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ORIGINAL RESEARCH

Understanding How to Improve Collaboration Between Hospitals and Primary Care in Postdischarge Care Transitions: A Qualitative Study of Primary Care Leaders' Perspectives

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BACKGROUND: There is limited collaboration between hospitals and primary care despite parallel efforts to improve postdischarge care transitions.

OBJECTIVE: To understand what primary care leaders perceived as barriers and facilitators to collaboration with hospitals.

METHODS: Qualitative study with in-depth, semistructured interviews of 22 primary care leaders in 2012 from California safety-net clinics.

RESULTS: Major barriers to collaboration included lack of institutional financial incentives for collaboration, competing priorities (e.g., regulatory requirements, strained clinic capacity, financial strain) and mismatched expectations about role and capacity of primary care to improve care transitions. Facilitators included relationship building through interpersonal networking and improving communication and information transfer via electronic health record (EHR) implementation.

CONCLUSIONS: Efforts to improve care transitions should focus on aligning financial incentives, standardizing regulations around EHR interoperability and data sharing, and enhancing opportunities for interpersonal networking. *Journal of Hospital Medicine* 2014;9:700–706. © 2014 Society of Hospital Medicine

Poorly coordinated care between hospital and outpatient settings contributes to medical errors, poor outcomes, and high costs.[1–3] Recent policy has sought to motivate better care coordination after hospital discharge. Financial penalties for excessive hospital readmissions—a perceived marker of poorly coordinated care—have motivated hospitals to adopt transitional care programs to improve postdischarge care coordination.[4] However, the success of hospital-initiated transitional care strategies in reducing hospital readmissions has been limited.[5] This may be due to the fact that many factors driving hospital readmissions, such as chronic medical illness, patient education, and availability of outpatient care, are outside of a hospital's control.[5,6] Even among the most comprehensive hospital-based transitional care intervention strategies, there is little evidence of active engagement of primary care providers or collaboration between hospitals and primary care practices in the transitional care planning process.[5] Better engagement of primary care into transitional care strategies may improve postdischarge care coordination.[7,8]

The potential benefits of collaboration are particularly salient in healthcare safety nets.[9] The US health safety net is a "patchwork of providers, funding, and programs" unified by a shared mission—delivering care to patients regardless of ability to pay—rather than a coordinated system with shared governance.[9] Safety-net hospitals are at risk for higher-than-average readmissions penalties.[10,11] Medicaid expansion under the Affordable Care Act will likely increase demand for services in these settings, which could worsen fragmentation of care as a result of strained capacity.[12] Collaboration between hospitals and primary care clinics in the safety net could help overcome fragmentation, improve efficiencies in care, and reduce costs and readmissions.[12–15]

Despite the potential benefits, we found no studies on how to enable collaboration between hospitals and primary care. We sought to understand systems-level factors limiting and facilitating collaboration between hospitals and primary care practices around coordinating inpatient-to-outpatient care transitions by conducting a qualitative study, focusing on the perspective of primary care leaders in the safety net.

STUDY DATA AND METHODS

We conducted semistructured telephone interviews with primary care leaders in health safety nets across California from August 2012 through October 2012, prior to the implementation of the federal hospital readmissions penalties program. Primary care leaders

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were defined as clinicians or nonclinicians holding leadership positions, including chief executive officers, clinic medical directors, and local experts in care coordination or quality improvement. We defined safety-net clinics as federally qualified health centers (FQHCs) and/or FQHC Look-Alikes (clinics that meet eligibility requirements and receive the same benefits as FQHCs, except for Public Health Service Section 330 grants), community health centers, and public hospital-affiliated clinics operating under a traditional fee-for-service model and serving a high proportion of Medicaid and uninsured patients.[9,16] We defined public hospitals as government-owned hospitals that provide care for individuals with limited access elsewhere.[17]

Sampling and Recruitment

We purposefully sampled participants to maximize diversity in geographic region, metropolitan status,[18] and type of county health delivery system to enable identification of common themes across different settings and contexts. Delivery systems were defined as per the Insure the Uninsured Project, a 501(c)(3) nonprofit organization that conducts research on the uninsured in California.[19] Provider systems are counties with a public hospital; payer systems are counties that contract with private hospitals to deliver uncompensated care in place of a public hospital; and County Medical Services Program is a state program that administers county health care in participating small counties, in lieu of a provider or payer system. We used the county delivery system type as a composite proxy of available county resources and market context given variations in funding, access, and eligibility by system type.

