PAYER-PROVIDER ROLE CONFLICT IN MUNICIPAL SAFETY-NET HEALTH SYSTEMS.

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Abstract

Little scholarly attention is paid to inherent conflict in safety-net health systems in which local governments both finance and deliver health services. In this paper, four typologies of role conflict are used to describe and illustrate role incompatibility in the Los Angeles County Public Safety-Net System and other municipal Safety-Net Health Systems which act as both payers and providers of health care. By connecting the dots between the potential negative outcomes conceptually illustrated in the case study and similar outcomes in empirical studies on Los Angeles County, the study suggest that the existence of role conflict in Municipal Health Care Systems can have negative effects on provider job satisfaction and the quality of health services. Governance, policy, and organizational context remedies are recommended to address potential ills of role conflict. Future directions for research are also suggested.

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Key Words:
Role Conflict and Role Ambiguity in Public Health Systems, Safety-Net Health Systems, Value incompatibility in health systems, Municipal Health Systems, Financing and Delivery Models in Public Health Systems, Emerging Organizational Configurations in Safety-Net Systems.

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BACKGROUND

Introduction

New health financing strategies in the last quarter of the 20th Century including the extension of market strategies to Medicaid, global budgets, and prospective payment systems (Folland et al., 1997; Henderson, 2005) have led to the cohabitation of financing and delivery functions in the same health care entities. Commonly known models that combine financing and delivery functions are Health Maintenance Organizations (HMOs) and other forms of Managed Care Organizations. While scholarly literature and media reports have focused on the potential ills in risk-sharing arrangements between providers and managed care organizations (Gold,1998, Miller 1998; Hillman, 1998; US General Accounting Office, 1993; Bloche, 1999), less attention is paid to inherent conflict in safety-net health systems in which local governments both finance and deliver health services. In this paper, four typologies of role conflict are used to describe and illustrate role incompatibility in the Los Angeles County Public Safety-Net System and other municipal Safety-Net Health Systems which act as both payers and providers of health care. Governance, policy, and organizational remedies are recommended to address potential ills of role conflict. Future directions for research are also suggested.

An understanding of organizational role conflict in municipal health systems is critical because the potential victims of role conflict in municipal health systems are the most vulnerable members of the United States society. Services offered by Los Angeles County's institutional providers, like other services in safety-net health systems, are predominantly used by disadvantaged classes including ethnic minorities, low income, the disabled and children.

This paper also sheds light on the health services payer function of local governments. The payer role of local governments is not usually that obvious since the local government is not a financier of health care in the traditional context. Local governments are usually not regarded by the public or in health care literature as payers. The payer role of Los Angeles County and other local governments is therefore not usually subjected to the level of scrutiny it deserves given the vulnerability of the beneficiaries or victims of local government actions.

Role conflict and role ambiguity can affect organizational outcomes and the nature of the impact is moderated by organizational and individual factors. Because of its potential and documented negative impact, a conceptual description of role conflict in municipal safety-net health systems and the identification of a practice, policy and research road map to better understand this phenomenon and avert its ills is critical.

Role Conflict in Organizations

Organizational roles are expected behaviors of persons in formal positions in relation with the behaviors or expectations of other organizational members so as to yield a predictable outcome (Katz & Kahn 1978, Naylor *et al.* 1980). An organizational role set constitutes organizational members who interact with the role incumbent in order to yield organizational outcomes. Members of the role set also make up a communication network which sends messages to the role incumbent who is the target (Focal) of the network's communication. The role incumbent is the Focal or focus of all communication and expectations in the network.

Role conflict occurs when role incumbents/Focal have more than one expectation occurring simultaneously with mutually exclusive compliance required. Performing one expectation undermines the performance of the other to

an extent (Katz and Kahn, 1978; Kahn et al., 1964; Kahn, 1996). Role ambiguity occurs when the person performing the role does not know what he is supposed to do (Kahn et al., 1964; Kahn, 1996). Role conflict and role ambiguity have a joint interactive effect on job performance, (Fried et. al., 1998) and can predict personal accomplishments (Peiro, Gonzalez-Roma, & Manas, 2001).

