

Pocket Guide to Cases of

medicine
&
public health

Collaboration

Roz D. Lasker, M.D.
David M. Abramson, M.P.H.
Grace R. Freedman, M. Phil.

Center for the Advancement of Collaborative Strategies in Health
The New York Academy of Medicine

The New York Academy of Medicine
1216 Fifth Avenue
New York, NY 10029-5293

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*To the partners in these cases of collaboration,
who are pioneering new strategies for improving
health and the functioning of the health system.*

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This *Pocket Guide*, like the monograph *Medicine & Public Health: The Power of Collaboration*, depended on the contributions of many individuals and groups. We are deeply indebted to the hundreds of health professionals who provided information about the cases in this book. Their willingness to share their experiences—problems as well as accomplishments—will enhance the capacity of communities around the country to initiate collaborative activities and to sustain existing partnerships.

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Part I

Introduction

In December 1997, The New York Academy of Medicine published *Medicine & Public Health: The Power of Collaboration*.¹ That monograph, funded by The Robert Wood Johnson Foundation, and jointly sponsored by the American Medical Association and the American Public Health Association, provides readers with a practice-based conceptual framework for thinking about and implementing cross-sectoral collaborations. The book reviews the historical relationship between medicine and public health and examines the current environment, identifying compelling reasons for the two sectors to work more closely together than they have in the recent past. Moving beyond the hypothetical, it analyzes 414 cases of medicine and public health collaboration—most of which involve other community partners as well—elucidating a set of common, and generally applicable, strategies for improving health and shaping the future direction of the American health system.

Recognizing that there is much that people involved or interested in collaboration can learn from each other, The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation have funded this *Pocket Guide to Cases of Medicine & Public Health Collaboration* to give readers direct access to the cases on which the monograph is based. Available in print form and as an interactive, searchable database on the World Wide Web (<http://www.nyam.org/pubhlth>), the *Pocket Guide* is structured so that users can quickly identify collaborations that share one or more characteristics of interest and network with the people involved. Toward that end, each case is described in a brief narrative abstract, which includes a contact person or literature citation. In addition, the cases are indexed according to the multidimensional framework developed in *Medicine & Public Health: The Power of Collaboration* (i.e., where the collaborations take place, the types of partners involved, the ways the partners combine their resources and skills to achieve certain health and institutional objectives, and the structural arrangements that undergird the partners' relationships). The print version of the *Pocket Guide* organizes the case abstracts geographically, listing all cases that correspond to each index term at the end of the book. The Internet version has special features that allow users to search the database through multiple index terms simultaneously, to search the text of the case abstracts (for example, to identify collaborations dealing with particular health problems, associated with particular foundation- or government-sponsored initiatives, or reported by particular individuals), to connect to relevant parts of the monograph, and to engage in on-line networking. Both versions provide readers with instructions for submitting new cases of collaboration for addition to the database.

¹Lasker RD and the Committee on Medicine and Public Health. *Medicine & Public Health: The Power of Collaboration*. New York: The New York Academy of Medicine. 1997. The monograph is also available on the Internet at <http://www.nyam.org/pubhlth>.

Cases Included in the *Pocket Guide*

The collaborations included in this edition of the *Pocket Guide* are drawn from the cases that were analyzed in *Medicine & Public Health: The Power of Collaboration*. Those cases were solicited in August 1996 from members of major medicine and public health associations, staff in government health agencies, and participants in potentially relevant foundation- and government-sponsored initiatives. Using a self-administered written or Internet questionnaire, respondents were asked to provide some basic demographic information about themselves and to answer five open-ended questions: What made the collaboration happen? Who was involved? What was the collaboration trying to achieve? What actually happened? What do you think were the critical elements that determined the project's success or failure?