Participants were identified through online public directories, community clinic consortiums, and departments of public health websites. Additional participants were sought using snowball sampling. Potential participants were e-mailed a recruitment letter describing the study, its purpose, topics to be covered, and confidentiality assurance. Participants who did not respond were called or e-mailed within 1 week. When initial recruitment was unsuccessful, we attempted to recruit another participant within the same organization when possible. We recruited participants until reaching thematic saturation (i.e., no further new themes emerged from our interviews).[20] No participants were recruited through snowballing.

Data Collection and Interview Guides

We conducted in-depth, semistructured interviews using interview guides informed by existing literature on collaboration and integration across healthcare systems[21–23] (see Supporting Information, Appendix 1, in the online version of this article). Interviews were digitally recorded and professionally transcribed verbatim.

We obtained contextual information for settings represented by each respondent, such as number of clinics and annual visits, through the California Primary Care Annual Utilization Data Report and clinic websites.[24]

Analysis

We employed thematic analysis[25] using an inductive framework to identify emergent and recurring themes. We developed and refined a coding template iteratively. Our multidisciplinary team included 2 general internists (O.K.N., L.E.G), 1 hospitalist (S.R.G.), a clinical nurse specialist with a doctorate in nursing (A.L.), and research staff with a public health background (J.K.). Two team members (O.K.N., J.K.) systematically coded all transcripts. Disagreements in coding were resolved through negotiated consensus. All investigators reviewed and discussed identified themes. We emailed summary findings to participants for confirmation to enhance the reliability of our findings.

The institutional review board at the University of California, San Francisco approved the study protocol.

RESULTS

Of 52 individuals contacted from 39 different organizations, 23 did not respond, 4 declined to participate, and 25 were scheduled for an interview. We interviewed 22 primary care leaders across 11 California counties (Table 1) and identified themes around factors influencing collaboration with hospitals (Table 2). Most respondents had prior positive experiences collaborating with hospitals on small, focused projects. However, they asserted the need for better hospital–clinic collaboration, and thought collaboration was critical to achieving high-quality care transitions. We did not observe any differences in perspectives expressed by clinician versus nonclinician leaders. Nonparticipants were more likely than participants to be from northern rural or central counties, FQHCs, and smaller clinic settings.

Lack of Institutional Financial Incentives for Collaboration

Primary care leaders felt that current reimbursement strategies rewarded hospitals for reducing readmissions rather than promoting shared savings with primary care. Seeking collaboration with hospitals would potentially increase clinic responsibility for postdischarge patient care without reimbursement for additional work.

In counties without public hospitals, leaders worried that collaboration with hospitals could lead to active loss of Medicaid patients from their practices. Developing closer relationships with local hospitals would enable those hospitals to redirect Medicaid patients to hospital-owned primary care clinics, leading to a loss of important revenue and financial stability for their clinics.

TABLE 1. Characteristics of Study Participants

	No. (%)
Leadership position	
Chief executive officer or equivalent*	9 (41)
Chief medical officer or medical director	7 (32)
Other†	6 (27)
Clinical experience	
Physician (MD or DO)	15 (68)
Registered nurse	1 (5)
Nonclinician	6 (27)
Clinic setting	
Clinic type	
FQHC and FQHC Look-Alikes	15 (68)
Hospital based	2 (9)
Other	5 (23)
No. of clinics in system	
1–4	9 (41)
5–9	6 (27)
≥10	7 (32)
Annual no. of visits	
<100,000	9 (41)
100,000–499,999	11 (50)
≥500,000	2 (9)
County characteristics	
Health delivery system type	
Provider‡	13 (59)
Payer§	2 (9)
County Medical Services Program‖	7 (32)
Rural county	7 (32)

NOTE: **Abbreviations:** DO, doctor of osteopathy; FQHC, federally qualified health center; MD, medical doctor.