In this paper, organizational factors are framed in two ways: (1) a view of organizations as role incumbents who experience role conflicts and (2) the examination of organizational behavior and structures which affect role incumbents in the role system. The literature on the social psychology of organizations generally ascribes role behavior to individual organizational members and not to organizations or their subsystems (Durkheim, 1947; Katz & Kahn, 1978). However, within an open system framework, an organization and its subsystems like other role incumbents can be regarded as role incumbents or focal entities responding to expectations from stakeholders who make up their role set. This perspective is necessary because the formal goals of the organization to a good extent determine the role expectations of its members. Also, the identity of the organization and the role it assumes in the bigger social system, as well as the role it gives to its own subsystems drives these goals. Katz & Kahn (1978), argue that to understand role behavior, we have to understand the relevant social systems and subsystems and locate activities that interact to transform inputs into outputs. Zald (1962), states that in its quest for maintenance and survival, an organization will exert a variety of influences on organizational members and subsystems[1] in order to direct the organization in one direction or another. A mental hospital organized as a

[1] My addition. Zald did not explicitly state that sub-systems are part of the influenced entities.

custodial institution in time will begin to look like a custodial institution. Within Zald's reasoning, a provider institution organized as a payer organization may in time begin to behave like a payer organization. Oneil et al. (2001), in recognizing the ability of organizations to influence the role behavior of its members, proposed a model that will use structure and culture to guide employee behavior towards strategic goals and minimize equivocation and uncertainty.

Power and importance are critical constructs in our understanding of coping behavior in a role conflict or role ambiguity environment. The relative power of a role sender (or of a role network) over a Focal is liable to affect the impact of expectations. The power of the role sender has been shown to have varying impact on the focal including the following: role behavior or actions driven by moral-expedient orientations to expectations (Gross, Mason, and McEachern (1957); performance and satisfaction (Pruden & Reese,1972); perception or amount of experienced role conflict (Van Sell et. al., 1981; Naylor, Pritchard, and Ilgen,1980); and role commitment and identity salience (Adler & Adler,1987). Coping is less likely to be successful when the role set is powerful than when a role sender is less powerful (Siegall & Cummings, 1995).

Role Conflict and Health Profession Practice

Organizational goals, decision making, organizational structure and incompatible values shape role conflict and moderate its impact on organizational outcomes in health professional practice. Very often, the formal goals or role expectations of the health systems might conflict with the operative goals of clinical providers because provider behavior is also guided by professional norms.

Organizational goals, as desires which the organization works to achieve (Etzioni,1964), vary with stakeholders and are often conflicting . One cannot maximize one without diminishing achievement of the other (Seashore 1991). Furthermore, official goals such as those stated in formal documents or milieus are not the same as operative goals. Operative goals guide the day to day organizational behavior. Changes in operative goals can undermine original goals (Hall, 1991). Operative goals could become the source of role conflict for organizational members in health systems.

Corporatization and the nature of clinical decision making have been a source of role conflict and role ambiguity and have exacerbated the divide between organizational goals and health professional operative goals. The transition for many doctors from sole proprietor in a cottage industry to an employee in a corporate enterprise has led to a significant weakening of professional independence (Starr, 1982), and the dominance of corporate bureaucracies in health professions. There is also a unique experience of what Scott & Hart (1990) called the organizational imperative. In the latter part of the 20th century, organizational members generally submit to the organizational imperative in the management culture. Traditionally, top management delegates functions to professionals but retains the responsibility for the functions. This means that leaders will delegate tasks to subordinates but will not delegate the responsibility for the outcome of the tasks. However, in institutional provider organizations, when top management delegates provider functions to physicians or nurses, management does not retain responsibility for clinical functions.

The deviant structure of most hospitals also contributes to role stress. Dual lines of authority generally exist between hospital nursing (medical) and administrative staffs. The problem of integration and coordination that

result stem largely from the fact that while organizational discipline is defined by charter or by administrative authority (position power), professional norms are upheld by collegial review (Berdelan et. al.1981). Clinical providers can therefore have a sub-culture that often espouses values different from those of corporate managers. Value differences between clinical providers and corporate managers in provider organizations may create an environment in which clinical providers are pursuing objectives that are in conflict with corporate culture.

Role conflict and role ambiguity often develop as a result of an internal inconsistency of role norms. Intra role conflict arising from the perceived professional role of nursing employees and their ascribed organizational professional role content has been shown to impact nurse job satisfaction and other components (Kubsch ,1996, Lu, While, Barriball, 2008). There is also the blurring of boundaries between professional and research roles for nurses *(*Wilkes & Beale, 2005). Robertson & Walter (2008), point to the psychiatrist's dual-role dilemma in the tension between their obligations of beneficence towards their patients, and conflicting obligations to the community, third parties, other health-care workers, or the pursuit of knowledge in the field. Role conflict and ambiguity was generated due to the introduction of a new professional category, the primary care mental health worker (PCMHW), to improve care in the Primary Care Mental Health setting (Bower & Gask, 2004).

Role Conflict Typology

Four role conflict typologies are generally identified in the literature: intra sender conflict, inter sender conflict, intra role conflict and inter role conflict (Katz and Kahn, 1978, Kahn, 1996).

Intra sender conflict occurs when incompatible expectations are received from a single role sender. For

example, a supervisor requires a person to obtain materials unavailable through normal channels and at the same time prohibits violations of normal channels.

Inter sender conflict consists of incompatible expectations from two or more role senders. An example is when there are different demands on a middle manager from upper management and lower staff.