Over 500 cases were collected through this process, of which 414 involved professionals and/or organizations in *both* medicine and public health—a prerequisite for inclusion in the study. These medicine/public health collaborations, which usually involved other community partners as well, were studied to elucidate the models and strategies presented in the monograph. The number and heterogeneity of these cases made them a suitable substrate for such an analysis. The collaborations were geographically well-dispersed, encompassing diverse regions of the country, urban and rural communities, and activities at local, state, and national levels. They were submitted by a broad array of professionals working in virtually every type of venue relevant to medicine and public health. They reflected both short- and long-term partnerships involving all of the domains of the health system: practice, policy, education and training, and research. They included collaborations associated with a broad spectrum of foundation- and government-led initiatives—such as All Kids Count, Community-Based Public Health, Community Care Network, Community Partnerships in Health Professions Education, Comprehensive Community Health Models, Health of the Public, Healthy Communities, Medicine/Public Health Initiative, Models That Work, Reach Out—as well as partnerships unaffiliated with any formal program. And they included not only successful partnerships, but also partial successes and failures. Because of this diversity, the 414 cases likely encompass most of the common types of medicine/public health interactions occurring in the country.

The *Pocket Guide* contains information about 380—or 92%—of these cases. Since the original solicitation assured confidentiality to case respondents, we were able to include only cases for which we could obtain permission to publish or which had been published previously. For the 35 missing cases, we were unable to obtain the necessary permission either because of problems locating the original case reporter (or a suitable substitute), or because the reporter was concerned that inclusion of the collaboration in the *Pocket Guide* would preclude publication of a forthcoming journal article. In spite of these gaps, the 380 cases in the *Pocket Guide* are fully representative—both demographically and by model of collaboration—of the 414 cases analyzed in the monograph.

It is important to point out, however, that the original 414 cases were not a random sample. Therefore, it is not possible to generalize from the frequencies observed.

The narrative abstract and indexing of each *Pocket Guide* case are based on information from a variety of sources. As a starting point, we reviewed the information that had been collected for the monograph analysis: the responses to the 1996 questionnaire, the published articles and reports submitted by case respondents, and notes from extensive telephone interviews that we conducted to clarify information in some of the case reports. Draft abstracts developed from this material were then sent to all case reporters for review. At that time, April 1998, the reporters also were asked to complete a second self-administered questionnaire to validate the way their case had been characterized. The results of this survey were used to confirm case contacts, to update narrative abstracts, and to refine the way cases had been coded. With this additional information, we found that many cases involved a greater range of collaborative activity than initially suspected. As a result, the *Pocket Guide* includes more examples of each model of collaboration than reported in the monograph.

Framework for Characterizing Cases

Cases in the *Pocket Guide* are characterized according to the framework developed in *Medicine & Public Health: The Power of Collaboration*. This framework, which is used to code and index each case, has four dimensions:

- geography: where the collaboration takes place
- partners: the types of organizations involved in the collaboration
- synergies: the ways the partners combine their resources and skills
- structural foundations: the partners' organizational relationships

GEOGRAPHY

In the *Pocket Guide*, cases are organized geographically, reflecting whether the collaboration or collaborative program initiative takes place in a particular state, in a multistate region, at the national level, or in a country other than the United States. This geographic information also is incorporated in the unique identifier assigned to each case. (These identifiers begin either with the two-letter postal abbreviation for a particular state, or with MST (for multistate), NAT (for national), or INT (for international). This prefix is then followed by a number.) It is important to point out that while some of the collaborations listed under particular states are statewide in scope, the vast majority reflect activity at the local level. Similarly, most of the national program initiatives promote collaboration at local and/or state levels.

PARTNERS

The cases in the *Pocket Guide* bring together individuals with diverse professional backgrounds working in a broad spectrum of organizations—including but also extending beyond the confines of medicine and public health. In the database, partners are coded according to the following scheme, which encompasses government agencies, medical providers/insurers, academia, professional associations, and community groups.

