Community Health Center-Led Networks: Cooperating to Compete

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EXECUTIVE SUMMARY

The primary mission of community health centers (CHCs) is to provide primary and preventive healthcare for the underserved and vulnerable populations, including the uninsured, underinsured, and Medicaid beneficiaries. Economic and regulatory challenges have placed these safety net providers in a precarious position, forcing some to respond using cooperative strategies. This article focuses on seven CHC-led networks, delineating their integrative efforts in the core areas of managed care, clinical, administrative, information, and finance. Interviews with key representatives from each network highlight the networks' accomplishments and the critical success factors and outcomes of their integrative efforts. Several underlying themes emerged from this study that are consistent with findings of previous studies conducted in other organizational settings. Specifically participants in CHC-led networks cite the following factors as contributors to success: reciprocity, communication, trust, and long-standing relationships among key individuals. This is the first study to provide a rich depiction of CHC network activities.

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A number of health providers have formed alliances in response to the changing environment (Bazzoli et al. 1997; Sparer and Brown 2000). Such affiliations create opportunities to learn from partners, increase resources, reduce organizational risk, strengthen competitive positions, gain political influence, and secure economies of scale (Bazzoli et al. 1997; Zuckerman, Kaluzny, and Ricketts 1995). For all these benefits, however, these affiliations also generate new challenges (Mueller et al. 1999; Sparer and Brown 2000). This article shares the stories of seven community health center-led networks throughout the United States that have built integrative affiliations. As varied as these forms have been, they share a common reliance on trust, communication, and shared visions and a willingness to look beyond immediate individual outcomes.

The Community Health Center (CHC) program, administered by the Division of Community and Migrant Health, Bureau of Primary Healthcare (BPHC) within the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services, has a 35-year history of providing primary and preventive healthcare services for low-income people. These centers began as migrant health centers and neighborhood health center demonstration projects as part of President Johnson's War on Poverty initiative in 1965 (BPHC 2000). Today, 768 health centers are in existence, with over 3,300 clinics and 7,100 primary care providers serving over 9 million people (BPHC 2000). CHCs are an important safety net provider for the uninsured, underinsured, and Medicaid beneficiaries (GAO 2000).

The past decade brought numerous challenges for CHCs. The uninsured population grew 12 percent, from 34.7 million in 1990 to 38.7 million in 2000, but the increase in the number of uninsured seen at the health centers was staggering at over 90 percent (BPHC 2000). Overall, 40 percent of CHC patients in 2000 were uninsured, 34 percent were covered by Medicaid, 7 percent were covered by Medicare, and 16 percent were privately insured. Compounding the situation was immigration, which significantly increased the proportion of nonEnglish speaking patients who have distinct health and cultural needs (BPHC 2000).

At the same time that CHCs became more reliant on Medicaid funding as a major source of revenue, Congress passed budgets that severely cut these revenues. These legislative changes included phasing out the Federally Qualified Health Center (FQHC) payments, which had allowed FQHC-designated CHCs to be reimbursed by Medicaid and Medicare on a "reasonable cost" basis. Additionally, changes in welfare eligibility and immigration laws left many without Medicaid coverage, shifting them to the uninsured ranks (BPHC 2000). At the state level, the expansion of managed care from 9.5 percent of Medicaid beneficiaries in 1991 to 55.6 percent in 1999 created other financial challenges for CHCs (Kaiser Commission on Medicaid and the Uninsured 2001).

To remain competitive under these conditions, CHCs are forming

integrative affiliations. HRSA has spearheaded this effort by providing grants to support network development. In 2000, a BPHC-sponsored workgroup of network representatives decided to study the challenges and outcomes of CHC-led networks. Seven CHC-led networks in the United States participated in the study: Community Care Network of Virginia, Inc.; Colorado Community Managed Care Network; Community Health Center Network of California; Neighborhood Healthcare Network of Minnesota; Community Health Integrated Partnership of Maryland; Pathways to Care Network of Oregon; and Health Choice Network, Inc. of Miami, Florida. These networks were selected as a purposeful sample for diversity in the nature of integrated functions, network structure (vertical versus horizontal), and geographic location. At each network, two investigators interviewed several people involved in each of two major functions or projects. The interviews, conducted from the fall of 2000 through the winter of 2001, were semistructured and taped when permitted; otherwise detailed notes were taken.