The third form of role conflict occurs when Focal's own role expectations are in disagreement with those of one or more role senders in his/her role set. This form of conflict is called person-role/intra role conflict.

Finally, inter role conflict exists when pressures from one role conflict with those from another. This usually occurs when role pressure is associated with membership in one organization and in conflict with pressures from membership in other organizations.

The common element in all four forms of role conflict is the "simultaneous occurrence of two (or more) sets of pressures such that compliance with one would make more difficult compliance with the other" (Kahn et al., 1964. P. 19). In the following section, the role conflict typology described above is used to illustrate and describe role conflict in the Los Angeles County Health System and one of its hospitals (King/Drew Hospital and Medical Center) as it existed in the year 2000.

METHODS

This is a single case study involving participant observation, personal experience and review of official documents. From January 1997 to 2000, the author was active in the social environments at King/Drew Hospital and Medical Center and Los Angeles County Department of Health Services. During this time he participated in strategic planning, budget development and tracking, operational re-engineering, and business development. In

the different roles above he became familiar with official and operative goals as well as procedures and processes that were used to operationalize both. The author also reviewed institutional reports such as policies and procedures; revenue and cost analysis reports; and strategic plans.

Part of the data relied on in the conceptual description and illustration of role conflict in the Los Angeles County Public Health System was originally collected and analyzed as part of the author's 2000 PhD Dissertation which investigated the effects of efficiency-driven financing policies at the federal, state and local government levels on pediatric outcomes at the King/Drew Medical Center.

Role Conflict In The Los Angeles County Health System In The Year 2000

In 2000, Los Angeles County financed and operated five safety-net hospitals and the King/Drew Hospital and Medical Center was one of the five Hospitals. A Board of Supervisors governs the county, and is both the legislative and executive body of the local government. The Los Angeles County King/Drew Medical Center is a very fitting case for the study of role conflict phenomenon for three reasons: the county is the single payer for services offered at King/Drew Medical Center; there is inherent role conflict in the governance of the County because the Board is both a legislative and executive body; and there are no county-level political checks and balances.

Figure one below illustrates revenue flow in the Los Angeles County Public Health Care System. The funding for King/Drew Medical Center is controlled through global budgeting from the county and the county is the sole financier of its five Public Hospitals. The financial behavior of the county in its role as a payer is therefore more likely to impact provider behavior and other

institutional outcomes than if King/Drew Hospital and Medical Center had more than one funding stream.

Hospital services are generally reimbursed from state and federal health financing programs such as Medicaid and Medicare. All reimbursements for services provided at the King/Drew Medical Center go directly to the county general fund. The cost of providing health services is covered through the county budgeting process from the general fund. Cost that is not covered by state or federal reimbursements is financed through the county operating budget. Just as the Board of Supervisors draws from the county's general funds to fill the gap between service reimbursement and cost of services provided by its institutional providers, it is conceivable, that the Board of Supervisors could also use health services revenue to pay for other county priorities. In the budget process, health services for the vulnerable populations compete with other priorities on the agenda of the Board of Supervisors.

Figure Two identifies role conflict at four organizational levels. The Board of Supervisors who govern Los Angeles County; The Los Angeles County Department of Health Services(LAC-DHS) which is the agency that administers all of the county's health services and supervises all of the five institutional providers; The King/Drew Hospital and Medical Center Administrators; and finally the Health providers who deliver quality care to underserved populations. The County of Los Angeles is the local government level and represents the highest social system in this analysis. The county assumes the responsibility of a payer and provider of health care to underserved populations. The Los Angeles County, Department of Health Services (LAC-DHS) is a subsystem within the county and the administrative agency assigned to carry out the conflicting county responsibilities of providing and paying for health services. The King/Drew Medical Center is a subsystem of LAC-DHS and one of the

institutional providers being asked to provide care for the indigent population while acting as a money saving/making entity for the county and LAC-DHS. The next level is the individual provider of care at King/Drew Medical Center. These are the nurses and the physicians who are asked to provide quality care, yet are not given the resource level necessary to achieve quality care. At the subsystems level (LAC-DHS and King/Drew Medical Center), there are individual role incumbents: the Director of Health services and the Hospital Administrator.

The County of Los Angeles Board of Supervisors

The County as an organizational role incumbent has inter role conflict for being a payer and provider of health services. The County of Los Angeles also experiences inter-role conflict by belonging to the health financing community as well as the provider community. As payer, the county identifies itself with employers, insurance companies, managed care organizations and other health financing entities. As a provider, it identifies itself with other hospitals and health delivery systems. The payer and provider communities play different roles in the health care industry and often have different role orientations and role behaviors. Payers such as insurance companies tend to want to manage risk and uncertainties and to reduce financial exposures and expenditures; on the other hand, safety-net providers want to provide care to vulnerable populations.

