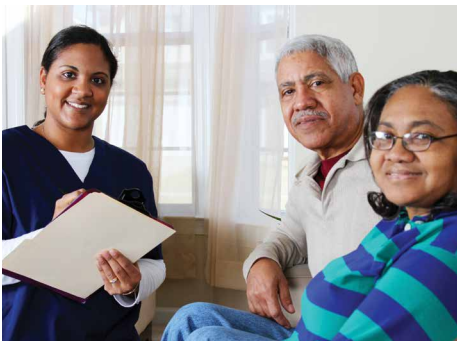
With input from AcademyHealth leadership and project partners, staff designed a semi-structured interview guide reproduced in Appendix A. Before each interview, staff provided the interviewee with a list of questions that focused on four broad areas: (1) interviewees' expected evidence and data needs over the next three to five years; (2) the ways in which interviewees and/or their organizations accessed and used analytic evidence, including HSR, to inform care delivery; (3) the ways in which interviewees and/or their organizations sought to identify and implement innovations in care; and (4) interviewees' experiences working with academic researchers and perspectives on how HSR could better inform delivery of care in safety net settings. For those interviewees employed outside a provider organization, we asked them to draw on their experience and expertise in safety net care to reflect on the most pressing issues facing providers now and into the future.



Two AcademyHealth staff members conducted each interview by phone, both posing questions to interviewees and taking notes. With the consent of interviewees, all interviews were audio recorded.

## Qualitative Analysis

AcademyHealth staff developed an a priori codebook and used qualitative data analysis software NVivo 10 to code verbatim transcripts of each interview for complex concepts as well as stated research and data needs in the safety net. The analysis focused on identifying key themes and diverse points of view that emerged within the semi-structured design of the study. Two AcademyHealth staff members blind-coded each transcript. Throughout the process, staff deliberated inconsistencies in transcript coding and added emergent codes based on discussions between coders. As a result, the code list was refined iteratively throughout the coding process. Appendix B reproduces the final code list.



The report that follows draws heavily on the use of verbatim quotes to illustrate each finding. In some cases, quotes were edited for grammar and length. To ensure candor in the interviews, we do not identify interviewees by name, nor do we attribute comments to interviewees' specific organizations. However, wherever possible, we precede the verbatim quotes with information about the respondent's role relative to the safety net, for example, as a provider, researcher, or other expert. We also attempt to indicate the general frequency with which particular points or themes arose over the course of the interviews.

The report includes results presented in four sections: (1) background on safety net health care in the United States; (2) interviewees' stated evidence needs; (3) interviewees' experiences with data, quality improvement, and research activities; and (4) interviewees' advice for researchers.



## Results

### Understanding Safety Net Care in the United States

The safety net health care system in the United States is not the uniform system that the name might imply, but instead a set of diverse institutions, clinics, and individual providers that serve some of the nation's most vulnerable individuals, regardless of their ability to pay. These organizations vary widely in how they are structured, financed and operated. The differences between organizations are largely shaped by factors at the state and local levels, particularly the health care needs of the local patient population.

In this section of the report, we provide a brief overview of safety net provider organizations, the patients they serve, and some of the relevant financial and policy issues they face. In doing so, we highlight comments from interviewees that, while not necessarily evidence needs, provide important contextual information for understanding the project findings that follow.

#### Safety Net Patient Populations

Safety net provider organizations, such as public hospitals, community health centers, and local health departments, serve a diverse group of patients that includes the uninsured, underinsured, Medicaid beneficiaries, and dual eligibles, among others. Safety net patient populations are often low income and may have complex medical and social needs. In the interviews conducted for this project, respondents cited the high number of chronic conditions such as diabetes, hypertension, obesity, and asthma among their patients, noting that it is not uncommon for patients to have multiple chronic conditions, which may also include mental illness or substance use disorders. Some interviewees noted that an added challenge is low health literacy among some safety net patients, which can make it difficult for them to follow discharge instructions and engage in other forms of self-care.

*“A couple of years ago, some of our nurses did a study because they were trying to figure out what was going on with the discharge process and why we were seeing so many of our patients coming back into the hospital from a specific unit. They actually took the discharge instructions and walked through them with patients and found out that our documents are written at a sixth grade level and the average health literacy for the patients that were being seen in their unit was third grade.”*

*-Interviewee*

Beyond literacy issues, safety net patients may experience economic and social challenges that add to the complexity of their care. Many respondents cited examples such as inadequate housing, lack of transportation, poor access to healthy food, and weak familial or social networks. In addition, several interviewees pointed to cultural differences within diverse patient populations that can impact how individuals seek and use care, an issue discussed later in this report. However, a few respondents, including a safety net hospital executive, cautioned against confusing patients' medical or economic vulnerability with a lack of determination or resolve.

*“This is quite a resilient population. I would like to know how many of us would be able to navigate four buses to get to work every day. [These] are some of the things that I think the population that we serve is doing every day that would really take most of us out.”*

-Interviewee

## Financial Viability in the Health Reform Era

Financial viability is a dominant concern for health care provider organizations across the country, and arguably, even more so among safety net providers using limited resources to serve high-need patients.

*“[It] often goes unstated but I think it’s the reality: the highest priority is economic survival...whether you’re a hospital or a clinician or anybody who serves any patient in the United States.”*

-Interviewee



The Patient Protection and Affordable Care Act (ACA), the major health reform law passed in 2010, broadened access to health insurance coverage through expansions in Medicaid eligibility and the creation of health insurance exchanges where qualifying low-income individuals and families can use subsidies to purchase private health care coverage. For safety net providers in some states, coverage expansions under the law mean that many previously uninsured patients now have insurance coverage, a change with potentially positive financial implications for these providers. The law also offers opportunities for safety net providers to participate in new models of delivering and paying for care that aim to improve health care quality and reduce overall costs. However, the law also carries some financial uncertainties for safety net provider organizations, particularly those located in the 19 states that have chosen not to expand Medicaid to date. For example, cuts to Medicaid Disproportionate Share Hospital (DSH) payments – a source of funding that policymakers assumed would not be needed as more people gain insurance coverage – are a key concern for safety net hospitals that continue to serve large numbers of uninsured patients. Hospital leaders are also concerned about benchmarks established as part of the ACA’s Hospital Readmissions Reduction Program, which imposes financial penalties on hospitals with excess 30-day readmissions. Some have claimed the program unfairly penalizes providers serving high numbers of low-income, high-need patients, a view that has received some support from recent research.<sup>6</sup> A safety net hospital leader was among those to raise this topic in the interviews.

*“We’re not used in creating the norm, but we’re going to be compared to the norm, then we’re going to lose that money, which is \$1.4 million we could use for access, care, and quality improvement.”*

-Interviewee

Concern over the readmissions penalties reflects a longstanding issue in safety net care: whether and how health care providers serving large numbers of high-need patients (relative to other providers) should be compensated differently for the services they provide. This issue of risk adjustment has been the topic of continued debate between providers, who feel they are not adequately compensated given the needs of their patients, and payers, who seek to keep costs down and incentivize high-quality health care. During the



interviews, a safety net-focused researcher recalled a related comment he heard during a project involving community health centers.

*“One person said it very well: ‘My diabetic who’s a homeless person living under a bridge is not the same as your diabetic who’s a millionaire.’”*

*-Interviewee*

Safety net provider organizations also face other financial concerns, such as the need to compete with private or not-for profit providers to attract and retain patients in their area. One safety net hospital executive described some of the challenges facing academic medical centers, known for their specialized services and research, education of medical professionals, and care of the very sick. This respondent noted that, because his organization is located in a service area that is not large enough to support a true academic medical center, the hospital is creating partnerships with other providers and expanding its services in the hopes of growing its patient base. It’s an example of the kinds of issues facing academic medical centers across the country.<sup>7</sup>

*“Pretty much all around the country, academic medical centers are trying to decide, ‘Do I have enough scale to survive and how will I link up with other entities in such a way that I get bigger scale and [become] dominant within a region?’”*

*-Interviewee*

Along similar lines, a few respondents noted that the ways in which some safety net provider organizations view themselves and their work is changing, due in part to financial pressures. For example, two hospital executives suggested that some safety net delivery systems are making a conscious effort to enhance their specialty services, attract a greater number of Medicare and privately insured patients, and establish themselves as the pre-eminent provider in their communities. In some cases, this means moving away from a “safety net” label.