The following section highlights these networks' accomplishments, featuring insights into what they saw as critical success factors and the outcomes of their integrative efforts in the core areas of managed care, clinical, administrative, information systems, and finance. Themes that emerged from the interviews included the importance of communication, trust, commitment, mutual learning, and reliance on longstanding relationships for CHC integrative efforts. Table 1 provides specific details regarding each network.

MANAGED CARE INTEGRATION

Community Care Network of Virginia, Inc. (CCNV)

A continuum exists along which study networks engage with managed care, ranging from contracting with health maintenance organizations (HMOs) to forming an HMO. CCNV first began when the CHCs aligned within the Virginia Primary Care Association (VPCA) to respond to the state's request to Healthcare Finance Administration for a Medicaid managed care waiver. The network divided the state into four functional marketplaces for its commercial managed care business. Contracts may affect specific marketplaces or apply statewide. CCNV has negotiated 12 Medicaid managed care contracts with five different HMOs, including contracts for medical, dental, transportation, and mental health services.

David Selig, CEO of CCNV, identified two key success factors: communication and trust. In his view, communication was the bigger factor: " . . . with a network like this that includes all community health centers in the state . . . you've got to maintain continuous, non-stop communications with all of your constituents, and use as many communication vehicles as possible." He has found sharing information within the network to make a significant difference. Selig attributes a high level of trust among organizations within CCNV to the mindset of the CHCs and their history of collaboration, which was originally fostered by

the VPCA. The organizations readily shared information and helped each other out when necessary, which created the foundation on which these future activities could occur.

As with other CHC-led networks, CCNV has yielded a range of benefits for its members. Most critically, CCNV has enhanced its members' power relative to payers both by consolidating for negotiations and by increasing CHCs' visibility in their markets. CCNV has also helped CHCs in ways that they did not initially anticipate. CCNV's delegated credentialing program and central business office have reduced the time shareholder centers have to spend on these administrative activities, making it possible to focus more on clinical improvement. Respondents also noted their satisfaction with having a forum to address common issues and learn from each other.

Colorado Community Managed Care Network (CCMCN)

Another CHC-led network has ventured even further along the continuum of managed care activity, developing shared risk arrangements with HMOs representing the majority of the Medicaid patients in the state. Colorado CHCs first began discussions about forming their own managed care network during their primary care association meetings, bringing in consultants to learn more about the issue. Medicus, a consultant to CCMCN, conducted a financial feasibility study to assess the viability of the network forming its own HMO. When it became clear that CCMCN would not be able to survive alone because of the requirement for large investment capital, CCMCN sought other safety net partners through the development of Colorado Access, a not-for-profit organization.

Colorado Access was created by CCMCN, Denver Health (a separate community health center network), University of Colorado Hospital/University Physicians, Inc., and The Children's Hospital. Colorado Access's mission was not only to provide Medicaid services but also to expand services to underserved populations in general. According to Dan Tuteur, executive director of CCMCN, "that was part of the deal that we tried to sell to hospitals when we built this network . . . trying to figure out a way to solve a problem in our community [access for the uninsured] and to do it on a community-by-community basis." University and Children's Hospitals had incentive to participate in the Colorado Access arrangement because they anticipated problems in retaining their current Medicaid referral business if non-safety net HMOs dominated the Medicaid market. Colorado Access established an initial contract through which CCMCN was paid fee-for-service at FQHC rates.

