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Health Care Linkage Project: Improving Access to Care*

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The primary objective of the Health Care Linkage Project, funded by a grant from the Chicago Community Trust, is to develop, implement, and evaluate a primary health care linkage network within the city of Chicago that creates formalized linkages between community health centers, the Chicago Department of Health clinics, and hospitals. Six linkage networks are currently operational, with an additional two sites phased in during 1991. The success of the pilot project has been demonstrated by hundreds of patients receiving primary care and ancillary services on a more timely basis, by greater coordination between the public and private sector, by cost-savings to both patients and providers through reducing inappropriate use of services, and by a variety of spin-off projects which have improved the quality and accessibility of services. A second important objective is the development of a Health Care Linkage Manual that describes the practical experience and lessons gained from the linkages, the status of comparable arrangements in other U.S. cities, replicability of the linkage models, and recommendations for policy changes which will make linkages more effective. (Henry Ford Hosp Med J 1992;40:9-12)

The problem of ensuring both access to comprehensive, high-quality primary health care services for persons either on Medicaid or lacking any third-party insurance and the continued viability of health care institutions providing this care has been of major concern for several years in Chicago. It is clear that a significant number of Chicago citizens face financial, geographical, cultural, physical, and/or informational barriers to receiving health care services.

The burden of providing these services falls disproportionately on a relatively small number of health care institutions, especially publicly operated and subsidized providers (specifically community health centers, the Chicago Department of Health [CDOH] clinics, Cook County Hospital and its outpatient clinics, the University of Illinois Hospital and outpatient clinics, and a small number of not-for-profit hospitals that operate outpatient clinics). Over the past several years, these sites have experienced increased demand for their services, especially primary care services.

Further documentation, description, and discussions about this complex problem resulted in several proposals from government agencies (1,2) and professional associations (3,4) in Chicago. Although these proposals are as diverse as the organizations that produced them, nearly all sectors agree that a major restructuring of the current system is needed to provide high-quality health services for the growing number of residents who need them. Further, there is consensus that any new system of health services must be centered around a network of ambulatory care facilities.

The Illinois Primary Health Care Association (IPHCA) received funding from the Chicago Community Trust to develop, implement, and evaluate a primary care linkage network within the city of Chicago that will create formalized linkages between

community health centers, CDOH clinics, and hospitals (community, tertiary, and/or specialty). Specifically, the Health Care Linkage Project is designed to:

1. Increase access by reducing appointment waiting times, expanding the scope of primary care services, and increasing the capacity of the system to treat more patients.
2. Improve the quality of health care by increasing continuity of care, improving patient satisfaction, and both tracking and improving various health outcomes.
3. Create a more efficient system by encouraging many providers to participate in prospective planning, enhancing coordination among providers, reducing duplication of services, and improving the cost-effectiveness of service delivery for the linkage network providers.

Major Players in the Health Care Linkage Project

In designing the Health Care Linkage Project, IPHCA believed that the most productive and natural linkages within Chicago's complex ambulatory care system should initially occur between community health centers and CDOH clinics as many are located in the same neighborhoods, serve the same clientele, and share similar missions. Following the establishment of ini-

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tial linkages between community health centers and CDOH clinics, hospital partners would be added to the linkage configuration to address the lack of formal referral mechanisms from hospitals to primary health care facilities and from primary health care settings to hospitals for inpatient and ancillary services.

Community health centers

In Chicago, the community health centers represented by IPHCA serve almost 150,000 persons per year, generating approximately 450,000 patient visits. The centers have a variety of funding sources including federal grants, Medicaid, Medicare, state contracts and grants, local governments, and limited revenue from patient fees, private insurance, and private contributions. The community health centers are located in the city's most impoverished communities and serve those people in greatest need of quality health services.

While each center is unique, both in history and current structure, most have the following features: direct provision of comprehensive primary care and ancillary services through a multidisciplinary team approach; a delivery orientation that emphasizes prevention, patient education, family focus, and cultural sensitivity; specialty, inpatient hospital, long-term care, and rehabilitative services provided in a coordinated manner through affiliation agreements and staffing privileges to insure continuity of care; governance by community boards and participation in community coalitions and organizations; special programs and services to address the unique needs of the community (teens, senior citizens, cultural issues, occupational safety, transportation, substance abuse and treatment, nutrition, human immunodeficiency virus [HIV] testing and counseling, and outreach); sliding scales or low fees and located near public transportation to assure accessibility; and quality assurance standards and systems.