*“We don’t want to be pigeonholed into that... We will live up to our safety net responsibilities and work with partners to a certain degree, but we don’t want to be viewed strictly as a safety net hospital. We’ve worked hard to broaden ourselves and be viewed as a major academic medical center.”*

*-Interviewee*

## **Partnerships with Community Organizations**

Given the types of financial challenges described above, safety net providers frequently partner with community organizations to help deliver services and improve the health of their patient population. Safety net providers may partner with a wide range of local organizations, such as school systems, social service agencies, churches, homeless shelters, medical respite programs, food pantries, and many other organizations, including other hospitals and clinics. In the interviews, a safety net hospital executive described his organization’s strategy for developing and leveraging partnerships with other providers.

*“We also, at the very beginning, set out to develop working relationships with other community providers, physicians and hospitals, with the intent of trying to develop win-win relationships. We felt that worked from both the public policy point of view as well as from a business perspective... We felt that lower acuity patients should stay at lower cost community facilities and not be dragged into academic medical centers. We felt that these [community] facilities, for the most part much smaller than us, are often, in a state like [ours], very important economic engines in their own counties.”*

-Interviewee

Another respondent, an executive in a public health care system, alluded to these partnerships as an important first step in addressing the health of populations.

*“At the population level, we have to begin to think outside of ourselves and in a more regional manner, and I think that is a unique challenge given our government structure. It’s certainly not something only our public system is dealing with. I think private systems also have to deal with this, it’s just a different set of issues... All of us need to figure out how do we come to the table as partners and how do we bring our government structures into that conversation and not use them as leverage or barriers. That’s one challenge or one opportunity.”*

-Interviewee

This interviewee was one of several people who described a growing focus among safety net systems on population health and the related challenges of defining one’s population, developing targeted strategies for improving health outcomes, and assessing whether those strategies made an impact.

*“With health reform and with these outcome-based payment schemes... how we define the population becomes really important. So for us as a safety net system, we are trying to figure out how to put boundaries around the population, particularly for payment purposes and for demonstration purposes, when we’ve not really done that [before].”*

-Interviewee

In discussing these and other challenges facing safety net providers, respondents expressed a desire for research findings that are practical, timely, and representative of safety net patient populations. In the next section, we take a closer look at the topics respondents identified as ripe for attention from the research community.

## Listening Project Interviewees' Stated Research Needs by Topic

- *Payment and Delivery System Reform*
- *Impact of Health Reform*
- *Care Coordination*
- *Patient Behavior and Engagement*
- *Non-medical Services and Supports*
- *Organizational Management*
- *Behavioral Health*
- *Implementation of Research*

## Evidence Needs

The primary purpose of this project was to help health services and policy researchers direct their efforts toward issues that are relevant and timely for safety net delivery system leaders and their staffs. Respondents identified eight areas where they believe new or better research is needed to help inform the delivery of care in safety net settings. With the exception of payment and delivery system reform, a topic cited across the interviews, the research areas that follow are not listed in priority order.

### Payment and Delivery System Reform

Across the interviews, respondents expressed significant interest in additional evidence on the impact of changes in health care service delivery and payment on safety net provider organizations. In particular, interviewees described the need for information that helps providers navigate the challenges and opportunities associated with the transition from fee-for-service payment to capitated arrangements and other forms of value-based payment.

#### Payment

Reflecting on the current state of payment reform, nearly all interviewees acknowledged the gradual move among payers towards value-based purchasing, which links provider payment to improved performance. While many interviewees noted that this shift could incentivize improvements in care, some expressed concern about the financial and logistical challenges providers face in successfully making the transition. One interviewee, a health policy advisor in a community health center network, noted that a chief need among safety net leadership is more information on how to effectively plan for the transition to value-based payment and predict the added financial risk of participation in this model.

*“We’d like to transition away from visits and more to the value of care that we can provide. But the cost analysis is really difficult for us to address because we are living on such a small margin...to reduce those visits would be very, very scary for us in terms of incurring financial risks without any sort of support and mechanisms [for] that transition.”*

*-Interviewee*

In light of the shift away from fee-for-service payment, many interviewees described the need for additional evidence on appropriate risk adjustment models as well as quality benchmarks that account for the severity of illness and socioeconomic challenges facing safety net populations. While a few people noted that risk adjustment is a well-documented and long-standing issue between safety net providers and payers, many respondents suggested that a renewed focus on this topic is needed in response to impending changes in payment.

*“If you are looking at benchmarks from someplace else, and there’s not a clear understanding of what is that culture or what are the demographics of the places that provided the benchmarks, then it’s really difficult to measure our data against data that’s coming from a suburban hospital that’s got 80 percent commercially-insured patients.”*

-Interviewee

In another line of comments, several interviewees described the need for evidence that could help safety net provider organizations assess their readiness to participate in accountable care organizations (ACOs) and other payment models with risk-sharing components. Interviewees suggested that providers are generally reluctant to engage in new payment models or pilots that involve financial risk to the provider organization. One interviewee, a hospital executive, suggested that this reticence is due in part to a lack of understanding of the true cost of delivering services.

*“... Many systems are going without knowing that true cost of care provision. It’s really difficult to take risk if you don’t know your costs....Somebody who makes a coffee pot knows more about the true cost of production than we do. I think it’s an unusual health system that has that level [of] data, but how do you take risk if you don’t know that? We take risks all the time with pretty incomplete data in that regard.”*

-Interviewee

In related comments, interviewees noted that many states have begun contracting with managed care organizations (MCOs) to provide some or all of the required health care services to Medicaid enrollees. Several interviewees suggested that these changes present opportunities for research evaluating the impact of managed care on costs, quality, and the patient experience, a theme also present in the Medicaid-focused Listening Project report. An interviewee from a state experiencing this growth in Medicaid managed care was among those to raise this issue.

*“How is [managed care] going to play out? What are going to be the implications? I think it’s a grand experiment and nobody is quite sure. I don’t think that managed care is the evil force that some people think it is. I see them really trying to implement controls that benefit their members but it also creates opportunities for research going forward...”*

-Interviewee

A quality improvement analyst from a community health center raised concerns about the impact of growth in managed care on patients and providers as both parties adjust to new rules around accessing care, quality reporting, and payment procedures. This interviewee noted that while new billing and reporting procedures have increased the administrative burden at her clinic, she is primarily concerned about patients’ ability to understand their managed care coverage and appropriately access care. This interviewee suggested that more research is needed regarding patients’ access to care in MCOs.

*“We’re afraid of what it will do to access for not only our patients but other community members that we might not be seeing right now. We see other kinds of public health issues that will spread because of people not getting the right treatment on time, people being admitted to the emergency room, or many people getting kicked off of their coverage because they’re accessing things inappropriately.”*

-Interviewee

Interviewees noted that safety net providers are at different stages of responding to changes in payment policy; some organizations are reacting to these changes as they are rolled out by public and private payers, while other providers are actively participating in payment-focused pilot programs. Given this variation among providers, several interviewees expressed an interest in learning from organizations that have already begun to make the transition.