Members of the Board of supervisors as individuals also have inter role conflict in their roles as legislators and administrators. By being the legislators and executives of the county, they set both the formal and operative policies of the health services administrative agency and institutional providers. The Board therefore has significant power over the role behavior of other role actors in the County health system.

The Los Angeles County Department of Health Services (LAC-DHS)

Leaders at the Los Angeles Department of Health services experienced Intra-sender conflict because the County of Los Angeles Board of Supervisor's expectations for the agency to formulate and implement cost and capacity reduction policies; might not be compatible with the expectations for the agency to stir institutional providers towards maintaining access to quality care for the indigent population. The level and quality of access is bound to fall as the resources to delivery systems are reduced below levels required to maintain quality care. Carrying out their cost and capacity reduction responsibilities means reducing the resources available for providing care.

LAC-DHS also operationalizes the county's role as payer while overseeing the day to day delivery of services by institutional providers. It therefore experiences inter-role conflict because it fulfills payer and provider role behaviors.

The King/Drew Medical Center

Leaders at the King/Medical Center experience inter-sender conflict when the County Board of Supervisors and LAC-DHS pressure the delivery systems to cut cost and reduce capacity while the underserved community of south Los Angeles is asking for better and expanded services. The Administrators at King/Drew Medical Center will find it hard to cut resources and expand services at the same time. The primary and formal goal of King/Drew Medical Center, which is providing quality care to the indigent population, can be affected if the county rendered the hospital less effective through its cost-saving efforts.

Health Providers (Nurses, Physicians, Physician Assistants, psychologists etc.)

Health providers experience person-role or intra-role conflict because they cannot carry out the expectations to provide quality care to an underserved population which has enormous and expanding needs with the limited and dwindling resources at their disposal. The health provider's role set is made up of clinical leadership, the patient, professional colleagues, and the administrators. The role expectations of cost reduction from the administrators are incompatible with the provider's perception of their professional role as clinicians who offer quality care to underserved populations. Their professional role is also potentially undermined by resource reduction.

Figure three below illustrates resource control, decision making points, and values in the Los Angeles County Corporate Health System. Provider intra-role conflict is further reinforced by the nature of decision making and the deviant chain of command at the King/Drew Medical Center as illustrated in Figure 3. Unlike traditional management and leadership norms, the Administrators at the hospital, delegate clinical functions to the providers, but they do not retain responsibility for the outcome of the clinical function. The provider is still held responsible for medical care and his or her primary responsibility is to patient care even as bureaucratic and corporate resource control affects his or her ability to deliver quality care to the patient.

The hospital's organizational structure is also deviant. At the hospital level there are three decision chains that do not formally meet anywhere. The nursing chain is headed by the Nursing Director. The Medical chain of command is headed by the Medical Director and the Administrative chain is headed by the CEO/Hospital Administrator. Patient care decisions are made by the medical and nursing staff but all patient care resource

decisions are in the hands of the CEO/Hospital Administrator who reports to the Director of LAC-DHS. The medical and nursing staff report to the Medical Director or Nursing Director for their clinical responsibilities but are administratively responsible to the CEO/Hospital Administrator. The Medical and Nursing Directors do not report to the CEO but they rely on the CEO for resources hence their clinical practice is dependent on the financial decisions of non-clinical administrators who sometimes have value orientations and interests different from theirs.

Top leadership at the LAC-DHS and the King/Drew Medical Center is predominantly driven by a different social responsibility from the providers. This is the efficient management of societal resources. The providers on the other hand are driven by a social responsibility based on equity values of providing care to a vulnerable population in order to reduce health disparities.

The county's formal goal to provide access to quality health can sometimes conflict and even be undermined by the operative goal to reduce expenditures. Reduced resource levels handicap the provider's ability to provide quality care, thereby creating an intra role conflict condition.

Power and Decision making as important constructs

Members of the Los Angeles County Board of Supervisors are very powerful role senders in their role relationships with LAC-DHS, king/Drew Medical Center administrators, and health care providers. The county is the sole financier of health services provided by its institutional providers and Supervisors have both legislative and executive powers and exert influence on both formal and operative goals in the system. When there is role conflict or role ambiguity, the success or failure of coping behavior is

dependent on how powerful the role sender is (Siegall & Cummings, 1996).

The Los Angeles County Corporate Health System is very centralized and decisions and information flow top down from the corporate office to institutional providers. The institutional providers respond to mandates from the corporate office with little or no initiative of their own. The centralized corporate managers at LAC-DHS and the non-physician administrators control resources while physicians and nurses have to live with resource decisions made by non-physician personnel. Also, as legislators and executives, the five members of the Board of supervisors possess and exercise immense powers in the governance of Los Angeles County. The Board controls both formal and operative policy making and implementation at every level of the organization and therefore exerts significant influence on the role behaviors and role stress of administrators and providers in the Safety-Net Health System. This role stress can generate strain that could lead to negative performance outcomes at the individual provider level and ultimately negative outcomes for the underserved community that depends on King/Drew Medical Center.