CDOH neighborhood health centers

In addition to providing traditional public health services, the CDOH operates a large clinical system comprised of comprehensive primary health care clinics, maternal and child health clinics, mental health centers, and tuberculosis and sexually transmitted disease (STD) clinics. The CDOH clinic system developed rapidly in the 1960s through Hill-Burton funding and has since become the largest ambulatory care provider in the city with nearly 1 million patient visits each year. All of the clinics are governed centrally from a "downtown" office where all policy, staffing, and program decisions are made.

According to the CDOH's 1989 report "Clinics in Crisis," 85% of its patient population lives below the federal poverty level. The CDOH clinic system is experiencing severe shortages in key personnel, including administrators, physicians, nurses, and clerks, while simultaneously facing its worst appointment waiting times. In some clinics patients may have to wait as long as six months for an appointment. Successive mayoral administrations have failed to provide the necessary budget increases needed to treat all of the CDOH's patients. Due to these system constraints, the CDOH has been eager to begin forming linkages with the nonprofit and private sectors not only to increase ser-

vice availability but also to decrease appointment waiting times for its patients.

Community, tertiary, and/or specialty hospitals

The hospital component of the Health Care Linkage Project was originally meant to address the lack of formal referral mechanisms from hospital emergency rooms, discharge planners, and outpatient departments to primary health care settings. After much discussion, this component has evolved to address the hospitals' need for the capability to schedule primary care appointments at community health centers through a linkage coordinator who in turn can provide the hospitals with information on the status of referred patients. Additionally, community health centers should also have the ability to refer to linked hospitals for ancillary, subspecialty, and inpatient services.

Implementation of the Health Care Linkage Project

The primary objective of the Health Care Linkage Project is the creation, operation, and evaluation of formalized linkages among those providers previously mentioned. A second objective is to develop a Health Care Linkage Manual to describe the practical experience and lessons gained from the linkage project and to examine other linkage sites both within Chicago and in other cities.

Oversight for these tasks is the responsibility of the project's Steering Committee which consists of representatives from the city and state health departments, the U.S. Department of Health and Human Services, the Department of Public Aid, community hospitals, community health centers, consumer representatives, a public health nurse, a private physician, and community advocacy groups. From the start and throughout the development of the linkage project, this group has remained active and a viable entity, partly because its mission has been broadened to include a forum for the discussion of health care issues by providers, funders, and advocates sharing common purposes.

Another critical aspect of the project was recognizing that the process had to be managed and facilitated by a "hands-on" staff—a staff with both a broad range of skills and time to undertake the myriad details of negotiating and implementing the linkage agreements.

Linkage Models

The original proposal for the Health Care Linkage Project suggested one model of linkage between a CDOH comprehensive neighborhood health center and a community health center. In fact, since each linkage is driven by an analysis of site-specific needs, each has reflected a different arrangement, thereby leading to a variety of experiences. Some examples of creative relationships that have developed in the various linkages are:

- Referrals from CDOH to community health centers of new, non-emergency patients who may have to wait too long for an appointment (as determined by patient preference and medical necessity).
- CDOH providing Women, Infants, and Children (WIC) services on-site one day per week at a community health center.

- CDOH providing a pharmaceutical dispensary for patients without third-party coverage who are referred from one community health center.

- Community health centers referring patients to CDOH for radiology, dentistry, and ophthalmology.

- CDOH providing HIV and chlamydia testing and lead screening for two community health centers, including transport of specimens and delivery of results.

- A Linkage Oversight Committee conducting a joint needs-assessment to assist in the establishment of priorities for service interventions.

- CDOH and two community health centers working cooperatively on a preventive dental campaign.

- A community health center accepting referrals from the CDOH's STD clinics.

- CDOH providing partial financial support for a provider at two community health centers to increase capacity to accept referrals.

All linkage agreements include a linkage coordinator, a telecopier machine, a Linkage Oversight Committee, and patient and staff education materials. The linkage coordinator is employed by the community health center with financial support from IPHCA and the CDOH. This person coordinates referrals for each site, is involved in patient education and tracking, and supplies updated information to all participating sites on capacity/waiting times for appointments in various services. The linkage coordinator also maintains a log used for both tracking and evaluation purposes and participates on the Linkage Oversight Committee. While all of the linkages have this basic framework, the implementation of each individual linkage has been approached with a great deal of flexibility to accommodate the unique needs of both the health centers and the constituencies they serve. This flexibility has been crucial in making the linkages work operationally.