- local health department (LHD)
- other local government agency (L-GOV)
- state health department (SHD)
- other state government agency (S-GOV)
- federal health agency (FEDHLTH)
- other federal government agency (FEDOTH)

- solo or group medical practice (MDPRAC)
- hospital or health system (HOSP)
- community health center or other publicly funded clinic (CLIN)
- managed care organization (MCO)
- health insurance company (INS)
- laboratory or pharmacy (LAB/RX)

- school of medicine (SOM)
- school of public health (SPH)
- academic research center (ARC)
- residency program (RES)
- academic health center (AHC)
- other university-level academic institution or department (U-OTH)

- medical/specialty society or other clinician association (MEDSOC)
- public health association (PHASSN)
- other professional association (PROFASSN)

- voluntary health organization or advocacy group (VHO)
- business (BUS)
- labor organization (LABR)
- school below the college level (SCHL)
- religious organization or clergy (RELIG)
- media (MEDIA)
- foundation (FNDN)
- other community group (C-OTH)

While most of these types of partners are self-explanatory, a few caveats are worth noting. First, depending on the structure of a particular state or local government, governmental partners responsible for mental health, substance abuse, the environment, Medicaid, or social services may be coded as “health department” or as “other government agency.” Second, both independent and state-run local health units are coded as “local health department.” Third, partners are coded as “academic health center” when they represent an academic health center as a whole rather than any of its component health professions schools or affiliated teaching hospitals. Finally, associations representing any type of clinician (i.e., not only physicians, but also nurses, dentists, social workers, etc.) are coded as “medical/specialty society or other clinician association.” Associations representing institutional providers (such as hospitals or managed care organizations), academic institutions or professionals, or professional groups unrelated to health are coded as “other professional association.”

SYNERGIES

One of the advantages of studying a large number of cases of collaboration, as was done in the monograph analysis, is that it is possible to move beyond individual experiences to identify common themes and strategies. Although each of the cases we collected is, in some sense, unique, analysis of the collaborations as a whole elucidated a set of models that are applicable to a broad range of localities, health problems, and program initiatives. One aspect of this modeling system relates to the way partners in a collaboration combine their resources and skills. We refer to these types of models as “synergies” because they allow partners to transcend their own limitations and achieve benefits that none of them can accomplish alone.

In the cases in the database, partners contribute an impressive array of assets to collaborative endeavors: technical, scientific, and pedagogic expertise; methodologic tools; individual-level services and population-based strategies; administration and management skills; legal and regulatory authority; convening power; influence with peers, policymakers, and the public; data and information systems; buildings and space; and financial support. These assets are valuable in and of themselves. But they can reinforce each other substantially when combined in certain ways. In the monograph, we describe six reinforcing combinations of resources and skills (synergies), including concrete models that partners use to put each synergy into action. These models are not mutually exclusive; most collaborations, in fact, involve more than one. In the *Pocket Guide*, each case is coded according to the particular synergy model(s) that it exemplifies.

Below, a brief description is provided for each synergy model. (For reference, a key to these synergy models is provided on page 319.) More detailed information about the synergy models can be obtained in *Medicine & Public Health: The Power of Collaboration*, which is electronically linked to the Internet version of the *Pocket Guide*.

Synergy 1: Improving health care by coordinating medical care with individual-level support services

In the first type of synergy, partners in collaborations seek to enhance the success of medical care—and address determinants of health that go beyond medical care—by coordinating a broad array of services directed at individuals. These collaborations link clinical care to: (a) wraparound services, such as transportation, translation, and child care, which help patients overcome logistical barriers to accessing care; (b) outreach services, such as home visits, which are needed to identify problems at an early stage, to help patients and their families deal with complex medical regimens, and to promote adherence with treatment programs; and (c) social services, which help patients obtain or retain health insurance, and obtain needed nutritional and economic supports.

- In synergy 1a, partners link medical and support services by bringing *new types of personnel to existing practice sites*, for example, by connecting

public health nurses to medical practices providing care for women or children in the Medicaid program.