*Equivalent = executive director or director.

†Includes clinic/site directors and local experts on quality improvement.

‡Counties with public hospitals.

§Counties that contract with private providers in lieu of a public hospital.

‖A statewide program that administers county health services underserved individuals in participating small counties in lieu of a public hospital or a payer system.

A subset of these leaders also perceived that nonpublic hospitals were reluctant to collaborate with their clinics. They hypothesized that hospital leaders worried that collaborating with their primary care practices would lead to more uninsured patients at their hospitals, leading to an increase in uncompensated hospital care and reduced reimbursement. However, a second subset of leaders thought that nonpublic hospitals had increased financial incentives to collaborate with safety-net clinics, because improved coordination with outpatient care could prevent uncompensated hospital care.

Competing Clinic Priorities Limit Primary Care Ability to Focus on Care Transitions

Clinic leaders struggled to balance competing priorities, including strained clinic capacity, regulatory/accreditation requirements, and financial strain. New patient-centered medical home initiatives, which improve primary care financial incentives for postdischarge care coordination, were perceived as well intentioned but added to an overwhelming burden of ongoing quality improvement efforts.

Mismatched Expectations About the Role and Capacity of Primary Care in Care Transitions Limits Collaboration

Many leaders felt that hospitals undervalued the role of primary care as stakeholders in improving care transitions. They perceived that hospitals made little effort to directly contact primary care physicians about their patients' hospitalizations and discharges. Leaders were frustrated that hospitals had unrealistic expectations of primary care to deliver timely postdischarge care, given their strained capacity. Consequently, some were reluctant to seek opportunities to collaborate with hospitals to improve care transitions.

Informal Affiliations and Partnerships, Formed Through Personal Relationships and Interpersonal Networking, Facilitate Collaboration

Informal affiliations between hospitals and primary care clinics helped improve awareness of organizational roles and capacity and create a sense of shared mission, thus enabling collaboration in spite of other barriers. Such affiliations arose from existing, longstanding personal relationships and/or interpersonal networking between individual providers across settings. These informal affiliations were important for safety-net clinics that were FQHCs or FQHC Look-Alikes, because formal hospital affiliations are discouraged by federal regulations.[26]

Opportunities for building relationships and networking with hospital personnel arose when clinic physicians had hospital admitting privileges. This onsite presence facilitated personal relationships and communication between clinic and hospital physicians, thus enabling better collaboration. However, increasing demands on outpatient clinical productivity often made a hospital presence infeasible. One health system promoted interpersonal networking through regular meetings between the clinic and the local hospital to foster collaboration on quality improvement and care delivery; however, clinical productivity demands ultimately took priority over these meetings. Although delegating inpatient care to hospitalists enabled clinics to maximize their productivity, it also decreased opportunities for networking, and consequently, clinic physicians felt their voices and opinions were not represented in improvement initiatives.

Outside funding and support, such as incentive programs and conferences sponsored by local health plans, clinic consortiums, or national stakeholder organizations, enabled the most successful networking. These successes were independent of whether the clinic staff rounded in the hospital.

Electronic Health Records Enable Collaboration By Improving Communication Between Hospitals And Primary Care

Challenges in communication and information flow were also challenges to collaboration with hospitals.