Accomplishments

The eight linkages phased in from August 1990 to February 1992 generated 708 referrals from the CDOH to community health centers (to decrease appointment waiting time for the patient) which in turn produced 1,702 appointments. Of these, 25% were obstetric referrals, 51% pediatric referrals, and 12% for family planning services. During the same period, 429 referrals were made from community health centers to the CDOH (for services the centers do not provide), generating 542 appointments. Of these referrals, 48% were for dental services, 42% for ophthalmology services, and 5% for x-ray services. Additionally, through various linkage arrangements, 476 patients have received WIC services, 246 patients have been enrolled in the Medicaid Presumptive Eligibility program, 63 patients have received STD services, and 77 patients have received mammography services. These data reflect that patients who are being referred through the linkage project receive improved access to care through decreased appointment waiting times and increased availability of specialty services.

The process of forming linkages between community health centers and CDOH clinics has resulted in many other accom-

plishments that benefit not only the participating health centers but the patients as well. For instance, communication has been facilitated between linkage providers. Many linked providers undertake joint projects (i.e., preventive dental campaigns and health fairs), participate in joint planning, and work together to share resources.

In sharing resources, the linked providers have the benefit of many cost-savings. In particular, community health centers have benefited from CDOH's support in providing laboratory services, pharmaceutical dispensaries, staff in-servicing, and, in some cases, funding for a health care provider. In return, the CDOH has saved on costs as its patient load lessens through referrals to a community health center for ongoing primary care. However, it is important to note not only the successes that have been achieved but the lessons that have been learned as well.

Lessons

From our experience in developing and implementing linkages, many lessons have been learned:

1. Misinformation and false assumptions exist between systems. For instance, we found that providers and administrators had not even visited each other's sites. This was unusual because in many cases the linked clinics were located nearby one another and basically served the same communities. Also, the linked clinics often referred blindly to each other without a clear understanding of the available services and capacity issues of the referral site. To avoid such problems, the process of developing linkage agreements should involve not just a formal contract addressing the concerns of high-level administrators, but emphasize the building of relationships between the front-line staffs of the different organizations in order to foster a greater understanding and deeper appreciation of both systems.

2. Considerable time is needed to develop working relationships in a variety of institutions at many different levels, to capitalize on opportunities and potential, and to solicit the necessary organizational approvals. In addition, linkage relationships are best developed in phases, proceeding as mutual trust, financial viability, clear clinical benefits, and political will are recognized.

3. The involvement of all levels of staff from both the health department and community health centers (including executive directors, physicians, and medical and nursing directors) is necessary to achieve a common ground for the development and implementation of linkage agreements. Such an inclusive approach to linkages promotes strong, personal working relationships and commitment to improving the health of the overall community. It is critical that all key people are involved in the implementation of the operational aspects of the linkage as early as possible.

4. Expanding linkage agreements to include hospital partners is more complex than envisioned because of the multiple layers of hospital systems and the potentially negative impact on some hospital revenue streams.

5. Ongoing staff education about the linkage arrangement is crucial for its success. This has been especially necessary at the CDOH clinics because in most cases the staff did not include a

member appointed to have sole responsibility for facilitating referrals.

6. Care should be taken in educating patients of the relationship between the linked health centers. Patients should be informed that a clinic in the linkage arrangement is "approved" by the other and vice versa.

7. Patients should be educated about the linkage and then given the option for referral. Patient choice in participating in a linkage arrangement is essential because patients are more likely to comply if they decide where they receive care and are given information about the provider/health center.

The Future of the Health Care Linkage Project

As the project continues, new types of linkages will be added to the growing network to include a wider, concentric circle of providers and provider types. For instance, the Health Care Linkage Project is currently developing bidirectional referral arrangements between existing linked providers and Cook County Hospital, the county public hospital. These linkages will facilitate decentralization of Cook County Hospital's outpatient clinic as well as enable the community health centers to access subspecialty clinics and testing for their patients. Tracking and follow-up of appointments and transfer of medical record infor-

mation by the linkage coordinators are important steps for a well-functioning process.

Expansion of the project will also entail both the implementation of applicable linkage components systemwide (such as group purchasing, joint needs-assessments, coordinated planning and marketing) and the continued assessment of the feasibility of networking other types of providers (e.g., home health, mental health) linked at a variety of levels. It is the hope of the Health Care Linkage Project that the initial linkages formed within the city of Chicago and the lessons learned in the process will constitute a framework that can be built upon for continued ambulatory care coordination, providing greater access, improved quality of care, and a more efficient health care system.

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