Henry Ford Hospital Medical Journal

Volume 40 | Number 1 Article 13

3-1992

Health Care Consortia: A Mechanism for Increasing Access for the Medically Indigent

Patricia A. Caplan

Bonnie Lefkowitz

Lynn Spector

Health Care Consortia: A Mechanism for Increasing Access for the Medically Indigent

Patricia A. Caplan, MA/MPA,* Bonnie Lefkowitz, MPA,† and Lynn Spector, MPA†

In response to poor coordination among health and social service providers, health care consortia have emerged in many areas of the United States. Consortia link multiple providers in a common structure to create comprehensive systems of care. They can be formally structured or informal combinations of providers that engage in coordination but otherwise do not comprise an independent organization. The functions most common among all types of consortia are shared services and service coordination; however, a number of consortia also operate outreach/education programs. Consortia represent an innovative response to the need both for vertical integration—case management of all levels of care—and horizontal integration to prevent duplication among primary care providers. We outline the history of consortia in which federally-funded community health centers have participated. We also suggest an analytical framework for the various types of consortia; discuss lessons learned about building and maintaining consortia; and provide preliminary outcome data. (Henry Ford Hosp Med J 1992;40:50-5)

Nationwide, some 33 million persons lack access, or have difficulty gaining access, to primary health care services. Access and utilization problems are often due to financial, cultural, linguistic, racial, and geographic barriers to the receipt of care. Equally important, however, are organizational barriers. Fragmentation among health care services and poor coordination with other needed social and support services make obtaining a continuum of services an almost insurmountable task for the underserved. In response to this situation, organizations around the United States have formed health care consortia in areas where unmet need, fragmentation, and duplication of services exist simultaneously.

Consortia bring together multiple organizations, such as community health centers, local health departments, social service agencies, and hospitals, to create more user-friendly systems of care. They devise collaborative arrangements to ensure that patients of member organizations gain access to a full range of primary care and preventive and social services, as well as secondary and sometimes even tertiary care. The coordination of activities enables individual agencies to have more use of their finite resources and leads all the participants to offer a wider scope of services to more people (1). Indeed, consortia constitute an innovative reaction to the need both for vertical integration—case management of all levels of care and specialized services—and horizontal integration to prevent duplication and overlap among primary care providers. Some consortia deal with health services delivery to all populations, while others have limited their scope to address a specific issue such as infant mortality. However, a universal characteristic of consortia is active, executive-level involvement and commitment to working through the coordinating structure (1).

We trace the history of consortia in the community health center program, emphasizing the federal role in their creation. An analytical framework is suggested for the various types of consortia, and some preliminary results of this multilateral approach to service delivery are presented. The consortia examined are those entailing comprehensive forms of coordinated efforts, which are to be distinguished from provider groups with linkage arrangements or contractual relationships for a limited number of services, or consortia comprised only of health centers.

History of Consortia Development

For the past 25 years, community health centers have provided comprehensive primary health care services in medically underserved areas. The 550 community health centers in the United States currently serve 6 million people, approximately half of whom utilize the 205 centers located in urban areas. The community health center program is administered by the Bureau

Submitted for publication: July 15, 1991.
Accepted for publication: August 16, 1991.
*Formerly Public Health Analyst, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Rockville, MD. Currently Fund Developer, Mission Neighborhood Health Center, San Francisco.
†Division of Primary Care Services, Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, Rockville, MD.
Address correspondence to Ms. Caplan, Mission Neighborhood Health Center, 240 Shotwell Street, San Francisco, CA 94110.

of Health Care Delivery and Assistance (BHCDA), which promotes the development and operation of community-based primary health care systems. BHCDA is part of the Health Resources and Services Administration, the agency of the United States Public Health Service which works to assure the availability of primary and preventive care services, particularly for the underserved and disadvantaged.

