

3-1992

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Recommended Citation

Getzenberg, Joy L. and Lenihan, D. Patrick (1992) "Federal, State, and Local Partnerships in Providing Primary Care: One Urban Health Department's Endeavor with a State University Medical Center," *Henry Ford Hospital Medical Journal* : Vol. 40 : No. 1 , 13-15.

Available at: <https://scholarlycommons.henryford.com/hfhmedjournal/vol40/iss1/5>

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Federal, State, and Local Partnerships in Providing Primary Care: One Urban Health Department's Endeavor with a State University Medical Center

Joy L. Getzenberg, MA,* and D. Patrick Lenihan, MS*

We describe how the federal government, the City of Chicago, and the State of Illinois worked together to increase the availability and accessibility of health care services on Chicago's underserved west side by reopening a bankrupt, federally-funded community health center. The federal government made the building available to the City which then contracted with a state university medical center to be the provider of services. This partnering has allowed the Chicago Department of Health to offer services in a previously underserved area. The University has gained an opportunity for community-based primary care teaching, as well as community relations. Patients have increased access to a wide variety of specialty and inpatient care. If public health providers are to be successful in this financial climate, they must look to new partners and new ways of delivering services to increase availability of services at a time when they are greatly needed. (Henry Ford Hosp Med J 1992;40:13-15)

Chicago's health care system which serves low-income and other high-risk communities is a microcosm of what can be found nationally, particularly in large cities: a poorly coordinated and underfunded patchwork of services to which the most vulnerable population has limited access. Overall constriction of funding for health care for the poor has been caused by 1) stagnant or decreasing Medicaid reimbursement, which inhibits quality providers from treating not only large volumes of Medicaid patients but the uninsured as well; 2) stagnant or decreasing federal funding; and 3) a fixed budget for local funding.

At the same time, there has been an increase in the number of people without health insurance. The Chicago and Cook County Health Care Summit, convened in 1990 by the Governor of Illinois, the Cook County Board President, and the Mayor of Chicago, reported over 400,000 medically needy in Chicago; this figure does not include Medicaid patients, who often experience barriers to care.

The closing of inner-city hospitals, leading to a severe maldistribution of hospital beds, has also contributed to the reduction of available primary care services. In Chicago over 10 hospitals have closed during the last seven years. These closings, along with constricted public funding, have contributed to a gap of over 1 million patient visits in Chicago, according to the Summit report.

We describe how the federal government, the City of Chicago, and the State of Illinois worked together to increase availability and accessibility of health care services on Chicago's underserved west side by reopening a bankrupt, federally-funded community health center.

Background

Mile Square Health Center, Inc., was founded on the west side of Chicago during the late 1960s, a product of former President Johnson's Great Society era. Located in one of Chicago's

most impoverished neighborhoods, the Mile Square Health Center was just one mile north of the largest concentration of medical services in the world, the West Side Medical Center complex. The Center thrived for decades, thanks to generous federal support through the 1970s and 1980s. The modern facility, surrounded by vacant lots and all the other trappings of a depressed inner-city neighborhood, was home to mental health programs; nutrition, health education, outreach, and social services; and a comprehensive array of primary care health and medical services. At its peak in the 1980s, the Center's annual budget exceeded \$12 million and provided over 200,000 patient visits annually.

During the last several years, the Mile Square Health Center became the victim of its own overextension and the dwindling of federal funding. In 1986, it lost its federal community health center funding. Because extensive management and financial problems could not be resolved, the corporation entered bankruptcy proceedings and the Center closed its doors almost two years ago.

The role of the Chicago Department of Health (CDOH) in providing primary care has changed with the financial and social climate. In the 1960s, CDOH took advantage of available federal Model Cities/Office of Economic Opportunity programs and built and staffed a network of neighborhood health centers and maternal and child health centers. The availability of funds allowed CDOH to greatly expand its role as a primary care provider to Chicago's poor beyond traditional current health programs.

During the last several years, CDOH has tried different ways of adapting to the increased demands for service and at the same

Submitted for publication: July 24, 1991.

Accepted for publication: October 17, 1991.

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time enduring stagnant funding. Partnerships have been developed with other health care providers, acknowledging that while all health care providers attempting to provide services to the poor suffer from inadequate financing, new configurations of providers can result in enhanced capacity and improved quality of care.