CCMCN attributes its successes to several factors. The health centers already had long-standing, good relationships with the local providers and hospitals. According to Pete Leibig, CEO of Clinica Campesina and a Colorado Access board member, the physicians even went out of their way to not compete with them for Medicaid business because they understood that they could not take the Medicaid patients out of the health centers if the CHCs

TABLE 1
Summary of CHC Networks

CHC Network	Year Network Formed	Structure	Numbers of Patients Served	Greatest Distance Between Members (miles)	Integrated Functions	Original Integration Funding Source
CCNV	1996	Horizontal; urban and rural; 18 shareholders; 44 sites statewide; 9 members on board; for-profit	150,000	600	Credentialing; central business office; managed care contracting; MIS; standardization of many financial and clinical processes; regulatory compliance; QI; network pharmacy access program	CHCs share purchases and BPHC network grant
CCMCN	1994	Horizontal; urban and rural; 12 members; statewide; 1 person per CHC on board and 5 clinicians, 3 from largest CHCs, 2 at-large; not-for-profit	160,000	500	Contracting; contract administration; financial analysis; governance of Colorado Access; some clinical and operational quality improvement; program evaluation	Member dues and BPHC network grant
CHCN	1995	Horizontal; urban; 7 members; 22 sites in San Francisco's East Bay Area; CHC executive directors serve on board; not-for-profit	100,000	90	Management service organization; CQI; IT support for both clinical and fiscal data; chronic disease management	MSO fees and BPHC network grant

NHCN	1995	Horizontal; urban; 16 members, 5 are CHCs; 46 sites in Minneapolis and St. Paul area; 13 board members; not-for-profit	96,000	15	Clinical, administrative CQI; advocacy; group contracting; IS data warehousing; information referral; CAP grant/insurance enrollment assistance	Annie Casey Foundation 5-year grant
CHIP	1997	Horizontal; urban and rural; 8 members, 6 are CHCs; 29 sites across MD; 8 board members; not-for-profit	54,700	150	Human resources; performance improvement; credentialing; chronic condition management	BPHC network grant
PCN	1997	Vertical; rural; 18 members, 1 is CHC; 18 members on board; not-for-profit	Not available	40	IS; QI indicators	BPHC network grant
HCN	1994	Horizontal; urban and rural; 7 CHCs; 48 sites in 6 counties; not-for-profit	130,000	280	Program development; managed care; clinical services; protocols; ITS; accounting; administrative	BPHC network grant

were to continue to care for medically indigent patients.

Once again, trust and seasoned executive directors were also among the critical success factors listed. According to Leibig, "a level of trust [was] there and a level of history with each other . . . that made it possible." The good of the entire organization was put first before the benefit of a single health center. Leibig adds, "almost everybody at the table has given in from time to time and said, 'Well, I know this thing that people want to do is not going to work out best for me, but I'm not going to walk away from the table because overall, it's still good for me to be a part of this'." Additional success factors included consistency between management and board visions and the inclusion of clinicians as board members.

Some outcomes of the network, besides financial stability and efficiencies gained through sharing of information, have been greater purchasing and negotiating leverage and expanded recognition of CHCs and their importance. CCMCN has become recognized as an expert in care for the uninsured and Medicaid populations and frequently provides insight on state policy issues. Don Hall, CEO of Colorado Access, also gives credit to the CHCs for Colorado Access's success: " . . . the reality is that CHCs really are the ones who bring in the members. And then the hospitals and the specialty physicians serve those members, so there really needs to be a strong voice for the CHCs in this, recognizing that without them, the rest of this starts falling apart."

Another benefit, according to Dr. Barry Martin, medical director of Metro Community Provider Network, is that "we generated some excess marginal revenue . . . and we've expanded a fair amount . . . built new clinics with the revenue that we've gotten through our Colorado Access contract." He went on to add that their working relationship with the other safety net providers has also benefited.

According to Don Hall, the CHCs have benefited from the Colorado Access association in many ways beyond their being the "bridge between the commercial world of managed care and the safety net." Colorado Access has provided quality benchmarks for its members and customer support training, assisted in developing individual CHC market plans, and established a comprehensive compliance program that has allowed them to fulfill contractual requirements.