Consortia have emerged as a by-product of a major transformation undergone by the community health center program since it began in 1965. Health centers began as an alternative to hospitals and state and local health departments which had neglected the primary health care needs of the underserved. The early centers were anti-establishment, independent, and determined to address the health care, environmental health, social, and economic needs of communities. However, over time, community health centers recognized the need to join forces with other organizations in order to create more comprehensive health care systems and thus cemented partnerships with the very elements they were created to supplant. They are now at the forefront of providers building systems of care and utilizing all community services and resources. Many centers around the country have joined and, in most instances, sparked the development of consortia.

The seeds for consortia were sown in the mid 1970s when community health centers first sought the support and cooperation of other provider organizations and public agencies. This was a period of substantial capacity expansion through the Rural Health Initiative and Urban Health Initiative. In both of these initiatives, the Bureau of Community Health Services, BHCDA's predecessor, conditioned funding on the coordination of primary health care services with those of other providers and service programs in the area. Federal concern about cost containment and rational use of resources stimulated this condition. Applicants were required to submit letters of support from state or local medical societies and hospitals.

Interest in community health center participation in organized systems of care for the underserved intensified in the 1980s. First came the recognition of the need to address the professional isolation and paucity of support services at small rural centers. In 1984, 17 rural consortia were funded for activities such as coordinated services delivery, strategic planning, shared professional services, and the development of compatible information systems. Among them were the Pee Dee Community Health Services and the Central Virginia Community Health Center, Inc., both consortia thriving today.

In 1985 and 1986, BHCDA launched the rural and urban strategies for expansion of community health center capacity in high-need areas. These strategies were premised on the notion that in order to become competitive health systems, community health centers had to integrate fully with state, local, and private entities. Therefore, a requirement for funding was the formulation of a community or citywide plan for coordination and resource-sharing with other health centers, local health departments, and hospitals. Most of the consortia that exist today began with or received a major impetus for formal organization from these initiatives. State cooperative agreement agencies and state primary care associations played a key role in the development of the consortia by assisting in the needs assessment and planning process and providing technical assistance. BHCDA has cooperative agreements with state agencies (usually health departments) and provides grants to state and regional primary care associations to elicit the participation of statewide organizations in the planning and development of primary care services.

Since 1988 the thrust toward consortia has been driven by BHCDA's focus on achieving integrated systems of care for special populations (i.e., vulnerable subgroups within the overall underserved populations, including high-risk pregnant women and children, homeless individuals, substance abusers, and those with human immunodeficiency virus [HIV]-related conditions) for whom specialized services are needed and case-managed care is particularly critical. The Comprehensive Perinatal Care Program again linked increased federal dollars to a demonstration that grantees were part of a system of care and had firm arrangements for prenatal, delivery, and postpartum services, needed specialty services, and other relevant programs such as Women, Infants and Children (WIC) and Medicaid. The Substance Abuse/Primary Care Demonstrations joined primary health care and drug abuse treatment to form comprehensive, integrated service delivery models, including close working relationships with local health departments.

Comparative Framework for Consortia

The consortia examined in this analysis have one of two organizational structures. They can be formally structured, with boards of directors and officers, incorporation as a 501(c)(3) organization, and often an administrative staff and committee structure. Alternatively, they may be informal combinations of providers that meet regularly and engage in coordination but otherwise do not comprise an independent organization. In a survey of consortia members, Lewis et al (1) determined that the structural approach depends on "unique circumstances and problems." In some contexts, formal organization is perceived as the only route to real coordination, whereas in others it is viewed as unwieldy (1).

Formally structured consortia can be further categorized according to their composition. Some have limited their membership to provider organizations such as hospitals, federally-funded community health centers, and local health departments. Others encompass a diverse and large membership that includes elements outside the health care system. Formally structured consortia also differ according to whether they apply for and receive funding for joint activities.

The Primary Health Care Consortium of Dade County, Florida, exemplifies a formally structured consortium with membership confined to health care institutions (Table 1). The goal of this consortium is to promote an integrated system of primary care for the medically underserved. It began in the early 1980s, sparked by BHCDA's Urban Health Initiative which made linkages with other providers a requirement for new funding of community health centers. Federal dollars for services continue to flow through individual community health centers, but the consortium decides how to spend new federal, state, or local dollars.