The first model, called Partnership in Health, links CDOH facilities with neighboring hospitals, providing continuity of care for our patients and providing hospitals with empty beds with patients, most of whom are eligible for Medicaid. This program started with obstetrics and has been expanded into other clinical areas.

The Illinois Primary Health Care Association Linkage Project links CDOH facilities with other community-based primary care providers to better coordinate patient care and decrease waiting times by referring patients to other providers with available appointments.

CDOH also subcontracts grant monies to other health care providers who offer specialized services (i.e., substance abuse services and human immunodeficiency virus [HIV] treatment) either more efficiently and effectively than CDOH or that CDOH does not provide. The closing of Mile Square Health Center offered us an opportunity for yet another type of partnership.

The Partners

CDOH, the single largest provider of ambulatory care to Chicago's underserved communities, was interested in developing a full-service neighborhood health center in the Mile Square community but desired to join with another health care provider to share the financial burden and enhance continuity of care for CDOH patients.

Because the building was financed with federal funds, the United States Department of Health and Human Services (DHHS) held title to the building and agreed to offer the facility as a health center for the low-income community. DHHS also agreed to provide \$150,000 specifically for renovation of the building.

The State of Illinois became a partner through several different routes. The University of Illinois Medical Center, a major teaching institution in Chicago which is located just south of Mile Square, agreed to become a partner in the Mile Square endeavor. The State's Medicaid agency agreed to extend the old Medicaid rate for Mile Square, which was significantly higher than the rate in the City of Chicago. Additionally, the state legislature awarded \$325,000 for renovation and start-up costs of the facility.

CDOH and the University of Illinois Medical Center jointly submitted an application to DHHS for the reopening of Mile Square. This application was accepted, and the City was awarded title to the building. The City contracted patient care services to the University, which also became responsible for the management of the facility and its programs; all Mile Square employees are part of the University's payroll, and the Executive Director reports to the Hospital Director.

Clinic Operations

The intent of the agreement is that the University of Illinois would operate the facility as a CDOH clinic. Patient financial procedures were established with CDOH approval to ensure that patients would not be denied service because of an inability to pay and that patients would be charged for services on a sliding-scale basis, as required by federal funding sources and CDOH policy.

To assure CDOH that the facility remained consistent with our mission, a Steering Committee was formed, which acts as a board of directors for the clinic. The Committee includes three members each from the City and the University. The Executive Director is hired by and reports to the University, but the selection must be approved by the Steering Committee.

Another way that CDOH has stayed involved with the operations of the facility is through the Community Liaison. The CDOH Director of Social Services, who has had extensive community-based experience, spends several hours each week engaged in marketing activities and listening for any concerns the community may have regarding the operation of the clinic. This role was critical, from the City's point of view, because the University had only recently branched out beyond its campus in providing ambulatory care, and because it was important for CDOH to be assured that patients, many of whom were former CDOH patients, felt they were being treated fairly and that the services offered at Mile Square suited their health care needs. The community liaison role was also important in planning the service array.

CDOH and the University of Illinois agreed to share capital and start-up expenses not covered by state and federal grants. Both the University and CDOH contributed to the first year's operating budget. The City provided grant funding redirected from a community mental health clinic that was phased out in concert with the reopening of Mile Square, as part of the Department's long-term plan to provide a comprehensive array of services. CDOH has also agreed to underwrite any financial losses in clinic operations.

As a CDOH facility, the Mile Square Health Center would benefit from an even more favorable Medicaid reimbursement once CDOH received the federally qualified health center designation as expected, which, given the projected high Medicaid population, would be a significant financial advantage.

Progress to Date

The Center opened in February 1991. Start-up was a bit slow. However, whereas only 600 patient visits were provided in March 1991, the first full month of operation, over 1,600 visits were reported in September 1991. By the end of the last month of the first year, it is quite likely that the annualized projection will be close to the goal of 25,000 patient visits.

According to patient surveys and informal communication between patients, other community members, and the CDOH community liaison, patients are pleased with the services provided at Mile Square.

Continuity of care appears to be a strength of the arrangement. Even though most practitioners do not work full-time at

Mile Square, schedules are consistent to allow patients to develop a relationship with, and see exclusively, one primary care provider. Since the clinic has reopened, continuity has been enhanced between services offered on-site at Mile Square and those at the hospital, with Mile Square staff directly making appointments for required ancillary services for the patients.