TABLE 2. Key Themes and Subthemes on Factors Affecting Collaboration

Theme	Subtheme	Quote
Lack of institutional financial incentives for collaboration.	Collaboration may lead to increased responsibility without reimbursement for clinic.	*Where the [payment] model breaks down is that the savings is only to the hospital; and there's an expectation on our part to go ahead and take on those additional patients. . . . If that $400,000 savings doesn't at least have a portion to the team that's going to help keep the people out of the hospital, then it won't work.* (Participant 17)
	Collaboration may lead to competition from the hospital for primary care patients.	*Our biggest issues with working with the hospital. . .[are] that we have a finite number of [Medicaid] patients [in our catchment area for whom] you get larger reimbursement. For a federally qualified health center, it is [crucial] to ensure we have a revenue stream that helps us take care of the uninsured. So you can see the natural kind of conflict when your pool of patients is very small.* (Participant 10)
	Collaboration may lead to increased financial risk for the hospital.	*70% to 80% of our adult patients have no insurance and the fact is that none of these hospitals want those patients. They do get disproportionate hospital savings and other things. . .but they don't have a strong business model when they have uninsured patients coming in their doors. That's just the reality.* (Participant 21)
	Collaboration may lead to decreased financial risk for the hospital.	*Most of these patients either have very low reimbursement or no reimbursement, and so [the hospital doesn't] really want these people to end up in very expensive care because it's a burden on their system. . .philosophically, everyone agrees that if we keep people well in the outpatient setting, that would be better for everyone. No, there is no financial incentive whatsoever for [the hospital] to not work with us.* [emphasis added] (Participant 18)
Competing priorities limit primary care's ability to focus on care transitions.		*I wouldn't say [improving care transitions is a high priority]. It's not because we don't want to do the job. We have other priorities. . . . [T]he big issue is access. There's a massive demand for primary care in our community. . .and we're just trying to make sure we have enough capacity. . . . [There are] requirements HRSA has been asking of health centers and other priorities. We're starting up a residency program. We're recruiting more doctors. We're upping our quality improvement processes internally. We're making a reinvestment in our [electronic medical record]. . . . It never stops.* (Participant 22)
		The multitude of [care transitions and other quality] improvement imperatives makes it difficult to focus. . . . It's not that any one of these things necessarily represents a flawed approach. . . . It's just that when you have a variety of folks from the national, state, and local levels who all have different ideas about what constitutes appropriate improvement, it's very hard to respond to it all at once. (Participant 6)
Mismatched expectations about the role and capacity of primary care in care transitions limit collaboration.	Perception of primary care being undervalued by hospitals as a key stakeholder in care transitions.	*They just make sure the paperwork is set up.and they have it written down, "See doctor in 7 days." And I think they [the hospitals] think that's where their responsibility stops. They don't actually look at our records or talk to us.* (Participant 2)
	Perceived unrealistic expectations of primary care capacity to deliver postdischarge care.	*[The hospital will] send anyone that's poor to us whether they are our patient or not. . . . [T]hey say "go to [our clinic] and they'll give you your outpatient medications." [But] we're at capacity. . . . [W]e have a 7–9 month wait for a [new] primary care appointment. So then, we're stuck with the ethical dilemma of [do we send the patient back to the ER/hospital] for their medication or do we just [try to] take them in?* (Participant 13)
		The hospitals feel every undoctored patient must be ours. . . . [But] it's not like we're sitting on our hands. We have more than enough patients. (Participant 22)
Informal affiliations and partnerships, formed through personal relationships and interpersonal networking, facilitate collaboration.	Informal affiliations arise from existing personal relationships and/or interpersonal networking.	*Our CEO [has been here] for the past 40 years, and has had very deep and ongoing relationships with the [hospital]. . . . Those doors are very wide open.* (Participant 18)
	Informal partnerships are particularly important for FQHCs.	*As an FQHC we can't have any ties financially or politically, but there's a traditional connection.* (Participant 2)
	Increasing demands on clinical productivity lead to a loss of networking opportunities.	*We're one of the few clinics that has their own inpatient service. . . . I would say that the transitions between the hospital and [our] clinic start from a much higher level than anybody else. . . . [However] we're about to close our hospital service. . . . It's just too much work for our [clinic] doctors.* (Participant 8)
		There used to be a meeting once a month where quality improvement programs and issues were discussed. Our administration eliminated these in favor of productivity, to increase our numbers of patients seen. (Participant 12)
	Loss of relationships with hospital personnel amplifies challenges to collaboration.	*Because the primary care docs are not visible in the hospital. . .[quality improvement] projects [become] hospital-based. . . . Usually they forget that we exist.* (Participant 11)
	External funding and support can enable opportunities for networking and relationship building.	*The [national stakeholder organization] has done a lot of work with us to bring us together and figure out what we're doing [across] different counties, settings, providers. . . .* (Participant 20)
Electronic health records enable collaboration by improving communication between hospitals and primary care.	Lack of timely communication between inpatient and outpatient settings is a major obstacle to postdischarge care coordination.	*It's a lot of effort to get medical records back. . . . It is often not timely. . . . Patients are going to cycle in and out of more costly acute care because we don't know that it's happening. Communication between [outpatient and inpatient] facilities is one of the most challenging issues.* (Participant 13)
	Optimism about potential of EHRs.	*A lot of people are depending on [the EHR] to make a lot of communication changes [where there was] a disconnect in the past.* (Participant 7)
	Lack of EHR interoperability.	*We have an EHR that's pieced together. The [emergency department] has their own [system]. The clinics have their own. The inpatient has their own. They're all electronic but they don't all talk to each other that well.* (Participant 20)