*“We’re going to be interested in not recreating the wheel, but learning from folks who are further down the evolutionary path than we are. We’re going to be interested in best practices in terms of outcomes and efficiency.”*

-Interviewee

## Innovations in Care Delivery



Interviewees noted that many safety net provider organizations are implementing both small- and large-scale innovations in the ways they structure and provide services to patients. These innovations may include changes in clinic operations, workflow, or care delivery, such as changes to the ways patients are reminded of appointments or provided with discharge instructions. Larger-scale innovations may include participation in pilot programs such as the patient-centered medical home demonstration projects through the Centers for Medicare and Medicaid Services or state-based telehealth pilot programs aimed at increasing access to specialty services. The interviews suggest that while many safety net provider organizations implement these types of projects, they do not always have the resources to rigorously evaluate project outcomes, a theme referenced throughout this report.

Many interviewees described the challenges safety net providers face in demonstrating an intervention’s value to stakeholders, such as boards, executive leadership, payers, and legislators. Interviewees noted that while an intervention might make sense intuitively, providers face pressure to demonstrate a return on investment in order to justify continuing an initiative after the initial pilot or grant has ended. An interviewee from a community health center was among those to raise this issue.

*“When our administration is trying to make a decision that [an intervention] is worth doing, they look for things that don’t increase your number of visits, but increase the [the quality of] care. Anything that can prove it actually saves money down the line and helps patients...we can use it as ammunition to do the right things...”*

-Interviewee

A health department leader noted that this issue, discussed further in this report, is also a key concern for the public health community.

*“I am very confident that what we’re doing will pay off in the long run. But like a lot of things in public health, how do you prove [it]? If something doesn’t happen, if somebody doesn’t go on dialysis or if somebody doesn’t have a stroke, how do you prove that you did anything to help that?”*

-Interviewee

In another line of comments, several interviewees expressed the need for more evidence on the most effective primary care models for meeting the needs of diverse safety net populations. Some interviewees questioned whether a more tailored primary care model is needed for populations with particularly complex health and social needs, such as homeless individuals. One interviewee, the leader of a school-based health center network, questioned how best to care for people “living in the chaos of poverty.”

*“Is the model of primary care the same for our children who live in poverty as people who don’t? Because I’m not sure that that’s the way we practice it... Could we do a better job of providing primary care if we were trying to meet our customer’s demands by better understanding what those are?”*

-Interviewee

A safety net hospital leader also commented on this issue, describing a shift among some provider organizations toward designing care around the needs of patients and their families versus those of the health care provider or system.

*“Everyone’s talking about it so we’re not that unique, but moving away from, ‘What’s the matter with you?’ to ‘What matters to you?’ That’s around bringing in patients and family members... We just don’t have the time, money or skills and spirit to be working on things that don’t matter to the patient. That’s a really important design principle.”*

-Interviewee

In related comments, a few respondents raised questions about the effectiveness of specific models aimed at integrating care for vulnerable populations, such as health homes, a state Medicaid option created by the ACA. One interviewee, a community health center leader, noted the need for more information on the effectiveness of these models for patients with complex medical and social needs.

*“As we see the medical home and health home movement [working] to integrate behavioral and primary care and integrate social services support and the community health workers as physician extenders, work validating that model of care in terms of both health outcomes and the overall efficacy would be something that I would love.”*

-Interviewee



## Coverage Expansion under Health Reform

Interviewees expressed significant interest in the impact of health reform on safety net provider organizations and their patients, particularly the implications of increased coverage for providers’ finances and patients’ access to care. Under the ACA and a subsequent Supreme Court decision, states have the option of expanding Medicaid coverage to individuals with incomes up to 138 percent of the federal poverty level. This has potentially profound implications for safety net providers in the District of Columbia and the 30 states that have chosen to expand Medicaid to-date, as previously uninsured patients who frequent safety net facilities gain insurance coverage. A few interviewees noted significant declines in the number of uninsured patients at their organizations, including a physician leader who described the drop in his clinic’s uninsured rate – from nearly 50 percent to single digits – as “a huge win.”

However, most of the respondents who spoke about coverage expansions under the ACA were more cautious, noting that further research is needed to understand the experiences of safety net provider organizations in non-expansion states, as well as providers across the country whose patients do not meet eligibility criteria for coverage.

*“One area that’s really important to recognize is that these impacts are obviously not going to be uniform across the board depending on where these facilities are in terms of Medicaid expansion versus non-expansion states, but also in terms of the demographics of the populations that they’re serving...It’s going to make a big difference and it’s something that’s going to need to be monitored and potentially addressed in terms of trying to find solutions [for] how to continue to support these areas that really aren’t benefiting from more newly-insured patients, whether that’s Medicaid or new private coverage.”* -Interviewee

Some respondents raised research needs related to the positioning of safety net provider organizations in health plans offered on the federal, partnership, and state-based health insurance exchanges. In order to preserve continuity of care for the previously uninsured and meet increased demand for care in underserved communities, the ACA requires Qualified Health Plans offered on the exchanges to include a sufficient number of safety net provider organizations as “essential community providers.”<sup>8</sup> However, given variation across states in how the policy is implemented, there is some concern about the representation of safety net providers in exchange plans, as articulated by a safety net researcher.

*“I think the big issue is going to be how well Medicaid expansions are working in terms of getting people enrolled and covered for their health care, how laws that are meant to regulate system transformation are working for this group of providers. For example, the assumption [was] that safety net providers would be essential community providers in Qualified Health Plan networks, [yet] it is not at all clear that that’s really happening.”* -Interviewee

One interviewee employed by a safety net hospital expressed concern about the ability of newly insured patients to continue to seek care at her facility given the organization’s placement in plans’ networks.

*“It’s a great thing that exchanges are available to individuals with tax credits and the subsidies, but there’s also a lot of positioning going on in our marketplace, as across the country, in which the plans are creating tiers in their networks. So, other academic medical centers, like us, are ending up in tier two or out of networks all together.”* -Interviewee

In another line of comments, some interviewees raised questions about the experiences of safety net provider organizations in providing enrollment assistance to their patients, particularly community health centers, which receive dedicated funding for this purpose under the ACA. Some health centers have provided this type of assistance for years, as described by the leader of a school-based health center network that focuses not only on child health, but facilitating coverage for the entire family.

*“Maybe only Child A gets services, but the rest of the family walks out with health insurance after some period of time working with our team. That’s incredibly powerful and I think, again, post-health care reform, it may be another area that’s ripe for study to better understand the impact.”*

-Interviewee

Beyond enrollment, interviewees were interested in understanding whether newly insured patients would continue to seek care at safety net facilities or use their new coverage to go elsewhere. One respondent, a physician leader at a safety net hospital, noted that his organization’s longstanding relationships with vulnerable patients have kept these individuals coming back.

*“Just because they have Medicaid does not change that relationship. Our experience has been that they continue to come see us. They know us. They’re not shopping around for high-end providers who are going to take their Medicaid.”*

-Interviewee

Indeed, research examining changes in demand for care at safety net provider organizations in Massachusetts following that state’s health reform implementation found that patients generally stayed with their current safety net provider after gaining insurance.<sup>9</sup> However, as one safety net-focused researcher observed, this choice may depend on patients viewing their provider as accessible and providing high quality care.

*“Part of it may have to do with how good were the nature of the services that you had in your safety net facility. I think that’s always the case. If patients find that there’d be huge, long waits to get a service and you sort of feel that the quality of the care that you get isn’t very good, then necessarily, it doesn’t matter whether you’re a safety net facility versus a private facility. People are not going to want to go there.”*

-Interviewee

Along similar lines, another researcher suggested it will be important for safety net provider organizations to track trends in patient retention and identify ways to compete with other providers on patient satisfaction.

*“It is important to monitor the issues around retention of patients and the impact it has on the facilities and how it’s best to adapt to that because it is going to become more and more of an issue for the safety net. [Providers] are going to have to, at least in some local areas more than others, learn how to compete better and that’s going to be a big learning curve.”*

-Interviewee

The interviews suggest that some safety net delivery systems are less concerned about competing with other providers than meeting increased demand for care in their communities, an issue some respondents described as a top priority for some safety net providers. One interviewee described the need for more evidence on how providers might experiment with telemedicine and other innovative ways of seeing patients as a way to alleviate potential access challenges in states like California.