Table 1
Formal Consortia

Name	Membership
Primary Health Care Consortium of Dade County	Five community health centers State/county primary care programs County health department Jackson Memorial Hospital
Denver Department of Health and Hospitals Ambulatory Care System	Public hospital Emergency medical services Community health center Mental health center Home care program
Bronx Perinatal Consortium	Four hospitals Nine health centers New York City Department of Health Community/consumer organizations
Indianapolis Campaign for Healthy Babies	Local hospitals Community health centers City Department of Health Corporations Medical societies Religious/civic organizations

Together, the Primary Health Care Consortium members serve over 200,000 patients—10% of the population of Dade County.

Two other formal consortia with the participation of health care institutions only are the Denver Department of Health and Hospitals Ambulatory Care System and the system centered around Cleveland Neighborhood Health Services (known as Hough-Norwood). Hough-Norwood has contractual agreements with the Case Western Reserve Department of Medicine and University Hospitals of Cleveland under which Case Western residents treat health center patients at three sites on the hospital campus.

The Bronx Perinatal Consortium and the Indianapolis Campaign for Healthy Babies are formal consortia notable for the size and breadth of their memberships. Both consortia are 501(c)(3) entities which raise and distribute funds to address the high infant mortality problem in their areas. They also have organizational structures consisting of a board, ad hoc and standing committees, and an administrative staff. Initially supported by BHCDA funding, the Bronx consortium is now financed by member contributions and funds from foundations and New York State. In 1991 it became the agency responsible for administering New York City's Healthy Start Infant Mortality Initiative in the Bronx.

Informal consortia involve primary care centers that have effective links to other parts of the health care system without a formal organization enveloping all of the collaborating players. The Oakland, California-based Alameda Health Consortium, composed of nine nonprofit health centers (two community health centers and seven county or state indigent care grantees), coordinates with the County Department of Social Services, two county hospitals, and Children's Hospital. In Seattle, most providers of obstetric services (i.e., the Seattle/King County Health Department, three community health centers, local hospitals, and the Seattle Indian Health Board) coordinate several aspects of perinatal care. There are also various agreements between and among different organizations for other types of services. Three additional informal consortia are outlined in Table 2.

Start-up Costs of Consortia

The Philadelphia Health Federation reports that the costs of developing and beginning implementation of consortia are highly variable and depend, minimally, on the resources of the leading or grant-receiving organization and on the relationship among the members. Some organizations which are at the locus of consortia development, such as city governments, may be able to donate space, equipment, and even personnel, whereas nonprofit organizations usually lack the resources to contribute. If there is a history of collaboration among the participating organizations, members are more likely to make large, in-kind contributions and donate the time of staff for meetings.

The experience of consortia funded under the federal Healthy Start Infant Mortality Initiative gives some indication of start-up costs. Applicant consortia could request up to $500,000 for the first six- to nine-month development phase. Alabama's Jefferson County Department of Health reports that the Birmingham consortium will expend its $500,000 on needs assessment, planning, surveys, and a public information campaign to be carried out by two project coordinators, one epidemiologist, and part-time community resource workers.

The Philadelphia Health Federation consortium will devote its initial funding to the hiring of a project director, three planners, three community organizers, organizational consultants, clerical staff, and an information officer. Initial development of informations system capability also will be supported.

Functional Characteristics of Consortia

Formal consortia with boards, standing committees, and administrative staff are more prone than informal consortia to institute functions such as community-wide needs assessment, planning, data collection and analysis, technical assistance, centralized quality assurance, integrated medical records, and common clinical protocols. The Bronx Perinatal Consortium, for instance, serves as the Comprehensive Perinatal Services Network which receives funding from the New York State Department of Health to conduct needs assessment and program planning and to foster cooperative relationships among health, education, and social service providers regarding perinatal issues. The Primary Health Care Consortium of Dade County is currently implementing common patient identification numbers and a linked computer system for registration and billing purposes. The Indianapolis Campaign for Healthy Babies uses volunteer auditors to examine quality assurance reports submitted quarterly by participating providers. Campaign officials conduct site visits to those health centers that receive Campaign funds to provide prenatal care and care coordination.