CLINICAL INTEGRATION: QUALITY IMPROVEMENT

Community Health Center Network (CHCN) of California

Quality improvement (QI) refers to areas such as regulatory compliance, program evaluation, standardized clinical protocols and guidelines, data tracking, risk management, and case management. Fundamentally all integration seeks to improve quality of care for the underserved. CHCN maintains a comprehensive QI program that evaluates and corrects deficiencies in clinical services provided to network members. The network administers its QI programs through the QI committee composed of medical directors

from each CHC, the network CEO, the chief financial officer, and QI/UM (utilization management) directors. This committee submits an annual QI work plan and reports quarterly to the board of directors. The committee is also responsible for the oversight of all QI activities within the network, including distribution of patient and provider satisfaction surveys, annual access studies, monitoring patient complaints, and evaluating clinical functions.

One of CHCN's QI goals has been in the area of diabetes management. According to Rhonda Aubrey, QI/UM director, the nationwide Diabetes Collaborative offered a chance for CHCs across the country to learn from each other. A registry of diabetic patients became part of CHCN's information system. The network also created a "data warehouse," which is used to extract clinical information on each CHC's patients. This in turn has fueled ideas for other QI initiatives, centering on the network's goal of reducing disparities among the different ethnic groups and geographic locations.

As in other networks, Ralph Silber, CHCN's CEO, also attributes the QI program's success to the network's ability to build on a history of collegiality among its long-standing key players. He also cited the following factors as contributing to their success: making good business decisions, maintaining a balance between mission and financial goals, mission clarity, obtaining federal and foundation dollars (with unusual levels of philanthropic support attributed to their ability to develop very good long-term relationships), and setting adequate capitation rates.

The annual QI assessments conducted at each clinic have identified areas for improvement and allowed for sharing helpful procedures among the various clinics. Through these QI efforts the network has succeeded in reducing emergency room use for nonemergent care by 50 percent just within the first three months of the project. The network's diabetes collaborative has resulted in increased numbers of annual eye and dental exams, with some clinics progressing from none of their patients even knowing what "self-management" was to 30 percent having a self-management goal in their chart.

Neighborhood Healthcare Network (NHCN) of Minnesota

NHCN has also used QI to better serve its populations. Leaders found that the most effective way to evolve into a network was to capitalize on their tradition of working together in quality work groups. QI thus became the main driving force behind the clinical integration and the network's further expansion into managed care. On the administrative side, QI has taken the form of a networkwide patient survey, conducted annually since 1996 to measure satisfaction with access to care, acceptability of care, and behavioral intention to return to that clinic. On the clinical side, preventive healthcare standards have been established for high-risk populations in five life cycles, including perinatal, pediatric, adolescent, adult, and geriatric. The care management committee, consisting of providers from each clinic,

determines the goal threshold level for each indicator, the methodologies for data collection, measurement, and analysis. Chart audit results are then compared to the local baseline data and national benchmarks.

One of NHCN's most notable accomplishments has been tracking newborns' clinical information, with 12 of 17 indicators surpassing the thresholds. As a result of collaborative efforts in data tracking, newborn data reported back from the hospital increased from only 2 percent of the newborn babies in the first year to over 80 percent by the fifth year of the program. As clinics implemented clinical outcome measures, they found that access to healthcare services also increased as a result of the greater emphasis on improving standards of care. Other network QI initiatives have included establishment of childhood asthma and adult diabetes practice guidelines, data-entry support and coding assistance to the clinics, and common coding for preventive clinical measures. Patient satisfaction survey results demonstrated these efforts' success: 98 percent of the respondents would recommend their provider, and 97 percent would recommend the clinic.

Madeleine Hart, NHCN quality management manager, attributes the program's successes to two factors that also emerged across the networks: strong communication and learning from each other. One key aspect is "to have face-to-face contact with key staff people on a regular basis"; another key aspect is making information readily available to the clinics as a resource. According to Hart, they have "tried to implant in people's mind that we should be the first phone call they make when they need something or are having problems . . . if we don't have the immediate answer, chances are that there has been another clinic that has already dealt [with it]."