- In synergy 1b, partners establish “one-stop” centers that locate a broad range of medical and support services in one place. This type of co-location makes services more convenient to clients and provides a structure for sharing staff, centralizing services, and coordinating the programs of different partners.
- In synergy 1c, partners coordinate medical and support services provided in various locations throughout the community. This “center without walls” approach assures that wherever an individual shows up, she or he is aware of the full range of services available through the system and has help in reaching and using those services. Some of the more integrated versions of this model use common contracting, centralized purchasing, and system-wide information systems to improve performance and achieve economies of scale.

Synergy 2: Improving access to care by establishing frameworks to provide care for the un- or underinsured

The second type of synergy makes it feasible for the mainstream medical sector to play a more active role in indigent care by overcoming a number of logistical, financial, and legal barriers that stand in the way.

- In synergy 2a, *free clinics* are established that provide indigent patients with free or discounted care.
- In synergy 2b, *referral networks* are established, which allow mainstream clinicians to provide free or discounted care where they usually work.
- In synergy 2c, academic or private medical practitioners are recruited to *enhance staffing at clinics run by government agencies or not-for-profit organizations* (such as community health centers). Often, this type of collaboration provides academic medical centers with additional sources of support for faculty salaries and with new training experiences for residents and students.
- In synergy 2d, contractual arrangements are made that *shift the care of indigent patients from public health clinics to private medical practices, hospitals, health systems, or managed care organizations*. Some health departments seeking to strengthen population-based services use this type of collaboration to move away from providing care directly to indigent individuals while continuing to assure the availability of safety-net services.

Synergy 3: Improving the quality and cost-effectiveness of care by applying a population perspective to medical practice

The third type of synergy applies a population perspective to medical practice in order to improve the quality and cost-effectiveness of medical care—as well as the economic viability of medical professionals and institutions.

- In synergy 3a, partners make *population-based information to support clinical decision-making more available and useful to medical practitioners*. By working together, they are able to make the content and format of this information more relevant to medical practice, and to reach a wider professional audience.
- In synergy 3b, partners *link community-wide screening programs to follow-up medical care*. By identifying patients who can benefit from medical care and then “funneling” these patients to appropriate providers for further diagnosis and treatment, this type of collaboration enhances the cost-effectiveness of public health screening and provides medical practitioners with new patients (many of whom have insurance).
- In synergy 3c, *population-based methodologies* (such as clinical epidemiology, cost-effectiveness analysis, or performance measurement) are *applied to clinical practice*. Usually, these tools are used to support quality-improvement activities and strategic planning, or to enable medical practices and organizations to take on and manage financial risk.

Synergy 4: Using clinical practice to identify and address community health problems

A fourth type of synergy takes advantage of what can be accomplished through clinical practice to achieve clinically oriented public health goals, such as immunization or prenatal care. These collaborations are particularly important as clinical preventive services increasingly become covered health insurance benefits, as patients move from one medical practice or managed care organization to another, and as purchasers and communities measure the extent to which Healthy People 2000 and HEDIS objectives have been achieved.

- In synergy 4a, partners design and/or implement *community-wide information systems that incorporate clinical data* from hospitals, laboratories, or office-based practices. When the medical and public health sectors design such information systems together, the systems often incorporate innovative features that make them more useful in the field. For example, some collaboratively developed immunization registries provide medical practitioners with information about vaccines, with automatic reminder and recall letters personalized to the clinician's practice, with patient flow charts, and with practice or management software.
- In synergy 4b, partners *take advantage of clinical encounters to identify and address underlying health risks in patients*. In some of these cases, supports provided by public health and community partners—such as counseling guides, culturally appropriate patient education materials, and resource directories—make it easier and less time-consuming for clinicians to elicit information about health risks, to counsel patients about personal behaviors that are detrimental to their health, and to connect them to community-based programs. In other cases of this type, partners address social or environmental causes of health problems in patients, for example, by using savings achieved by moving lead treatment from inpatient to outpatient

settings to finance environmental strategies that reduce the need for chelation therapy.