The functions most common among both formal and informal types of consortia are shared services and service coordination. Several consortia share obstetric providers, private physician backup, and on-site Medicaid eligibility determination workers. The Central Seattle Community Health Center operates two translation services, one for the benefit of the three

Table 2
Informal Consortia

Location	Collaborators
Philadelphia	Health Federation of Philadelphia Teaching hospitals
Boston	Boston Conference of Community Health Centers City Department of Health Family planning agency Health Care for the Homeless programs Other state/city agencies and task forces
Jackson and Hinds County, Mississippi	Jackson-Hinds Comprehensive Health Center Hinds County Health Department Three local hospitals

health centers and the other for all area hospitals. The examples of service coordination are more varied. In the Dade County consortium, the Economic Opportunity Family Health Center offers extensive radiologic services to the county health department and other community health centers. The county health department, in turn, immunizes and supplies insulin to uninsured community health center patients and performs most of the laboratory services needed by the health centers. The Jackson-Hinds Comprehensive Health Center has an agreement with the University of Mississippi Medical Center for obstetric care to uninsured women. The prenatal record travels with the woman when she is admitted for delivery; the hospital sends the patient back to Jackson-Hinds with the delivery and newborn records. Jackson-Hinds and two other local hospitals currently are collaborating on the construction of an alternative birthing facility. One of the hospitals, the Mississippi Baptist Medical Center, has agreed to accept transfers of mothers who experience complications during delivery.

A somewhat less common function of all types of consortia is outreach/education. The Philadelphia Health Federation operates a lay home visiting program providing expanded, prevention-oriented services to high-risk perinatal patients and their infants. Project activities are fully integrated with existing primary care and specialized perinatal care services. In addition, the program model has been expanded to include linkages with two academic medical centers and two managed care organizations. The Bronx Perinatal Consortium also has implemented a community health worker program in four areas of the Bronx. The workers are local residents who, after completion of a training program, are assigned to a specific neighborhood to function as a link between people needing services and agencies offering services—providing education, referral, advocacy, and support, with special emphasis on low birthweight and HIV prevention. The Bronx consortium also maintains an Educational Resource Center for its member organizations and has a contract with the New York State Department of Health for the implementation of a citywide infant mortality education campaign.

A handful of consortia have implemented more unusual functions which may be replicable elsewhere. The administrative staff of the Bronx Perinatal Consortium develops applications for individual members' capital improvements, such as for the recent renovation of the prenatal unit at Lincoln Hospital. The Dade County consortium provides incentives, such as prenatal vitamins for women who enroll during the first trimester of pregnancy, and operates a central telephone hotline for intake and referral of pregnant women. Through the Boston Conference of Community Health Centers' association with area hospitals, community health centers are currently working to gain access to a captive insurance arrangement for more favorable malpractice coverage. Boston's community health centers receive funding for the uninsured from a free care pool to which area hospitals are required to contribute.

Results

Consortia development

BHCDA has learned through its experience in promoting consortia that they are most effective when: 1) developed at the *community* level, because those concerned recognize the need to come together; 2) formed to create an *integrated system of care* and to increase comprehensiveness of needed services; and 3) focused on ease of access and effective, high-quality care for the *user* of the system.