Regarding the implementation of the clinical healthcare guidelines, Dr. Bud Clawson, NHCN medical director indicates " . . . one of the things that we did . . . was to go out to the clinics for meetings and insist that those meetings include the executive director, medical director, and any other key personnel that were involved in some of the indicator monitoring or putting together the charting tools. I think, for the most part, we were fairly successful by having such eyeball-to-eyeball relationships . . . they would talk about things in a context that gave me the impression that they never really discussed the topic as a group before. I know it was a positive action."

ADMINISTRATIVE INTEGRATION: HUMAN RESOURCES

Community Health Integrated Partnership (CHIP) of Maryland

Human resources (HR) centralization can entail sharing personnel, establishing common protocols, joint hiring, group purchasing of staff benefits, and training development. CHIP has experimented with two of these (shared personnel contracts and training development) after an unsuccessful effort at a third (group purchasing of staff benefits).

HR integration arose from two challenges that CHIP member CHCs shared with many other providers. First, the costs of employee benefits have been skyrocketing, while reimbursements for care have not risen accordingly. Second, complying with increasingly complex regulations has made HR issues a major challenge for many small CHCs in particular, often forcing non-HR employees to devote a substantial amount of time to HR functions.

CHIP's first HR effort was foiled by legal complications. This was the network's attempt to purchase insurance collectively for all CHIP-member CHC employees. Unfortunately, Maryland's small group benefit program actually rendered such collective purchasing less economical than contracting by individual CHCs. Undeterred, CHIP pursued other forms of HR integration, drawing on the resources of the network's largest CHC, the Baltimore Medical System (BMS), which had a very strong HR department. After careful deliberation among all the involved CHCs, BMS began to provide HR support on an outsourced basis to other CHCs.

Through this contract, CHCs are able to choose desired services. Services include training and development programs (one particularly popular module focuses specifically on new managers); revising HR policies and the attendant documentation; creating personnel records and an employee database; and assisting with compliance for such governmental regulations as COBRA, unemployment, the Americans with Disabilities Act, and equal employment opportunity laws.

The outcomes of integrating HR functions have included cost-effective increases in the variety of services and benefits available to member CHCs. Non-HR employees at smaller CHCs can now focus on their jobs rather than spend a significant portion of their time managing HR tasks. Paperwork hassles have decreased, and regulatory compliance has become easier. Employees also benefit from better communication, professional assistance in problems, access to accurate information on regulations, and streamlined claims processing.

INFORMATION SYSTEMS AND FINANCIAL SYSTEMS INTEGRATION

Pathways to Care Network (PCN) of Oregon

Electronic medical records (EMRs) and other data management systems, web sites, and e-mail systems hold great promise and yet remain generally underused especially among safety net providers. One pioneer in this area is PCN, which is working to link EMRs to improve continuity of care for its rural population.

Using technology is one means to streamline processes and reduce long-term costs. Of course, the up-front costs of information technology systems are substantial, while payoffs are uncertain and often delayed. To implement the EMR, PCN developed a data server, configured the network, installed EMR software, and trained staff. Two clinics and one physician

office are now using EMR, and the connection to the local emergency room is underway. Two other providers are using the software for billing and scheduling purposes. The system is also able to track clinical data and collect data on patient satisfaction, quality, cost, and access, thereby enabling providers to assess the needs of their patients. As Dr. Jim Shanes, a physician at Siskiyou Community Health Center, puts it, the quality assurance potential of EMR is "tremendous."

Progress on this very challenging integration initiative can be credited to PCN's history of cooperation among providers, very competent staff support, a shared focus on meeting the needs of the local communities, and the passionate commitment of a few visionary individuals within the network. As in other networks, participant continuity also appears to have facilitated progress because people trust each other enough to take shared risks.

Health Choice Network (HCN) of Miami, Florida

HCN has made great strides in financial and information system (IS) integration using a combined network-level chief financial officer (CFO)/chief information officer (CIO) to link finance and IS functions. The centralized CFO/CIO position was created in 1996, and in 1997 a state-of-the-art fiscal and management information system was launched, which has grown and evolved to meet member CHCs' needs.