TABLE 2. *Continued*

Theme	Subtheme	Quote
		Our system has reached our maximum capacity and we've had to rely on our community partners to see the overflow. . .. [T]he difficult communication [is] magnified. . .. (Participant 11)
	Privacy and legal concerns (nonuniform application of HIPAA standards).	*There is a very different view from hospital to hospital about what it is they feel that they can share legally under HIPAA or not. It's a very strange thing and it almost depends more on the chief information officer at [each] hospital and less on what the [regulations] actually say.* (Participant 21)
		Yes, [the EHR] does communicate with the hospitals and the hospitals [communicate] back [with us]. . .. [T]here are some technical issues, but. . .the biggest impediments to making the technology work are new issues around confidentiality and access. (Participant 17)
	Interpersonal contact is still needed even with robust EHRs.	*I think [communication between systems is] getting better [due to the EHR], but there's still quite a few holes and a sense of the loop not being completely closed. It's like when you pick up the phone—you don't want the automated system, you want to actually talk to somebody.* (Participant 18)

NOTE: **Abbreviations:** CEO, chief executive officer; ER, emergency room; FQHC, federally qualified health center; EHR, electronic health record; HIPAA, Health Insurance Portability and Accountability Act; HRSA, Health Resources & Services Administration.

No respondents reported receiving routine notification of patient hospitalizations at the time of admission. Many clinics were dedicating significant attention to implementing electronic health record (EHR) systems to receive financial incentives associated with meaningful use.[27] Implementation of EHRs helped mitigate issues with communication with hospitals, though to a lesser degree than expected. Clinics early in the process of EHR adoption were optimistic about the potential of EHRs to improve communication with hospitals. However, clinic leaders in settings with greater EHR experience were more guarded in their enthusiasm. They observed that lack of interoperability between clinic and hospital EHRs was a persistent and major issue in spite of meaningful use standards, limiting timely flow of information across settings. Even when hospitals and their associated clinics had integrated or interoperable EHRs (n = 3), or were working toward EHR integration (n = 5), the need to expand networks to include other community healthcare settings using different systems presented ongoing challenges to achieving seamless communication due to a lack of interoperability.

When information sharing was technically feasible, leaders noted that inconsistent understanding and application of privacy rules dictated by the Health Insurance Portability and Accountability Act (HIPAA) limited information sharing. The quality and types of information shared varied widely across settings, depending on how HIPAA regulations were interpreted.

Even with robust EHRs, interpersonal contact was still perceived as crucial to enabling collaboration. EHRs were perceived to help with information flow, but did not facilitate relationship building across settings.

DISCUSSION

We found that safety-net primary care leaders identified several barriers to collaboration with hospitals: (1) lack of financial incentives for collaboration, (2) competing priorities, (3) mismatched expectations about the role and capacity of primary care, and (4) poor communication infrastructure. Interpersonal networking and use of EHRs helped overcome these obstacles to a limited extent.

Prior studies demonstrate that early follow-up, timely communication, and continuity with primary care after hospital discharge are associated with improved postdischarge outcomes.[8,28–30] Despite evidence that collaboration between primary care and hospitals may help optimize postdischarge outcomes, our study is the first to describe primary care leaders' perspectives on potential targets for improving collaboration between hospitals and primary care to improve care transitions.