*“Now that we have 1.4 million people entering the system, a lot of them going into safety net settings, how do we make sure we don’t have these gigantic wait lists? ...Are there alternatives to the face-to-face visit and are there ways to get people the care they need without the traditional model of how they’re seen?”*

-Interviewee



Despite coverage gains in some regions, respondents noted that safety net delivery systems will continue to serve many uninsured patients, especially in non-expansion states and in areas with high numbers of patients who do not qualify for coverage under expanded Medicaid, such as undocumented immigrants. Some interviewees noted it will be important to assess how these providers are faring, especially given reductions in DSH payments and cuts in funding for local indigent care programs. One person commented that some newly insured patients remain underinsured, resulting in another source of uncompensated care for some providers.

### Care Coordination

Across the interviews, respondents raised a number of questions about the most effective models of coordinating care for complex, high-need populations. In particular, respondents described the difficulty of determining which components of a care coordination model or intervention actually work.

*“What are the elements of [care coordination] that really make a difference? Is it the amount of patient service representative support or clinical interventionists who are following up on the clinical aspect? Is it the community health workers? Is it the actual technology platform?”*

-Interviewee

As suggested above, part of the issue is determining the right combination of health care personnel.

*“There is the issue of team-based care and the best ways to utilize different sorts of personnel to take care of safety net populations... we don’t really know still what are the best mixes, roles, responsibilities, and organizations for this type of team-based care and coordination of care.”*

-Interviewee

In related comments, several respondents identified the need for evidence that helps safety net providers determine the appropriate level of care coordination and case management required for patients of varying needs.

*“What are the factors that best determine which people benefit from more intensive face-to-face case management? There’s a lot of talk about stratification. There is not a lot of research on which are the most effective methodologies for doing stratification.”*

-Interviewee

Interviewees noted that clinical and executive leaders in safety net hospitals are interested in evidence to help them effectively transition patients from hospitalization to home care and community-based treatment, an issue with particular salience given the penalties established under the ACA's Hospital Readmissions Reduction Program. One interviewee, a researcher, raised this issue and highlighted the importance of communication and data sharing.

*“How do primary care providers know their patients enter the hospital or the emergency department, and how do you make that transition as seamless as possible so that people are getting the appropriate follow-up care they need? How can people parse out what really works in those settings? Then there are a lot of questions around how you get the data to the right people.”*

-Interviewee

Another respondent noted that data sharing and information exchange has added complexity when a patient receives care in multiple managed care networks.

*“We’ve seen that in some communities that have multiple Medicaid managed care plans, the way in which the plans chose to include different providers didn’t necessarily correspond to the traditional referral patterns that existed within the system... The most basic thing of coordination of care is will one organization take the other organization’s patient and then will they share some information back and forth?”*

-Interviewee

Pointing to the growth of telemedicine, some interviewees posed questions about how best to leverage this technology to implement effective and cost efficient models of care coordination. Several respondents noted that many safety net providers are piloting efforts in telehealth despite the upfront investment in infrastructure and barriers to reimbursement. In light of these concerns, interviewees cited the need to understand how safety net providers can best use emerging technology to improve care coordination while efficiently managing staff time and reducing costs.

*“Everybody’s been dabbling in telehealth for 25 years...I think there’s so much more that can be done with it, but how do we do it? If it is going to save dollars and [improve] population health, then I think [providers] will start using it... but if you can’t bill for it, nobody is going to use it.”*

-Interviewee

## **Patient Behavior and Engagement**

Interviewees described the need for additional evidence on the factors that influence patients’ perceptions of health and health care, their health behaviors, and their interactions with the health care system. Beyond documenting the influence of these factors, safety net health systems also seek evidence that outlines effective strategies for actually changing patient behavior in support of improved health.

## Understanding Factors Influencing Patient Behavior

Noting the significant economic, social, and environmental challenges often faced by safety net patient populations, respondents expressed interest in understanding the variety of factors that influence patients' attitudes about health care and their health care-seeking behaviors. One respondent, a state health official, was among those to raise this issue.

*"I think that the concept of the safety net really has to be refined from the standpoint of figuring out what prevents people who may be ill from using care. Some of them are afraid of a diagnosis. Some of them are afraid of the bill..."* -Interviewee

Within this line of comments, several respondents pointed to the need for more information on the impact of factors such as culture, language, and immigration status on a patient's health care-seeking behavior. One interviewee, a research director in a community health center network, raised this issue in the context of immigration status.

*"There are so many additional dimensions that are added to a person's health care-seeking behavior and attitude from being an immigrant, and it is an area of research that I think is underdone."* -Interviewee

Another interviewee, a community health center leader, suggested that understanding a patient's cultural heritage might provide insights into his or her health behaviors and perceptions of health.

*"People will often throw together Latinos, Hispanics, but one of the things we also know is that just because somebody speaks Spanish doesn't mean an Argentinean looks at health the same way as someone from Central America. That's a challenge. It's not a 'can't-do-it', but it's a challenge."* -Interviewee

## Promoting Patient Behavior Change

Several interviewees described the need for research that moves beyond simply documenting the influences on patient behavior and instead uses information on these factors to identify effective strategies for promoting behavior change among diverse populations. Respondents expressed particular interest in additional evidence on interventions that aim to change behavior through improvements in health literacy and adoption of culturally sensitive practices.

*“I think patient behavior modification is also a really big one especially as it relates to literacy and multiple languages... how do we get people who have very complicated lives to be able to change their behavior given all the constraints they have? On the commercial side, I think there are huge opportunities there where we just don’t know very well so we keep pushing on the same levers that don’t seem to be working.”*

-Interviewee

In another line of comments, some interviewees, particularly staff at community health centers, raised questions about the effectiveness of electronic patient portals and other efforts aimed at collecting and sharing health information with patients. One interviewee, a researcher and clinician, described the need for research on whether these efforts are accessible and comprehensible to safety net populations with low literacy levels and those whose first language is not English.

*“If we look at patient-facing technology, we’ve made this large policy investment in personal health records or patient portals... and we don’t know if diverse patients actually can, will, want to or do use them....There has been pretty minimal effort to make it available in other languages or to assess its literacy....That means doing things like qualitative interviews, usability testing, and large observational studies.”*

-Interviewee

In related comments, several respondents expressed an interest in effective strategies for improving patients’ health literacy as it relates to the larger health care system, noting that patients need to understand not only their own health, but how to use the health care system as a whole.

*“For many people, it is not just about understanding what insurance and copays are, but really how it works and how to utilize primary care.”*

-Interviewee

Finally, several interviewees described an interest in working with community partners on efforts to improve health literacy and engage with diverse patient populations, suggesting that organizations such as churches, community centers, and schools may help extend the efforts of safety net provider organizations, a theme seen throughout this report.



## **Non-medical Services and Supports**

Many respondents raised questions about the role of safety net providers in addressing patients’ social determinants of health, factors outside the health care system such as access to healthy food, transportation, and housing that may affect a person’s health. In the interviews, respondents mentioned a variety of small- and large-scale efforts taking place at their organizations that directly provide or connect patients with non-medical services and supports, such as transportation to and from clinic visits or access to fresh produce.

Several respondents described the need for research that goes beyond documenting the link between patient health and various social determinants of health to actually evaluating the effectiveness of health system and community-level interventions.

*“The safety net certainly doesn’t need any convincing that [non-medical services and supports] are important, but there might need to be more information on what is the best way to implement and finance these kinds of support services and to coordinate providing these services, either through the safety net provider or through partnerships with community-based organizations. What are the best models that provide care more efficiently and more effectively that meets the non-medical needs of patients?”*

-Interviewee

In related comments, interviewees suggested that more research is needed to parse out the most effective components of interventions addressing non-medical needs in order to identify where to devote limited resources.