- In synergy 4c, *partners combine individual-level and population-based strategies to assure the delivery of a particular clinical service in private and public medical practices throughout the community.* These cases involve a broad range of community groups in a variety of activities, including education and media campaigns to increase awareness of the problem among the public, screening programs to identify people in need of the particular clinical service, outreach efforts to address logistical barriers that some patients face in obtaining the service, and supports for clinical practices.

Synergy 5: Strengthening health promotion and health protection by mobilizing community campaigns

A fifth type of synergy moves away from clinical care, demonstrating how diverse groups in the community can work together around population-based strategies. Often, these collaborations address underlying causes of health problems, such as violence, tobacco use, high-fat diets, and physical inactivity. Many strengthen the capacity of health departments to carry out their essential population-based functions. More than any other synergy, these models show how the combined assets of the medical and public health sectors can be reinforced by other public, private, and not-for-profit organizations in the community.

- In synergy 5a, *partners conduct community health assessments* to identify health problems in the community. In many of these cases, the involvement of a spectrum of public and private sector partners facilitates the collection of relevant data from diverse sources, the analysis and reporting of data, and the often difficult move from data collection and the identification of health problems to the implementation of community interventions.
- In synergy 5b, *partners mount public education campaigns* to make people in the community aware of important health problems and what they can do about them. By involving diverse community groups in these campaigns, messages are more likely to be credible, understandable, and culturally acceptable, and to be delivered through routes and media that are most effective in reaching targeted population groups.
- In synergy 5c, *partners advocate health-related laws and regulations*, such as cigarette taxes, seat belt and helmet laws, or restrictions on the sale of firearms. In these cases, collaboration enhances the capacity of partners to gather policy-relevant information and to make a persuasive case to the public and policymakers.
- In synergy 5d, *partners seek to achieve particular community health promotion objectives* by implementing multipronged strategies. Often these collaborations include one or more of the activities described above in synergies 5a–5c, as well as voluntary community initiatives, such as those that increase the availability of healthy food choices in schools, workplaces, and restaurants, or that establish incentives, opportunities, and safe environments for exercise.

- In synergy 5e, partners *launch “Healthy Communities”-type initiatives*. These collaborations go beyond categorical health promotion activities by establishing a broad-based process to deal with multiple community health issues over a prolonged period of time. Reflecting community perceptions about health problems, and recognizing the importance of socioeconomic determinants of health, these collaborations address issues that go beyond the traditional purview of the health sectors, such as education, jobs, and housing.

Synergy 6: Shaping the future direction of the health system by collaborating around health system policy, health professions training, and health-related research

In collaborations oriented around health system policy, partners identify areas of common concern, and then combine their authority, influence, practical experience, and scientific expertise to do something about them. While most of the cases address governmental policy issues, particularly at the state level, some relate to organizational policy as well.

- In synergy 6a-1, partners focus on policies that influence *access to care* for the un- and underinsured. Examples include the leveraging of public funds to support safety-net facilities, expansions in the availability of health insurance coverage, or legislative initiatives that give medical practitioners immunity from liability when they provide indigent care.
- In synergy 6a-2, partners influence *provider payment* policies, such as the relative amounts that a state Medicaid program pays for pediatric care in emergency departments and medical offices.
- In synergy 6a-3, partners influence *insurance benefits* policies, for example, by using established guidelines or cost-effectiveness analysis to expand coverage for preventive services in public or private insurance programs.
- In synergy 6a-4, partners influence policies related to the *quality of medical care*, such as the development and application of practice guidelines, quality assurance standards, or performance measures.
- In synergy 6a-5, partners influence policies related to the *regional organization of health care services or facilities*, such as perinatal care or trauma services.
- In synergy 6a-6, partners influence policies related to the *organization and financing of public health services or activities*, for example, by working together to restructure health departments, boards of health, or particular public health programs, such as those concerned with maternal and child health or mental health.