The CFO/CIO oversees the CHC finance directors, managing the network-wide accounting system, implementing policy changes, and working with external funding sources. The network also has standardized payroll processing and cooperative purchasing of payroll services. Centralized IS and finance staff at HCN meet monthly with an IS committee and a billing committee and quarterly with the medical manager users from each of the clinics.

Betsey Cooke, HCN president and CEO, attributes the network's successes to the early and strong commitment from each of the centers' CEOs, who contributed time; financial support; and, as with other networks, a willingness to collaborate in a manner unprecedented among Florida CHCs. She also noted that the emphasis on improving IS and fiscal functions has been crucial to everything else within the network, particularly because these functions were traditionally challenging to CHCs. Consensus among the CEOs on critical decisions and the fact that the CEOs had worked closely together for a number of years prior to establishment of the network also helped the network move forward.

Having a centralized finance/IS function has resulted in numerous favorable outcomes for the network CHCs. Complex cost reports to BPHC are now accurate and on time or early. Financial records are consistent across centers, allowing data to be compared and aggregated. Recent BPHC accounting network audits have generated no reportable conditions and not a single management comment. Better reporting to the network board and clinic CEOs has also provided a vital management tool. Use of the shared IS enables CHCs to improve and monitor

clinical outcomes for patients through common quality care guidelines and compliance benchmarking.

CONCLUSION

The seven CHC-led networks' integrative efforts have brought about many benefits to the individual centers and their patients. CHCs have gained improved visibility in the marketplace, greater purchasing power, improved efficiencies, and the chance to learn from each other. Additionally, these alliances have enhanced communication and improved relationships with local hospitals and group practices.

Forming and maintaining successful alliances can be a major challenge. Although this is the first study to provide a rich depiction of CHC network activities, the experience of these seven networks has been consistent with previous studies in other organizational settings in several key respects (Zuckerman, Kaluzny, and Ricketts 1995; Lipson 1997; Weiner and Alexander 1998; Nelson et al. 1999). A strong reliance on mutual benefit and reciprocity is evident. The affiliated organizations must agree to cooperate and forego their right to pursue individual interests for the sake of the network's interests, but they do so with the understanding that individually they will all also benefit (Weiner and Alexander 1998).

The networks in this study were able to surpass turf and territorial conflict and experience beneficial outcomes because of their strong communication, trust among members, long-standing relationships with the other CHCs, and the consistency of vision and decision making within their networks. In keeping with predictions from previous theoretical work, the trust among the members, whether derived from preexisting relationships or newly developed, appears to have reduced the perceived risk inherent in strategic alliances (Ring 1994; Das and Teng 1998; Das and Teng 2001). As greater opportunities become available for CHCs to integrate and compete in the marketplace, developing solid trusting relationships will become critical to the success of these alliances.

These findings suggest several implications for CHC managers, other safety net providers, and any community with an interest in access to quality care for the underserved. Considering the current economic environment and the ever-growing number of uninsured, safety net providers will need to pursue alternative approaches for providing quality services in the most efficient manner possible. Survival of the safety net may depend on the development of integrative alliances. According to a recent General Accounting Office (2000) report, those CHCs that had formed partnerships and networks and were involved in managed care were more likely to be successful than those that did not. As illustrated by these seven networks, a variety of routes is available to pursue successful integration. Regardless of the integrative path chosen the results of this study affirm the need for trust and mutual benefit to succeed.

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References

Bazzoli, G., R. Stein, J. Alexander, D. Conrad, S. Sofaer, and S. Shortell. 1997. "Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships." *The Milbank Quarterly* 75 (4): 533–61.

Bureau of Primary Healthcare Publication. 2000. "Experts with Experience: Community and Migrant Health Centers Highlighting a Decade of Service 1990–2000." Policy Assistance and Development Branch, Division of Community and Migrant Health, pp. 1–17.

Das, T., and B. Teng. 1998. "Between Trust and Control: Developing Confidence in Partner Cooperation in Alliances." *Academy of Management Review* 23 (3): 491–512.

———. 2001. "Trust, Control, and Risk in Strategic Alliances: An Integrated Framework." *Organization Studies* 22 (2): 251–83.