From the perspective of those who have actually built them, there are other common lessons about the development of successful consortia (2):

- In many cases, one or more federal representatives forced the issue of collaboration, thus causing the initial development of each consortium. Primary care staff of the regional offices of the United States Public Health Service play a valuable role by providing leadership, bringing in reluctant organizations, mediating conflicts, and accessing the resources of other federal programs.
- A strong commitment by major officials to the consortium helps to generate enthusiasm and resources in the developmental period. Especially in urban settings, the involvement of major officials helps deal with some of the local politics that any consortium will encounter. The President of Jackson Memorial Hospital and the Assistant City Manager of Miami were firmly behind the Dade County consortium. Similarly, consortium leaders should be those at the highest level of their respective organizations so that commitments can be made immediately during the developmental stages.
- Substantial start-up resources are required to organize the infrastructure of the consortium. Start-up costs are always higher than anticipated, largely because of the time needed for the consortium to become established and to operate efficiently.
- The building and operationalization of consortia is a time-consuming and often painful process because of the difficulty of building trust among the participants, convincing them of the benefits of collaboration, and establishing the consortium's credibility. The Center for Community Education at Rutgers University in New Jersey reports that the benefits often are not immediately apparent because of turf and time: members question whether the cost of giving up each is worth the benefits of participation. The problem is especially acute for direct service providers who are concerned about the potential time taken away from clients. Another disincentive, reported by the Bronx

consortium, is the competitiveness of the health care funding structure; in some instances, individual agencies may have to forego applying for certain grants which the consortium as a whole has a better chance of winning. In addition, the limits on funding for administrative costs often means that the consortium members receive little or no financial support for the indirect costs of operating a new program. The Philadelphia Health Federation notes that each agency has its own mission, board, and leadership to which it is accountable; if there is no historic relationship among the members, it takes a great deal of time and skillful leadership to persuade agencies to accept affiliation and to believe that the leading organization(s) will fulfill expectations. All of those involved with consortia agree that to overcome initial skepticism, the benefits as well as the roles, organizational structure, and operating procedures of the consortium must be clearly stated at the beginning; follow-through on activities planned has to be continuous; and individual providers have to be assured a substantial degree of independence even while contributing to consortium policy decisions.

- Maintaining a focus on the people in need helps the participants "make better decisions and avoid some of the resistance to sharing that naturally occurs" (3).
- Consortia should establish clear goals and objectives and maintain a focus on them throughout the planning, implementation, data collection, and evaluation processes.
- Different advantages are entailed in using consortia as a comprehensive strategy for addressing access and quality of care issues as compared with establishing categorical consortia (e.g., perinatal or HIV/aquired immunodeficiency syndrome [AIDS] consortia). According to the Philadelphia Health Federation, a comprehensive consortium has the cooperation of a network of agencies with a general mission and therefore the flexibility to respond to new funding opportunities and changing population needs. The consortium may survive longer because of this flexibility. Working towards a single, quantifiable goal (such as the reduction of infant mortality or HIV transmission), however, can be more unifying and cause the consortium to move more efficiently toward identifying and accomplishing a specific set of goals. Another important factor is the community or area in question. A small city or rural area may be more amenable to a general consortium. However, a highly focused categorical consortium is more appropriate for a large and densely populated area.
- The determination of who should be involved in the consortium should be driven primarily by patient need. The key participants are those who can make a difference, i.e., those who can agree on and collectively accomplish an identified set of goals and objectives. Size of an organization should also be a determining factor. In addition, it is advisable to choose organizations with similar management philosophies.
- Depending on the circumstances, it may or may not be possible to make the consortium the grantee. In Dade County, none of the participating organizations would consider centralizing the funding, so federal dollars continue to flow through individual community health centers. However, in cases where the consortium is the grantee, such as the Bronx Perinatal Consortium, accountability and the conduct of evaluations are easier.

Improved outcomes

Most of the consortia described herein have not evaluated the community-wide impact of their activities on a wide range of indices. However, some have demonstrated specific, positive impact.

At the end of the initial two-year funding period for the Philadelphia Health Federation's home visiting program, 705 pregnant and postpartum women had been served. Of the prenatally enrolled home visiting clients who delivered live infants, the low birthweight rate was 9.4%, as compared to a rate of 16.2% for a sociodemographically similar population of citywide residents (4). The postpartum return rate of program participants was 90%, as contrasted with a baseline rate of 55%.