Another way to shape the future direction of the health system is by changing the way health professionals are educated and trained. While students, residents, and faculty in academic institutions participate in many of the collaborations in the database, cases coded as one of these synergy models bring partners together for the explicit purpose of promoting education and training that link the perspectives of medicine and public health.

- In synergy 6b-1, a cross-sectoral perspective is incorporated in the *curriculum of health professions degree programs*. The extent of curriculum change in this model ranges from the marginal (e.g., opportunities to participate in extramural programs, or elective courses and rotations to which only a small proportion of students are exposed) to the substantial (e.g., the incorporation of a broad perspective in a school's mission or structure, or the institution of courses, rotations, or practica that are required of all students).
- In synergy 6b-2, *dual-degree programs* are established that give students an MD/MPH or an RN/MPH, for example. This model may or may not involve much interaction between the schools or programs in different sectors.
- In synergy 6b-3, *formal, functional connections are established between medical and public health schools or academic programs*. In some of these cases, faculty have dual appointments and/or teach courses in schools or departments in more than one sector. In others, students from a range of schools work together in interdisciplinary teams, sometimes for prolonged periods of time. Another example of this type of collaboration is the development of cross-sectoral academic centers.
- In synergy 6b-4, *academic training is linked to medical and public health practice sites and/or other organizations in the broader community*. When dual appointments occur in this model, the health professional often serves as a faculty member at a school of medicine and as an official in a local health department. Some cases encourage cross-sectoral links between academia and practice by requiring that faculty devote a proportion of their time to community projects, or that students rotate through health departments, community health centers, or COPC practice sites.
- In synergy 6b-5, *cross-sectoral education or training is provided to health professionals in the field*. In this model, perspectives are broadened through continuing education courses, leadership institutes, or degree-granting programs specifically designed for professionals in active practice.
- In synergy 6b-6, opportunities are provided for *cross-sectoral networking*, such as collaborative conferences focusing on the interaction between medicine and public health.

A third way to shape the future direction of the health system is by advancing the knowledge base that supports health-related work. While research plays an important role in many of the collaborations in the database, cases coded as one of these synergy models explicitly bring together multidisciplinary perspectives to strengthen the research enterprise. This cross-sectoral investigative approach is valuable in identifying important research questions; in designing, implementing, and disseminating research findings; and in obtaining financial support.

- In synergy 6c-1, *partners establish multidisciplinary research centers*. Some of these centers bring together diverse types of professionals within a single school. Others connect various schools within an academic health center or connect academic institutions with health departments or other government agencies.

- In synergy 6c-2, partners promote cross-sectoral research through other, *less formal*, means.

STRUCTURAL FOUNDATIONS

Combining resources and skills is one aspect of how collaborations work. Achieving these synergies, however, requires structural arrangements that allow partners from the two health sectors—as well as from the broader community—to continue to work within their own organization while, at the same time, linking up with professionals or institutions in other sectors. The analysis in *Medicine & Public Health: The Power of Collaboration* described six distinct models that partners use to establish these relationships. In the *Pocket Guide*, each case is coded according to the particular structural foundation(s) it exemplifies.

Below, brief definitions are provided for each type of structural foundation. *Pocket Guide* abbreviations follow in parentheses. (For easy reference, this key to structural foundations is also provided on page 323.) More detailed information about the structural foundations can be obtained in the monograph, which is electronically linked to the Internet version of the *Pocket Guide*.