*“Many of the other things that we do within the clinics such as interpretation, coordinating benefits, making sure people are signed up for entitlements, transportation, and things like that, we know that if we don’t do that for our patients, they’re not going to come to appointments. They’re not going to improve their health because a lot of it is something that’s provided by us. So, one of the things that would be helpful is to know what kind of supportive services are really making an impact so we know where to target because right now it’s really piecemeal.”*

-Interviewee

Many providers noted that they collaborate or have collaborated previously with community organizations in order to address social determinants among their patients, but more information is needed on the most effective ways to create and sustain these partnerships, particularly after seed money or grant funding has run out. One respondent, a provider and researcher focusing on child health, noted that there is a need to clarify and formalize these partnerships in order to develop collective responsibility for improving the health of vulnerable populations.

*“I think one thing that’s not done well enough is how community-based organizations, including physicians, organize themselves and their resources to address the ecological needs of families...It all goes back to ‘it takes a village’ but the point is, who’s in-charge of that village? How do we organize it? Because if no one’s in-charge, then there’s no accountability or everyone’s only accountable for their piece of the pie, which doesn’t include accountability for the overall child health.”*

-Interviewee

## **Organizational Management**

Several interviewees described the need for evidence that helps inform the effective organization and management of safety net provider organizations. These comments focused primarily on how to leverage the structure of safety net institutions and the skills, attitudes, and responsibilities of health care professionals in order to provide high quality care for patients. For example, a few respondents raised the topic of leadership, questioning whether there are leadership characteristics of top-performing organizations that might be emulated elsewhere.

*“Look at all the FQHCs [federally-qualified health centers] in the country and tell me what the common themes on leadership [are] for the organizations that are in the top decile of quality metrics. I want to copy them...I think I know, but I would love to see, “These four things need to happen at the leadership level for our quality metrics to improve or for access to improve or [for] costs to be contained.”*

-Interviewee

Other interviewees raised evidence needs related to the identification and training of effective managers, an issue that one respondent, a physician with both clinical and academic experience, identified as a persistent challenge throughout his career.

*“How do we figure out what good management should look like? ...I think the research really needs to start with, how do you identify people with the potential to do this? What are the personality traits that allow us to engage in this?”*

-Interviewee

Another respondent, a safety net hospital executive, questioned how provider organizations should integrate physicians into leadership positions. This respondent noted that his organization, which lacks physicians with leadership training, has started to include physicians in strategy-focused meetings with the aim of expanding their perspectives and helping them become more business-oriented.

In another line of comments, some respondents described the difficulty of enacting change in safety net provider organizations, a challenge that is not unique to these institutions. These comments primarily focused on the challenges associated with motivating behavior change among an organization's staff. The quality director at a safety net hospital described this issue in the context of implementation of an electronic health records system.

*“I don't know that I would know how to do anything else and many of the physicians and nurses are in the same position. They've been doing it for so long in this way it's hard to imagine doing it another way...as we move to [EHRs], we are having a hard time getting them to go on and do that sort of thing. In fact, they are still handwriting orders and putting them in the chart. It just doesn't work.”*

-Interviewee

Some respondents described a role for the research community in helping identify effective strategies for promoting behavior change among leadership and staff within safety net provider organizations, perhaps by applying relevant insights from the business and management literature. Echoing comments cited later in this section about implementation of research findings, a few respondents, including two safety net hospital executives, indicated that simply having a good idea is not enough if staff in the organization cannot or will not adopt it.

*“Understanding the study is one thing. Using information to change physician behavior [is] a whole different animal. Once you understand what you want to do, then you’ve got to change physician behavior.”*

-Interviewee

*“You [need to] have the right culture to match with the strategy you just thought up, because our predicament typically is we have better strategies than we have the cultural appetite to change.”*

-Interviewee

## Behavioral Health

Behavioral health, including the prevention and treatment of mental illness and substance use disorders, was another high-priority research area raised in the interviews. In particular, several respondents described the need for additional evidence on models for effectively integrating physical health and behavioral health services, a need that reflects the challenges in caring for patients with both a significant behavioral health diagnosis and a major medical condition.

*“As you know, in most states, Medicaid physical and mental health delivery models are completely separate in their payment model and in the actual delivery system. That’s completely unbelievable because these are the most complex patients...Anytime you have a behavioral health diagnosis it radically increases the cost of physical health issues, even if it’s as simple a thing as pregnancy. So, that whole issue about the best models for integration – what are they? Are there models that produce better outcomes?”*

-Interviewee

*“What are the most critical elements [of integrated models]? What’s good to have but not critical? What is it that patients most value?”*

-Interviewee

In commenting on integration, some interviewees cited the need for evidence that helps safety net hospitals and community health centers partner most effectively with the community-based providers that deliver the majority of behavioral health services in some areas. A physician leader at a safety net hospital was among those who raised this issue.

*“A lot of the behavioral health care occurs in communities, delivered by small agencies scattered throughout the community, and leveraging those resources and creating those connections most effectively is really important...so, how much of that do you co-locate? How much of that do you try to take out into the community or into the home or wherever the patient resides? There are lots of really interesting and simple, elegant research questions there.”*

-Interviewee

One interviewee, the CEO of a behavioral health provider organization, described several ways in which his organization provides behavioral health services as part of a larger integrated health system, for example, by embedding psychiatrists and social workers in primary care offices and placing screening teams in hospital emergency departments. As part of the latter work, the organization is experimenting with how best to provide

wrap-around services to frequent emergency department users. Yet a continuing challenge, identified here and echoed elsewhere in this report, is determining exactly which interventions work and for whom.

*“[When] you’ve got 42 variables, do we really know what piece made the impact? I think it would be [useful] from a research perspective as we engage in some of these unique pilots, are we setting them up in ways that really allow us to determine what factors created the biggest impact?”*

-Interviewee

Closely related is the challenge faced by behavioral health care providers in demonstrating the value of their services to health plans, hospitals, and others. This challenge was articulated by the CEO of an organization providing services for substance use disorders.

*“If you look at health outcomes, they are immensely improved by substance abuse disorder treatment, for example, or the management of mental health issues, so you save money on the physical health side...nowhere is there a good accounting system, for one thing, or research that is meaningful at the level that I can go to a health plan or hospital and say, ‘This is how much money I’m saving you.’”*

-Interviewee

In another line of comments, several respondents described the need for evidence on effective strategies for identifying, managing, and even preventing behavioral health issues before they reach crisis levels that are costly for both patients and providers. Some interviewees indicated that this work must involve addressing underlying socioeconomic issues that can mitigate the benefit of health care services.

*“Treating somebody for their mental illness or for their addiction and then sending them back in the community where they don’t have appropriate housing or access to appropriate food or transportation to ongoing medical appointments is really just a set up to have them go through the revolving door of the ED.”*

-Interviewee

Similarly, a few respondents noted that partnerships with organizations outside of the health care system present promising opportunities for getting ahead of behavioral health issues more effectively and systematically. A couple of people, including a safety net hospital executive, raised this point in the context of the criminal justice system.

*“How do we leverage those hundreds of thousands of law enforcement encounters to really push [care] further out into the community and how do we get out of the walls of the hospital and the health center proper and start working with these other sectors to introduce an intervention in a place that’s not only less risky, [but] more affordable and sustainable?”*

-Interviewee

Finally, some interviewees described high-priority needs related to the training and availability of new behavioral health professionals and the resources available to support technology investment. While these topics were not associated with specific research questions, they provide further insight into the issues that are top-of-mind for safety net provider organizations serving large numbers of patients with behavioral health needs.