Members of the Bronx Perinatal Consortium have enrolled 4,800 women in the Prenatal Care Project administered by the consortium. From 1986 to 1989, the number of prenatal visits increased from an average of 3.5 to 7.8. The Bronx consortium's Community Health Worker Program also has shown positive results. As of October 1991, 90% of the women participants kept their postpartum visits and 85% of infants were enrolled in pediatric primary care, as contrasted with 50% and 30% averages, respectively, in the Bronx.

Other improvements

Besides enhancing the effectiveness of health services, consortia increase the convenience to and participation of patients as well as the efficiency of the overall system of care. The Cleveland consortium illustrates the advantages that can accrue to all of the parties involved. University Hospitals of Cleveland incurs less of a financial burden and Hough-Norwood has generated more revenue as a result of the pragmatic decision to allow the community health center to operate the hospital's indigent care sites. The Case Western Department of Medicine now earns compensation for care provided by residents and has a better setting for residency education as a result. Patients benefit from the better defined standards of care that have been adopted and from the improved continuity of care resulting from the requirement that ambulatory care residents see patients within 24 hours of admission (5). The Primary Health Care Consortium of Dade County, with its extensive service coordination and other collaborative activities, has significantly broadened the scope of services available and accessible to the community served.

Consortia can be a boon to health care institutions in other ways. The Bronx Perinatal Consortium and the Alameda Health Consortium note that smaller organizations such as community health centers have increased their influence in the provider community through consortia. For example, consortia serve as an arena for open negotiations of admitting agreements with hospitals. Federally-funded health centers and public hospitals have benefited from their access to a forum through which they have increased their understanding of each other's organizational cultures and where issues can be discussed collectively without any one organization being singled out for taking a controversial position. In a few instances, through association with community-based providers, hospitals have gained access to more favorable Medicaid payments and reimbursement for nonpaying patients. In addition, a viable consortium, by virtue of its

aggregation of multiple providers, can leverage funding from a variety of sources.

Conclusions

The idea of collaborative planning is inherently contradictory to Americans' deeply embedded notions of individualism and autonomy (6). Yet there is a parallel tendency toward "good citizen–good government" which originally fostered health planning. For at least two reasons, consortia follow the second trend. The interactions among players in a consortium constitute an exchange relationship, i.e., they are mutually rewarding (7). Second, consortia harbor the essential ingredients for effective cooperation: an agreement about objectives and outcomes and the appropriate means of attaining them (6).

Because of their effectiveness in bringing divergent interests to the bargaining table and redistributing community resources in ways that respond to the needs of the underserved, consortia have served as models for other Public Health Service programs which require extensive and firm linkages among providers, such as the Healthcare for the Homeless Program, the Healthy Start Infant Mortality Initiative, and Title III (early intervention grants) of the Ryan White Comprehensive AIDS Resources Emergency Act. Over the next several years, BHCDA funding for new health centers will be tied to participation in or a relationship with a community or citywide primary health care plan. New funding could well include support for consortia, particularly those in urban areas.

References

1. Lewis-Idema D, Falik M, Ginsburg S. HRSA programs and coordinated systems of primary care. Rockville, MD: Health Resources and Services Administration, 1990.

2. Perinatal consortia development. Seminar proceedings. Rockville, MD: Bureau of Health Care Delivery and Assistance, Health Resources and Services Administration, 1991.

3. Networking and linkages: An urban and a rural perspective. Primary Care Perspectives, 1991:1,3.

4. Lefkovich N, Webb D. Lay home visiting: An integrated approach to prenatal and postpartum care—the final report and evaluation. Submitted to the William Penn Foundation, 1991.

5. Stevens D. Primary care at a hospital, community health center and academic department of medicine: A perfect ménage à trois. Presented to the Health Resources and Services Administration Colloquium, Rockville, MD, March 5, 1991.

6. Arnold MF, Welsh IM. Community politics and health planning. In: Arnold MF, Blankenship LV, Hess JM, eds. Administering health systems: Issues and perspectives. Chicago: Aldine-Atherton, 1971:154-75.

7. Blau PM. Exchange and power in social life. New York: John Wiley and Sons, 1964.