Our results highlight the need to modify payment models to align financial incentives across settings for collaboration. Otherwise, it may be difficult for hospitals to engage primary care in collaborative efforts to improve care transitions. Recent pilot payment models aim to motivate improved postdischarge care coordination. The Centers for Medicare and Medicaid Services implemented two new Current Procedural Terminology Transitional Care Management codes to enable reimbursement of outpatient physicians for management of patients transitioning from the hospital to the community. This model does not require communication between accepting (outpatient) and discharging (hospital) physicians or other hospital staff.[31] Another pilot program pays primary care clinics $6 per beneficiary per month if they become level 3 patient-centered medical homes, which have stringent requirements for communication and coordination with hospitals for postdischarge care.[32] Capitated payment models, such as expansion of Medicaid managed care, and shared-savings models, such accountable care organizations, aim to promote shared responsibility between hospitals

and primary care by creating financial incentives to prevent hospitalizations through effective use of outpatient resources. The effectiveness of these strategies to improve care transitions is not yet established.

Many tout the adoption of EHRs as a means to improve communication and collaboration across settings.[33] However, policies narrowly focused on EHR adoption fail to address broader issues regarding lack of EHR interoperability and inconsistently applied privacy regulations under HIPAA, which were substantial barriers to information sharing. Stage 2 meaningful use criteria will address some interoperability issues by implementing standards for exchange of laboratory data and summary care records for care transitions.[34] Additional regulatory policies should promote uniform application of privacy regulations to enable more fluid sharing of electronic data across various healthcare settings. Locally and regionally negotiated data sharing agreements, as well as arrangements such as regional health information exchanges, could temporize these issues until broader policies are enacted.

EHRs did not obviate the need for meaningful interpersonal communication between providers. Hospital-based quality improvement teams could create networking opportunities to foster relationship-building and communication across settings. Leadership should consider scheduling protected time to facilitate attendance. Colocation of outpatient staff, such as nurse coordinators and office managers, in the hospital may also improve relationship building and care coordination.[35] Such measures would bridge the perceived divide between inpatient and outpatient care, and create avenues to find mutually beneficial solutions to improving postdischarge care transitions.[36]

Our results should be interpreted in light of several limitations. This study focused on primary care practices in the California safety net; given variations in safety nets across different contexts, the transferability of our findings may be limited. Second, rural perspectives were relatively under-represented in our study sample; there may be additional unidentified issues specific to rural areas or specific to other nonparticipants that may have not been captured in this study. For this hypothesis-generating study, we focused on the perspectives of primary care leaders. Triangulating perspectives of other stakeholders, including hospital leadership, mental health, social services, and payer organizations, will offer a more comprehensive analysis of barriers and enablers to hospital–primary care collaboration. We were unable to collect data on the payer mix of each facility, which may influence the perceived financial barriers to collaboration among facilities. However, we anticipate that the broader theme of lack of financial incentives for collaboration will resonate across many settings, as collaboration between inpatient and outpatient providers in general has been largely unfunded by payers.[37–39] Further, most primary care providers (PCPs) in and outside of safety-net settings operate on slim margins that cannot support additional time by PCPs or staff to coordinate care transitions.[39,40] Because our study was completed prior to the implementation of several new payment models motivating postdischarge care coordination, we were unable to assess their effect on clinics' collaboration with hospitals.

In conclusion, efforts to improve collaboration between clinical settings around postdischarge care transitions will require targeted policy and quality improvement efforts in 3 specific areas. Policy makers and administrators with the power to negotiate payment schemes and regulatory policies should first align financial incentives across settings to support postdischarge transitions and care coordination, and second, improve EHR interoperability and uniform application of HIPAA regulations. Third, clinic and hospital leaders, and front-line providers should enhance opportunities for interpersonal networking between providers in hospital and primary care settings. With the expansion of insurance coverage and increased demand for primary care in the safety net and other settings, policies to promote care coordination should consider the perspective of both hospital and clinic incentives and mechanisms for coordinating care across settings.

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