*“Mental health across the board is so poorly funded. The infrastructure is nowhere near what it is for physical health and a variety of policy issues that are behind the problem would be ripe for further study.”*

-Interviewee

## Implementation of Research

When asked about areas where new or better evidence could help inform the delivery of safety net care, some interviewees emphasized that, beyond the production of new research, safety net delivery system leaders seek evidence that helps them implement existing research findings in their unique settings. Several respondents expressed frustration with the presumption that the uptake of study findings by delivery system leaders is something of a given.

*“...it isn't as simple as you do the research and you prove a superior approach and then everybody adopts it. So that's the part I'm troubled by. What do we know about the science of adoption and what can we do to accelerate the adoption of proven evidence-based practices?”*

-Interviewee

*“We need to understand that the delivery of care is not about the clever ideas. It's about executing and operationalizing and implementing in a credible, sustainable fashion. [I've] heard a lot of lip service given to all of those things, but if I've opened up, you name the journal...98 percent of it is not useful information for us as we try to actually take care of patients.”*

-Interviewee

The latter speaker, a physician with experience in both academic and policy settings, was among the interviewees who identified implementation of research findings as their highest priority evidence need. A few interviewees stated outright that they would prefer evidence that helps them implement a proven innovation over new research findings that lack practical application. This sentiment was expressed by a physician researcher with extensive safety net hospital experience.

*“[People in the] safety net constantly tell me, 'I don't want a new shiny thing. I want everybody in my system to be performing at the level of the high performers. I want the pilots or the innovations that originate within my system spread throughout it. I want innovations that are coming from other systems that are peer institutions. I want to understand how they were able to do that innovation and how I can put it into practice.' That's what they want. So they do not want another secondary analysis with a bunch of Medicaid data, they do not want another randomized trial, because those things are not helpful.”*

-Interviewee

As suggested above and discussed further in the following section of this report, many interviewees cited peer organizations as an important source of information for safety net delivery systems. A central challenge, however, is determining whether a promising intervention from a peer organization is the right fit for another provider's setting, and if so, how the intervention should be implemented most effectively. As one physician leader noted, the type of information that's most helpful to safety net decision makers isn't necessarily in the published literature.

*“Probably some of the most effective innovations aren’t being written about at all in the traditional literature. Much of it is in the grey literature. How do you begin to understand and have a way of weighing evidence that’s in the grey literature and pulling it in or making it accessible as appropriate?”*

-Interviewee

In discussing the spread of innovations in care, several interviewees described the need for evidence that helps safety net leaders tailor an intervention to the specific needs of different patient populations, for example, according to severity of illness, cultural background, or socioeconomic status, a theme that emerged throughout the interviews.



## Data, Quality Improvement, and Research

In addition to asking about high-priority evidence needs, we asked interviewees to comment on the availability and use of data in safety net provider organizations, approaches to quality improvement in these organizations, and the extent to which safety net provider organizations are interested and able to conduct research or evaluation projects for both internal use and external dissemination.

### Data Challenges

Interviewees indicated that data is used in safety net delivery systems for a variety of purposes: to comply with reporting requirements, for quality improvement projects, to inform broader decisions around care delivery, and to a lesser extent, to engage in research for dissemination in peer-reviewed publications. While the interviews suggest there is variation among safety net provider organizations in their ability and interest in collecting and analyzing data, respondents identified a number of shared challenges associated with accessing data, translating it into meaningful information, and using that information to address the types of evidence needs described in this report.

For example, interviewees noted that many provider organizations are inundated with patient data following the implementation of electronic health records (EHRs) and other data collection and integration efforts. Respondents from both hospitals and community health centers suggested that this influx of data, combined with lack of staff time, capacity, and barriers to data sharing across organizations, limits the ability of many provider organizations to mine available data and convert it into actionable information.

*“Suddenly we have all this data but we have no easy way to mine it, to use it. We’re overwhelmed by the amount of data we have and getting it organized is very hard.”*

-Interviewee

*“The data submission requirements are enormous. People are not stopping to take the time to put the data together to see the complete picture.”*

-Interviewee

One interviewee, an expert with experience working with safety net health systems, described the challenge of using a variety of data sources to inform improvements in care delivery.

*“How do we take advantage of the fact that we have all this new data from EHRs? There are great geographic information system (GIS) data, community level data, so how do we start using that to manage patients differently and improve the health of the community?”*

-Interviewee

The interviews suggest that safety net provider organizations are also interested in using data to track patients’ perceptions of quality and satisfaction with the care they receive. Several interviewees noted that coverage expansions under the ACA have played a significant role in this trend as providers seek to retain newly insured patients who now have increased choice of providers. The challenge for providers, as articulated by one respondent, is accessing the right data and knowing how to leverage it.

*“I think there are a number of different factors that are pushing people to really care about patient experience, yet we have terrible data. We don’t know exactly, especially for underserved populations, what works. Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys are required by some of the commercial plans and Medicare. There’s no requirement for Medicaid health plans...People don’t know how to get real time data and use it to drive change. Given that [safety net providers] can’t spend a lot of money on redoing their waiting rooms and redoing a lot of the physical space issues, what else can they be focusing on that makes a difference?”*

-Interviewee

In another line of comments, a few interviewees raised questions about the impact of Meaningful Use requirements enacted under the Health Information Technology for Economic and Clinical Health (HITECH) Act on safety net providers and their patients. These requirements, rolled out in three phases, offer financial incentives to providers for adopting EHRs, using them to promote care coordination and information sharing with patients, and demonstrating improved outcomes.<sup>10</sup> A quality director at a community health center was among those to raise this issue.

*“Has it made a difference? I’d really like somebody to take a look at Meaningful Use, almost like a cost-benefit analysis in addition to [looking at] patient outcomes, and see what effect it has had because it’s really not – we don’t see it as meaningful to our patients, to be quite honest.”*

-Interviewee

## Quality Improvement

The interviews suggest that safety net provider organizations engage in a number of quality improvement activities aimed at improving the quality and efficiency of care for their patients. These activities may range from introducing a chronic disease management program, to investing in telehealth, to modifying reading levels in patient discharge instructions. Respondents noted that the type, size, and duration of these activities are often dependent on a variety of factors, including the type of provider organization, available funding, staff capacity, and the organization's current priorities. One respondent, a safety net hospital leader, reflected on his experiences with quality improvement.

*“Nobody’s going to tell you that a lot of these things aren’t worth doing. The question that comes up over and over again is how do you afford to do this given all the various constraints? We can think of 25 things to do. We have one resource to devote.”*

-Interviewee

Several respondents noted that, amid resource constraints and competing priorities, safety net provider organizations often look to peer organizations for guidance on promising quality improvement activities. As discussed further in the box below, several respondents described the value of these peer-to-peer exchanges over findings from the academic literature, which some people viewed as having limited applicability to safety net settings. Other interviewees, including a quality director at a community health center, described a process of experimentation largely informed by the organization's own data.

*“If we can get some loose guidance, some evidence-based resources like the ones I’ve mentioned, [then] we do [them]. But otherwise, we try and see what works and if outcomes are going the right way then keep on plugging the right way.”*

-Interviewee

The interviews suggest that, to a lesser extent, safety net provider organizations partner with external researchers to implement and evaluate innovations in care. During the interviews, respondents generally did not articulate the difference between a quality improvement project and a research project, though most seemed to associate “research” with rigorous methods, long timeframes, and publishable findings. Defined this way, some interviewees noted that their organizations simply do not engage in this type of activity.

## Sources of Information

As part of the interviews, we asked respondents about sources of information that safety net delivery system leaders use to help inform decisions about care delivery and the management of their organizations. Interviewees indicated that safety net leaders usually turn to peer organizations and connect with each other through direct relationships or through regional, state, or national networks, including those established by trade organizations.