Figure One
Revenue Flow , Los Angeles County Health System

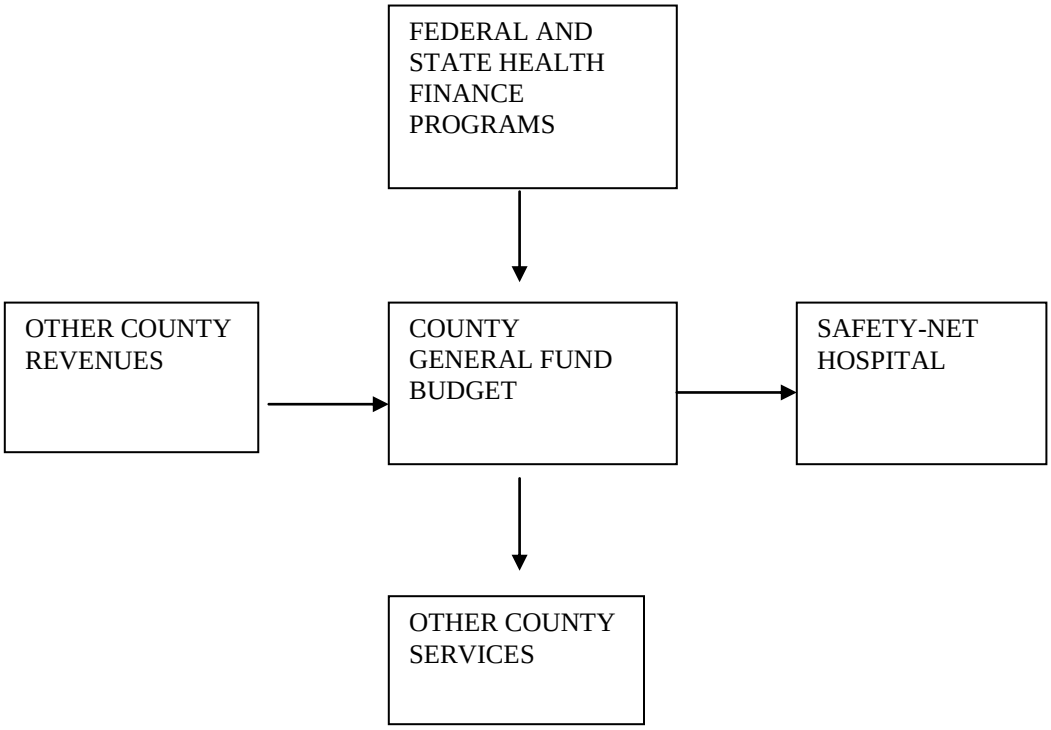


Figure Two
Illustration Of Role Conflict In Los Angeles County Safety Net Health System