General Accounting Office. 2000. "Community Health Centers: Adapting to Changing Healthcare Environment Key to Continued Success." GAO/Health, Education, and Human Services Division-0039 (March): 1–44.

Kaiser Commission on Medicaid and the Uninsured. 2001. "Medicaid and Managed Care Fact Sheet." [Online information; retrieved 2/01]. www.kff.org.

Lipson, D. 1997. "Medicaid Managed Care and Community Providers: New Partnerships." *Health Affairs* 16 (4): 91–107.

Mueller, K., A. Coburn, S. Cordes, R. Crittenden, J. Hart, T. McBride, and W. Myers. 1999. "The Changing Landscape of Healthcare Financing and Delivery: How are Rural Communities and Providers Responding?" *The Milbank Quarterly* 77 (4): 485–509.

Nelson, J., H. Rashid, V. Galvin, J. Essien, and L. Levine. 1999. "Public/Private Partners: Key Factors in Creating a Strategic Alliance for Community Health." *American Journal of Preventive Medicine* 16 (3S): 94–102.

Ring, P. 1994. "Developmental Processes of Cooperative Interorganizational Relationships." *Academy of Management Review* 19 (1): 90–118.

Sparer, M., and L. Brown. 2000. "Uneasy Alliances: Managed Care Plans Formed by Safety-Net Providers." *Health Affairs* 19 (4): 23–35.

Weiner, B., and J. Alexander. 1998. "The Challenges of Governing Public-Private Community Health Partnerships." *Healthcare Management Review* 23 (2): 39–55.

Zuckerman, H., A. Kaluzny, and T. Ricketts. 1995. "Alliances in Healthcare: What We Know, What We Think We Know, and What We Should Know." *Healthcare Management Review* 20 (1): 54–64.

PRACTITIONER APPLICATION

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Competing pressures in the healthcare industry confront healthcare managers with conflicting challenges. On one hand, restricted reimbursement has limited the resources available. On the other hand, continuous advances in healthcare technology and the growing sophistication of healthcare consumers demanding quality services have led to rising healthcare costs. The aftermath of September 11 and the current economic recession have exacerbated these issues, increasing the number of uninsured individuals and the difficulties employers encounter in

meeting health insurance costs. The description of innovative approaches used by healthcare providers in this article should be of great interest to healthcare managers and clinicians struggling to do more with less.

The article describes the integrated services delivery initiative and provides examples of projects undertaken by networks created through this initiative. These networks demonstrate the benefits gained when organizations perform key functions as a group. The initiative provides an innovative alternative to achieve these benefits without merger or compromise of individual organizational integrity. The specific examples describe a rich variety of possible projects that managers might explore. The topics addressed, ranging from managed care contracting, credentialing, and privileging to quality improvement and clinical practice guideline implementation, have virtually universal application. The successes achieved may stimulate healthcare administrators to seriously consider these strategies to meet their own needs and suggest partnership opportunities in their own environments.

Challenges that the networks have faced and strategies that have been successful are also described throughout the examples. Principles emerging from this experience are extremely helpful to those considering network formation and certainly to any organizations currently involved in network activities. The discussion may also address concerns or negative past experiences that may be deterring managers from using the collaborative approach.

Clinicians may find some aspects of the article especially interesting. The discussions on implementation of clinical practice guidelines can serve as a positive model for clinicians considering or involved in implementing guidelines in their own setting and demonstrate the utility of working with other practices. Similarly, the examples of quality improvement projects point to the benefits of working with other practices in establishing benchmarks and in having comparison data to drive improvement efforts.

Examples of shared administrative functions may stimulate clinicians to think of other such processes that can be integrated to facilitate their work. The natural professional interaction that clinical staff often have with clinicians at other institutions may serve as a bridge for administrators to develop these valuable collaborations.

In summary, utilizing shared resources is a valuable strategy that can be used by healthcare managers seeking to increase the quality and sophistication of their services while containing costs. By providing concrete illustrations of these collaborations, the article may enable both clinicians and clinical managers to pursue similar horizontal and vertical integration efforts.