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*“I think everybody looks to the high profile, clinically integrated enclosed networks to see what they’re doing and how that might be able to translate to not so integrated networks, which is probably more typical throughout the country. So what are the Cleveland Clinics or Intermountain or the Kaiser, what are they doing to be able to provide the integration?”*

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One interviewee, a physician in a large safety net health system, noted the usefulness of learning communities that convene providers around shared goals. This respondent provided the example of a collaborative event around innovation in patient-centered medical homes.

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*“We have a lot of the same issues ...It was really about getting some engaged leaders and teams at each of the clinics to start learning about patient-centered medical home innovation. Everything from group visits to e-visits, how to use your data systems, how do you look at your data, then how do you innovate around that.”*

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Interviewees noted that while some safety net leaders read high-profile, peer-reviewed journals, this is not a significant information source for most organizations given challenges associated with accessing gated content, applying findings to safety net populations, and devoting time and energy to this activity amid competing priorities.

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*“Not that we ignore published literature...It is nice and helpful, and we use evidence-based practices in what we do so we’re very interested in those kinds of interventions that have passed peer review. But in terms of the structure of delivery of services and how we partner with people at this point, not a lot of that’s guided by research; more of it is guided by speculation...”*

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One interviewee also noted the usefulness of grey literature for providing more timely evaluations than what is available in most peer-reviewed literature.

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*“A lot of the evaluation needs are not like the usual studies. They’re more like rapid and informative type of evaluations to help people learn from what works quickly.”*

*“We found out that for our health center physicians, if they wanted to do research they would have stayed in academia... Our physicians don't have the time or necessarily the interest and motivation to pursue what's really required for research.”*

-Interviewee

Safety net providers who do participate in more formal research activities cited a number of challenges in doing this work, described further in the box below.



### **Safety Net Providers' Participation in Research**

Safety net provider organizations that engage in more formal research activities do so either through the use of staff to evaluate and publish on a particular project, or by partnering with external researchers to plan, implement, and evaluate an intervention. Interviewees noted that providers may face several challenges in carrying out this work, such as navigating the grant application process, gaining Institutional Review Board (IRB) approval, collecting and managing data, and mitigating the burden on patients and staff.

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*“Everyone thinks it's so easy to get this consent or do this for the IRB or just add this to your workflow. We're already stretched thin. So, any change to workflow is really hard.”*

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Other respondents, including a community health center leader, described the challenge of keeping up with required grant deliverables and renewal processes without staff trained in grants management.

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*“There has been a lot of conflict in terms of meeting deadlines for projects that we just can't meet because we just don't have the infrastructure for it. We don't have a dedicated grant research department or a grant specialist that understands the nuances and the differences between an operational grant and a research grant.”*

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Several interviewees noted that their organizations rely on internal committees to review proposals from external researchers seeking to conduct a study with their patients, staff, or data. These committees are meant to ensure that study objectives align with the organization's priorities and that the study design is not onerous for patients or staff.

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*“It is important that [the project] could be done in such a way that confidentiality is key, consent is clearly not connected to patient care, it doesn't disrupt workflows, and it's not going to be a demand on the organization which we can't provide.”*

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## Advice for Researchers

During the interviews, respondents were asked whether they had advice for health services researchers seeking to produce useful work for safety net delivery systems. In one line of comments, several interviewees described ways in which researchers might better collaborate with safety net provider organizations to “co-produce” research that meets the needs of both parties. In particular, respondents advised that successful co-production of research is facilitated when the researcher:

- Actively consults with the provider organization in shaping the goals and activities of the research project.

*“We haven’t found too many research partners who are interested in really collaborating with us from the bottom up. Meaning, ‘What are the questions that you’re interested in answering for yourself internally? Let’s refine those questions, let me help you with the methodology to answer that question and then let’s write something up; together we can find funding for it if needed.’”*

-Interviewee

- Considers the feasibility and potential burden of different research designs and activities given the financial, staffing, and other resource constraints facing the provider organization.

*“Be sensitive to the impact that you have on clinical operations when you’re trying to run a study, especially clinical operations that are small in scale. When you have a single provider, asking that provider to do anything is going to have a significant impact on their ability to see patients. The margins in the setting are so tight that it puts a lot of stress on the system.”*

-Interviewee

- Offers the provider organization compensation for its role in the project.

*“Very few safety nets have any money. So [researchers] are going to get them to cooperate if they come in with funding sources, particularly if they have people that can help them gather data.”*

-Interviewee

- Includes a staff member from the provider organization as co-principal investigator on the project.

*“It’s really important for it to be a true collaboration where the health center is an equal partner with the research institution...it should be a partnership and they should be much more interdependent on each other.”*

-Interviewee

- Produces findings that can help inform decision-making by the provider organization beyond the life of a single grant.

*“When it’s appropriate, we feel like these research projects should also build infrastructure in the health center so that it can leave the body of knowledge and expertise beyond the actual outcomes.”*

-Interviewee

## Communication of Research Findings

Several interviewees also offered suggestions for how researchers might better communicate the results of their work to leaders in safety net delivery systems. Citing the technicality of the academic literature, some interviewees encouraged researchers to learn to speak and write using clear language that is meaningful to clinicians, health system executives, and others. A few people, including a former academic currently employed by a community health center network, described a communication gap between researchers and the business leaders who can initiate change within an organization.

*“We’ve been trained to write in a particular style, but that style is very different than you would see in a magazine or see in a newspaper...I think communication tools have to be devised to better translate not only to clinicians what’s coming out of the research community, but to translate to leaders in the health care community because it has to be a partnership.”*

-Interviewee

Interviewees also suggested tailoring a publication’s length and detail according to the needs of the intended audience. One person suggested that when writing for health system leaders, researchers should be brief, practical, and to the point, while clinicians or others who implement interventions will want more detail. Several respondents pointed to the usefulness of one-page research briefs or syntheses that describe the problem being examined, the intervention tested, and the outcomes, with links or citations that direct the reader to more information. Interviewees cited clear statements about the research methods and study limitations as especially important.

*“When I look at an article that’s got all kinds of numbers and equations in it, I’m out. That’s nice if I am also a researcher, but I’m not.”*

-Interviewee

*“There’s got to be a simpler way of expressing research methods...When people write up their [research] summaries, they often write a summary of their findings but they don’t explain in simple terms how they went about doing the study and why the methods are designed to control for things that might throw the results off and what the limits are, what you can’t infer from the study. That is, to me, the cardinal offense.”*

-Interviewee



The latter speaker, an academic with safety net expertise, went on to describe the role of “policy translators” in helping health system leaders interpret and understand findings out of the academic literature. For example, a policy translator may be an academic who has established trusted relationships with health policymakers or health system leaders and may be called upon to help decision makers understand the evidence on a given topic.

*“If you’re trying to run a health center or a hospital today, you can’t read this stuff. You’re looking for the Sacagaweas out there whom you’ve developed some relationship with, who are going to do the translating, whose translations you know you can read, and we in turn as the Sacagaweas are looking for the researchers who will work with us by getting [us] something very simple.”*

-Interviewee

It is worth noting that advice around translating research findings was also a theme in previous Listening Project interviews with Medicare and Medicaid policymakers, respectively.

## Discussion And Next Steps

Findings from AcademyHealth’s Listening Project provide useful insights into the issues that are top-of-mind for leaders in safety net delivery systems and highlight opportunities for health services researchers to work collaboratively with providers to explore these topics. The interviews conducted for this project suggest that:

- **Safety net providers generally see the value of research as a resource for helping inform decision-making.**



Providers and other safety net experts interviewed for this project identified a range of topics where new or better research would be useful to them. An important caveat is that for research to be perceived as valuable, it must reflect the realities and priorities of safety net institutions and their patients and be available to providers in a format and language that is accessible.

- **Safety net providers particularly value information that helps them implement evidence-based practices in their unique settings.**

Interviewees reiterated a desire among safety net provider organizations to implement, scale, and spread promising innovations in care developed in their systems or in those of peer organizations. Respondents generally did not view the peer-reviewed literature as providing useful insights into the practical application of research findings and encouraged further work by researchers in this area.