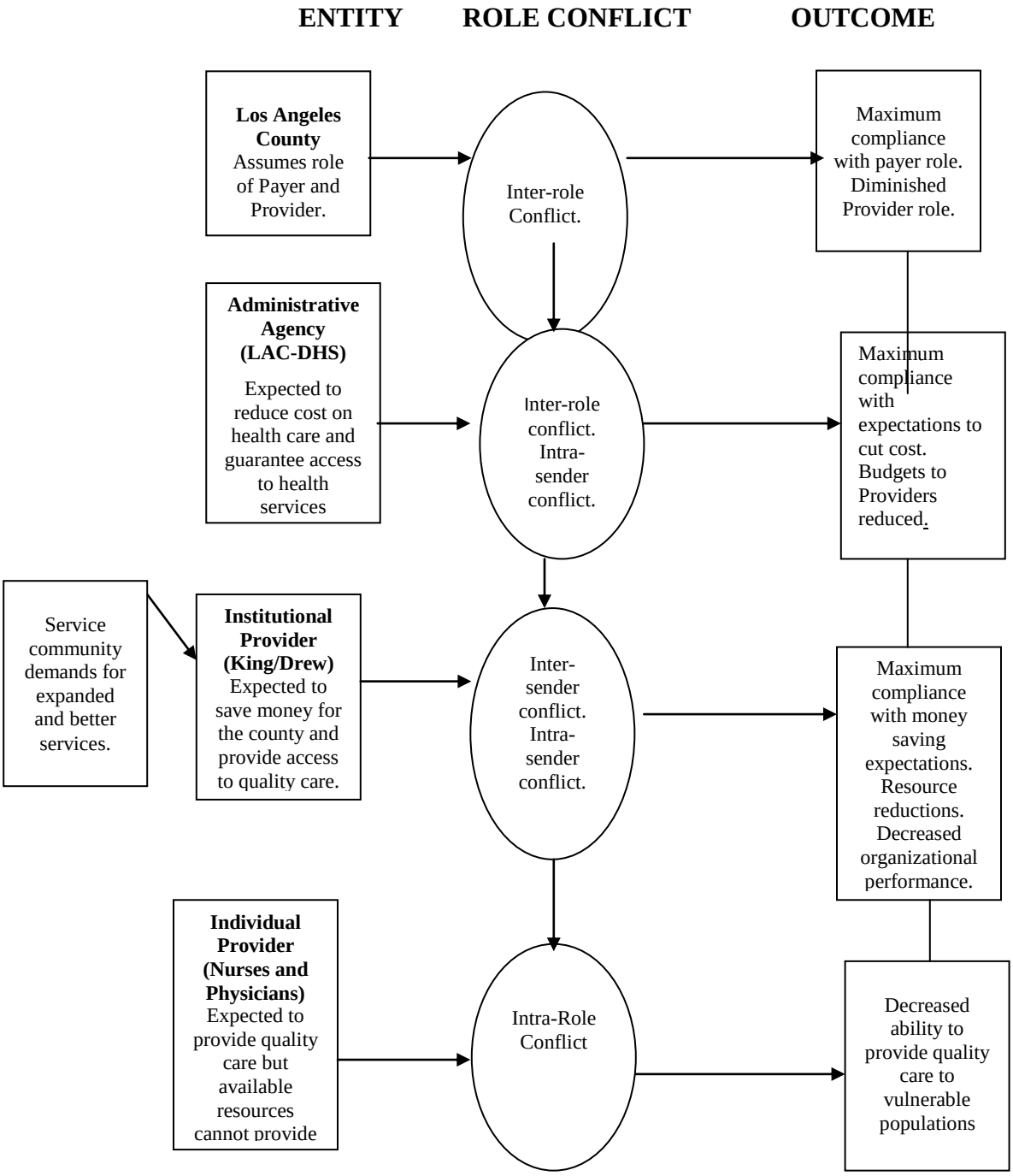
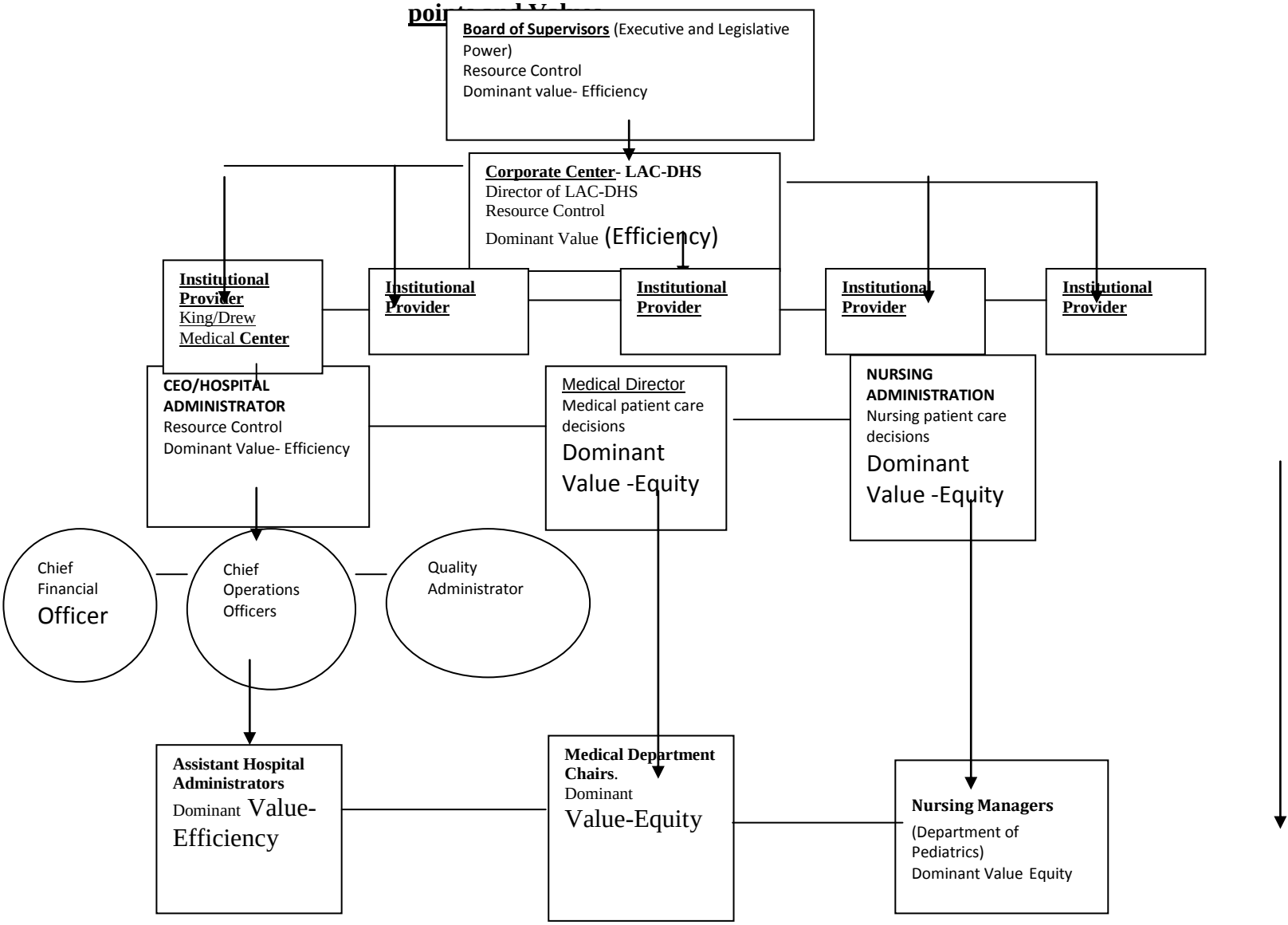