Regarding its potential as a major teaching site for primary care, Mile Square has had rotating students from medicine, pharmacy, and nurse midwifery programs. As of this time, residents and interns have not yet been placed at Mile Square; it was believed that the clinic should have more experience before becoming a major teaching site for primary care physicians.

Mile Square has been a valuable site for a staff and service complement that goes beyond the purely medical model. The obstetrics clinic is staffed primarily by certified nurse midwives, and nurse practitioners also staff the other clinical programs. A pharmacotherapist, a doctoral-level pharmacist, conducts pre-screening histories of patients currently taking prescribed medications, works with physicians as needed, and provides one-to-one counseling for all patients for whom medications are prescribed. Additionally, based on patient demand, weight reduction and hypertension education classes are being offered.

Conclusions

We at CDOH have found that partnerships are beneficial in leveraging resources, particularly of private institutions. A partnership with another public institution, such as the University of Illinois, has a particular advantage in that public health care organizations have a common mission and tend to serve similar populations.

Patients benefit from the partnering of a major medical center and a more community-oriented public health agency in several ways. When CDOH developed the service configuration for Mile Square, we used a modified community-oriented primary care approach and designed the services around the primary care needs of the population. There was some resistance on the part of the University to this method; with teaching and research as primary missions, they would not generally embrace that viewpoint. The University's approach would most likely have been to offer specialized medicine which traditionally has been the mainstay of academic medicine.

A partnership with the University of Illinois gave Mile Square patients access to a wide variety of specialty and inpatient care services. As continuity with diagnostic, specialty medical care, and inpatient services has been problematic for CDOH patients, this partnership has been most welcome for this reason alone.

The contribution by the federal government of the Mile Square facility was particularly valuable given the size and layout of the available building. The potential for "one-stop shopping" for our patients is greatly enhanced by the physical plant. For example, in addition to the current array of services—maternal and child health, general medicine, social services, and health education—plans have been finalized to move comprehensive sexually transmitted disease services into the building,

including HIV treatment, which will be provided by CDOH. Other potential on-site services include specialty care for tuberculosis, mental health services, and Women, Infants and Children program services—all of which are programs offered by CDOH at other sites.

The University has also experimented with alternative models of health care delivery at Mile Square. For example, space and staff configuration have allowed for the provision of extensive patient prescription drug counseling. Although not a new model, the staff complement includes nurse practitioners and certified nurse midwives, who compose the bulk of the primary caregiver staff.

This partnering has benefited CDOH in that we now have a presence in an underserved community not previously served by CDOH. We also have been able to use our available resources to leverage those of a major medical center.

The University has an opportunity for community-based primary care teaching for medical, nursing, and allied health students, as well as community relations benefits.

One of the lessons learned by both the University of Illinois and CDOH was the importance of marketing in planning for and providing health care services. Although a needs assessment was completed for the application submitted to DHHS and used to make service projections and determine service array, it would have been helpful to have received more information from community residents on such factors as abandoned public housing projects, which are not reflected in census and other official data. Although it is unlikely that such information would have significantly altered our estimates of service need in the community, it could have helped to focus where we actually conducted outreach and marketing.

Perhaps most important from a marketing perspective, we learned that documenting a shortage of primary care services does not guarantee that provided services will be utilized. Given the huge gap created in primary care services by the closing of Mile Square, we assumed that a significant portion of these patients would return to the reopened facility. We did not sufficiently take into consideration that many of the former patients would either have found another source of care or, given the nonemergent nature of primary care, only seek medical care when absolutely necessary, most likely from an emergency room. Aggressively marketing the service, and creating a demand, has been absolutely critical to the success of this endeavor. Since the opening of the Center, active marketing has taken place, resulting in the steady increase in patient volume.

As a more general lesson, CDOH has learned from this process, and other partnerships we have attempted, that if public health providers are to be successful in this financial climate, they must look to new partners and new ways of delivering services. Public health agencies have often not been as responsive to the changing health care climate as their private sector counterparts. Public health care institutions should look to new partners, find a synergy in these partnerships that can benefit their patients and their health care partners, and increase availability of services at a time when they are greatly needed.