- **Many safety net providers wish to better assess the effectiveness of their quality improvement efforts, which may or may not involve formal research activities.**



Many providers expressed a desire to better understand the effectiveness of interventions implemented within their organizations, noting the difficulty of teasing out which changes in care lead to improved outcomes, for whom, and why. While some providers interviewed for this project conduct formal, rigorous evaluations as part of their quality improvement projects, other organizations lack the interest, ability, or capacity to incorporate traditionally-defined research activities into their day-to-day work.

- **Safety net providers wish to be treated as partners in research studies involving their patients, data, or other resources.**

Many safety net providers interviewed for this project expressed openness to working with external researchers on research studies, but cited frustrations with projects that they view as resource intensive, overly burdensome on patients or staff, or misaligned with the organization's priorities. These providers suggested that research findings are most likely to be useful and used when the external researcher consults with staff in the formulation of research questions, suggests a study design that is least burdensome on patients and staff, provides staff with actionable project findings, and generally treats the provider organization as an equal partner in the work.



We recognize that there were topics interviewees did not mention or emphasize as much as expected. For example, content experts asked to review an earlier version of this report noted few or no comments about issues such as opiate abuse and substance abuse more generally; veteran's health; rural health; reproductive health services; and trauma-informed care and resiliency. A possible explanation is that these issues simply did not rise to the top of the discussion during the approximately 60 minutes we had for each interview.

Following the lead of our previous Listening Project reports, AcademyHealth will share findings from the safety net interviews through a variety of channels, including professional meetings. Through these and other activities, we hope to spur discussion among the producers, funders, and users of research about opportunities for strengthening the evidence available to help inform safety net care.

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## Endnotes

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# Appendix A

## Instrument Used for Semi-Structured Interviews

### Organization Background

1. What is the demographic make-up of your patient population? Has it changed in recent years? Are you anticipating future change in the patients you serve? Why?
2. What is your role within the organization? How long have you been in this role?
3. What additional external community organizations, stakeholders, or (non-patient) individuals do you interact with? Why and in what way?

### High-Priority Issues and Research Needs

1. What are the most significant issues related to the financing, organization, and delivery of care for underserved populations that you expect your organization/other safety net providers to face three years from now? Five years from now?
2. Do you see a role for researchers in helping address these issues? If so, how?
3. How can the research community be most helpful in providing relevant, research-based evidence to you and your organization?

### Identification and Implementation of Innovations

1. To what extent does your organization attempt to identify evidence-based innovations in provider payment or the organization and delivery of care? (Examples may include potential ACO participation, bundled payment approaches, novel ways of diagnosing, preventing, or managing chronic illness, care coordination, etc.)
  - 1.1. If so, how do you identify these innovations? To what extent do you rely on published peer-reviewed literature? Summaries of research and specific innovations in trade publications and other non-peer reviewed sources? Conferences and professional associations? Word of mouth?
  - 1.2. What information would your organization need in order to introduce a particular innovation?
  - 1.3. How do you evaluate the appropriateness of the innovation for your organization?
2. What types of innovations in the organization or delivery of care has your organization introduced in the last three to five years? How did they come about? Have they been successful?

### Sources of Information

1. Are there key sources you rely on for research or other evidence on the health care system?
2. Are there any specific key sources your quality assurance/quality improvement professionals rely on to identify innovations and best practices for safety net delivery systems?
3. In general, who/what do you consider trusted sources of technical information in terms of trying to improve the delivery of care? Are there common sources you consider untrustworthy in some way? Why?
4. What do you think is the most useful format for receiving information about the results of a research study?
5. Do you currently work with researchers (off-site or embedded)?
  - 5.1. If so, how? How has that experience gone?
  - 5.2. What are the benefits and challenges of such collaborations? What makes for a good academic collaboration? Bad collaboration?
  - 5.3. If you've had experience with embedded health services researchers, how did that come about? How were researchers used and with what results?
  - 5.4. What advice would you give to health services researchers interested in conducting research in safety net settings?
6. What didn't we ask that we should have?

## Appendix B

### Final Codebook Used to Analyze Interviews

Parent Code	Child Code	Definition
Advice		Advice to health services researchers on improving how research is produced or communicated.
Behavioral Health		Issues or research questions related to behavioral health, including mental illness and substance use disorders.
Care Coordination and Transitions		Issues or research questions related to the coordination of care for safety net patients, including transitions between care settings.
Chronic Disease Management		Issues or research questions related to the care of patients with chronic conditions.
Data Collection and Reporting		Comments about the data collection and reporting practices of safety net delivery systems, including issues around data availability and quality. Does not include comments about the use of data for research and evaluation projects.
	EHRs	
	Comments about the use of data from electronic health records (EHRs) by safety net delivery systems.	
Financial Viability		Issues or research questions regarding the financial viability or sustainability of safety net delivery systems.
	DSH Payments	Issues or research questions regarding reductions in Disproportionate Share Hospital (DSH) payments under the Affordable Care Act.

	Risk Adjustment	Issues or research questions related to changes in provider payment to account for the treatment of complex and/or vulnerable populations.
	Primary Care Payment Increase	Issues or research questions related to the effect of the temporary primary care payment increase under the Affordable Care Act.
Implementation of Research		Comments about the implementation of research findings in safety net delivery systems.
Insurance Eligibility and Enrollment		Issues or research questions about the eligibility or enrollment of safety net populations in health insurance coverage, including comments about the role of safety net providers in helping patients enroll in coverage.
Medicaid Expansion		Issues or research questions about the implications of Medicaid coverage expansion or non-expansion, including comments about the characteristics and health care needs of the newly-insured.
Miscellaneous		Comments worth noting that do not fit in any other category.
Non-medical Services and Supports		Issues or research questions about the non-medical needs of safety net patients and the role of safety net delivery systems in addressing these needs.
Organizational Management		Issues or research questions related to how safety net delivery systems are organized and managed, including issues around individual and organizational behavior change.
Patient Behavior and Engagement		Issues or research questions about patients' health care decision-making and/or engagement with the health care system, including strategies for prompting behavior change.

	Culturally Appropriate Care	Issues or research questions about the provision of health care services to patients from diverse racial and ethnic groups.
Payment and Delivery System Reform		Issues or research questions regarding payment or delivery system transformation, including the move from fee-for-service payment to value-based payment approaches.
	ACOs	Issues or research questions related to accountable care organizations (ACOs) or other similarly structured models.
	Health Homes	Issues or research questions related to health homes or other similar care models.
Pharmaceuticals		Issues or research questions related to development, cost, or coverage of drugs and the general role of pharmaceuticals in health care.
Public and Population Health		Issues or research questions related to public or population health as it relates to safety net delivery systems.
Quality Improvement and Innovation		Comments, issues, or research questions related to the quality improvement activities of safety net delivery systems, including comments about how innovations in care delivery are identified, implemented, and evaluated.
Quotes		Comments from the interviews that we may want to reproduce as quotes in the report.
	Anecdotes	Case studies from the interviews that we may want to highlight in the report.
Research Interest and Infrastructure		Comments or issues related to the interest and ability of safety net delivery systems to conduct their own research or evaluation projects beyond regular data reporting and analysis activities.

Safety Net Environment		General comments about safety net providers and the patients that they serve, including common challenges and opportunities.
Sources of Information		General comments about sources of evidence and other information used by safety net delivery systems to help inform decision-making or increase understanding of an issue. Does not include comments about use of internal data and analyses to inform decision-making.
Specific Patient Populations		Issues or research questions about specific patient populations served by safety net delivery systems.
Telemedicine		Issues or research questions about the delivery of health care services using telemedicine, including issues around reimbursement.
Workforce		Issues or research questions related to the health care workforce, including adequacy, capacity, team composition, and scope of practice.