Figure Three
Los Angeles County Corporate Health Delivery System. Resource control, decision making point and Values



DISCUSSION

The above description shows an elaborate presence of role conflict in the Los Angeles County Public Health delivery system. The conceptual illustration in figure 2 above projects that the health care system's role conflicts can lead to low performance at the provider level and ultimately low health consumer outcomes. Some empirical data suggests role negotiation and definition in the health system with a shift towards the payer role. Siegall & Cummings (1996), identify role negotiation and role definition as examples of coping with role conflict. Other data also suggests some negative organizational outcomes which were confirmed by citations issued to King/Drew Medical Center for poor patient care from federal, state, and non-governmental accrediting bodies between 2001 and 2006.

Studies of the Los Angeles County health system conducted in 1998 and 2000, reveal the following three outcomes which are usually associated to role conflict in the literature: dominance of the payer role in the county's behavior evidenced by the pursuit of capacity reduction at King/Drew Medical Center; provider low job satisfaction; and low health consumer outcomes. The dominance of the payer role is an outcome of the county's inter role conflict. The county could not equally perform both roles, "compliance with one would make more difficult compliance with the other" (Kahn et al., 1964. P. 19). Role conflict and role ambiguity have been shown to have a joint interactive effect on job performance (Fried et. al., 1998); and on job satisfaction, job commitment, or personal accomplishments (Pruden & Reese,1972; Peiro, Gonzalez-Roma, and Manas, 2001, Glazer & Boehr, 2005; Pomak, Supell, & Verhooeven, 2007, Concha, 2009).

Los Angeles County health services policies from 1982 to 2000 emphasized cost-reductions, service reductions and employee downsizing (Tataw, 2001, 2010). This trend persisted even though revenues as a percentage of expenditures in both the outpatient and inpatient areas continuously increased (Tataw, 2001, Tataw, 2010). Furthermore, research conducted after capacity reduction and restructuring at Los Angeles County Safety-Net systems revealed poor access outcomes for vulnerable populations and symptoms of low job satisfaction for providers. A 2001 study of pediatric social outcomes at King/Drew Medical Center showed evidence of low provider job satisfaction and low community satisfaction with services (Tataw, 2001). A 1998 cross sectional study of adult outpatient services revealed delays and barriers to needed care for adult consumers of health care in the five institutional providers of Los Angeles County and their network of community clinics (Diamant et al., 2004). In 2007, Los Angeles County closed down the King/Drew Medical Center, after many highly publicized patient safety incidents and citations from federal and state accrediting bodies for non-compliance with minimum standards of patient care.

The poor outcomes identified in the conceptual illustration above; and results of the two studies cited above are in agreement with other studies on similar organizational structures and risk sharing arrangements. Review of other health care organizations where there is payer and provider cohabitation in the same organizational system, show a tendency to emphasize payer characteristics. Gold (1998) indicates that models of care among providers follow product proliferation among managed care organizations. The strategies adopted by payers quickly transform the tactics of providers seeking to conform. Many studies on the impact of efficiency driven reforms on safety-nets show disturbing patterns (Miller,

1998; Hillman; 1998). Poorly designed and ill financed systems generate capitation incentives that undermine quality by rewarding providers for underutilization (US. General Accounting Office., 1993).

CONCLUSIONS AND RECOMMENDATIONS FOR PRACTICE, POLICY, AND RESEARCH

This study contributes to the literature on the United States health system in general, and public safety-net systems in particular by projecting the health services payer-provider role of municipal governments serving vulnerable communities and demonstrating the scope of organizational role conflict in municipal public health care systems. By connecting the dots between the potential negative outcomes conceptually illustrated in the case study and similar outcomes in empirical studies on Los Angeles County, this study also suggest that the existence of role conflict in the Los Angeles County Health Systems could have negative effects on provider job satisfaction and quality of health services. The existence of these poor organizational outcomes in the public health delivery system suggest that the prevalence of role conflict in the system is affecting employee performance and the quality of services received by the vulnerable population which relies on the Los Angeles County public health care system. It is appears that government failure evidenced by poor organizational outcomes and the ultimate collapse of the King/Drew Medical Center hospital system in 2007 can be traced , at least in part, to role conflict.

The existence of negative effects of role conflict in the Los Angeles Public health care system, calls for remedies that will eliminate role conflict and/or improve organizational coping capabilities. Role conflict can be eliminated through changes in municipal public health system governance and intergovernmental policy action at

the state and federal government levels. Also, the ability of the system to cope with role stress can be improved through organizational socialization strategies which address employee achievement and autonomy needs.

Local Governance and Intergovernmental Policy

Los Angeles County and other local governments which provide and finance health care should consider surrendering one of their conflicting roles as both a health care financier seeking the reduction of health care cost and a provider seeking to guarantee care for the poor. Holding to both functions generates role conflicts that can lead to diminished quality of health care services and low job satisfaction for providers.

The provider-payer role conflict in the Los Angeles County Health System and other municipal health systems can be eliminated by shifting the provider role to entities that are independent and separate from the municipal government and have a single focus of providing health care to a specified vulnerable community. The voluntary sector of the US economy can assume this role. A non-profit entity can assume the role of provider in an interdependent relationship between the non-profit entity (provider) and various levels of government (local, state, and federal) acting as payers. Non-profit entities have demonstrated the ability to focus singularly on specific communities and on the narrow interest of particular populations or communities. The voluntary sector has historically succeeded in catering for the special needs of particular communities where the government has failed.

A change in governance can be facilitated by intergovernmental policy from the state and federal governments mandating the separation of payer and provider functions and the housing of the provider functions in entities that are separate from, and independent of the local government. The federal and state governments

can demand the creation of autonomous administrative bodies to run public hospitals before municipal governments receive federal or state money for health services provided. Federal and state governments can also enact rules or policies barring municipal entities from assuming the role of providers and restricting that role to non-profit entities with community control. Similar policies at the federal level have successfully facilitated the creation of Federally Qualified Community Health Centers. These Health centers are community-based and patient-directed organizations that serve populations with limited access to health care. These include low income populations, the uninsured, those with limited English proficiency, migrant and seasonal farm workers, individuals and families experiencing homelessness, and those living in public housing. They are generally located in or serve a high need community governed by a community board composed of a majority (51% or more) of health center patients who represent the population served and meet other performance and accountability requirements regarding administrative, clinical, and financial operations**.**

Organizational factors can also be created to increase the coping capabilities of health professionals by responding to the achievement and autonomy needs of health professionals. This effort could include employee involvement in decision making, alignment of organizational goals and activities with health professional clinical responsibilities, management support , job redesign to improve employee autonomy in their professional roles, and training employees on how to cope with the inherent conflicts in their professional and organizational responsibilities. These steps will respond to research findings that show a negative relationship between role stress (role conflict and role ambiguity) and numerous measures of leadership including goal emphasis, team work facilitation and supervisory support (Rizzo House, and

Lirtzmann, 1970, Bedelan, 1981); and with organizational climate variables such as communication flow, decision making practices, concern for employee wellbeing, human resource primacy, and motivational condition (Bedelan et. al., 1981).

Implications for Future Research

Though empirical studies show that Los Angeles County has a bias towards the payer role, pursues capacity reduction , and runs a health systems with significant negative organizational outcomes; the relationship between organizational role conflict and performance in the Los Angeles County municipal health system is still suggestive rather than conclusive. Future research should seek additional support for a relationship between role conflict and organizational outcomes such as job satisfaction and quality of services accessed by consumers in public health care delivery systems. Given the existing evidence that conflicting work tasks are associated with job satisfaction and performance in various health provider work groups (Hardgrave, 1969; Davis, 1975; Bedelan et al., 1981,Lu, While, Barriball,2008), and that organizational factors such as socialization tactics lower role conflict and role ambiguity (Jaskyte, 2005); scholars have called for further research into factors that can be potentially protective of the deleterious effects of role conflict (Pomak, Supell,& Verhoeven,2007) and for occupationally and even organizationally specific models of stress (Bacharach & Bamberger, 1992).

Future research should also seek to expand research methods beyond quantitative and experimental methods to include qualitative methods; and to use longitudinal as well as case studies approaches. Many role conflict studies use quantitative methods, few have used qualitative methods to get to role and performance nuances that are difficult to

unearth through quantitative approaches (e.g. Kubsch, 1996; Bower & Gask, 2004).

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