- **Coalitions (Coalition)** are formal groups that bring together representatives of autonomous organizations to address a common problem or objective. The authority, responsibility, and capacity to take action lies with the coalition itself rather than with any one partner or external agency. Coalitions are particularly useful in collaborations that benefit from a broad range of community partners, particularly if they do not require equal or consistent involvement on the part of all partners or close coordination of partner activities.
- **Contractual agreements (Contract)** are binding agreements (e.g., legal documents, memoranda of understanding, or verbal agreements) that commit one partner in a collaboration to carry out a function or to provide a service for another partner. Contracts are used in collaborations that depend on certain interactions between partners—usually the delivery of various health services to individuals. These agreements clarify partners' roles in critical interactions and assure that they are carried out.
- **Administrative/management systems (Adm/Mgmt)** are personnel or offices that run some or all aspects of collaborative enterprises, allowing partners to closely coordinate their activities and resources, or to centralize organization or control. Depending on the work involved, such a “system” may be a full-time staff person dedicated to managing a collaboration, a management office within one partner's organization, or a separate, autonomous management office. These arrangements make it possible for collaborations to integrate activities, to reduce duplication of services, and to achieve economies of scale.
- **Advisory bodies (Advisory)** are groups convened to provide an organization in one sector (such as a government agency or research entity) with input or support from other sectors. Advisory bodies may deliberate independently

in constructing recommendations, but they do not have the authority to make operational or policy decisions.

- **Intraorganizational platforms (Intraorg)** are structural arrangements that allow a single organization to expand its perspective by bringing in professionals with the skills and expertise of another sector. Examples include a managed care organization that establishes a clinical epidemiology branch to assess quality or outcomes, or a section on public health within a medical society.
- **Informal arrangements (Informal)** are any of a variety of *ad hoc* relationships among partners, which are generally dependent on personal, rather than structured, interactions.

How to Use the *Pocket Guide*

The *Pocket Guide* is a compendium of cases that illustrates the broad range of models of medicine and public health collaboration taking place in the field. It is structured so that users can quickly identify cases that are of particular interest to them and gain access to knowledgeable sources from whom they can obtain additional information. To serve these functions, the *Pocket Guide* consists of two main components: a series of case entries and tools to facilitate case searching.

CASE ENTRIES

The case entries, which are organized geographically in the print version of the *Pocket Guide*, provide information about collaborations in three complementary ways. As can be seen in the sample below, each entry contains a brief narrative abstract, a set of indexing codes that characterize the case, and a case contact or alternative source of information.

The diagram shows a rectangular box representing a case entry. On the left side, there are three labels with lines pointing to specific parts of the box: 'Unique (Geographic) Identifier' points to the 'AL-8' code; 'Characterization Codes (Keys to Abbreviations are in Part IV, page 313)' points to the 'Partners', 'Synergies', and 'Structural Foundations' sections; and 'Sources of Additional Information' points to the 'Contact' section. On the right side, there are two labels: 'Title' points to the 'University of Alabama at Birmingham Cross-sectoral Training Program' header, and 'Narrative Abstract' points to the main body of text. The box contains the following text:

AL-8
Partners
LHD, U-GOW, SHD, SOM, SPH,
AHC, U-OTH, C-OTH

Synergies
5b, 5d, 6b-3, 6b-5

Structural Foundations
Coalition, Intraorg

Contact
Marian Osterweis, PhD
Association of Academic
Health Centers
1400 Sixteenth Street, N.W.
Suite 720
Washington, DC 20036
mosterweis@acaahdhithctr.
org

University of Alabama at Birmingham Cross-sectoral Training Program
The Medical Center of the University of Alabama at Birmingham (UAB) is comprised of six schools, that, with the graduate school, offer training in medicine, dentistry, optometry, nursing, health-related professions, public health and basic biomedical sciences. According to the faculty and administration, UAB's "open system" encourages interdisciplinary work, networking across the specialty fields, and cooperative sharing of resources. In addition, as of 1992, UAB had several formal collaborations that involve faculty and students from different schools as well as government officials and members of the community. For instance, the Lister Hill Center for Health Policy, in the School of Public Health, has studied health care service delivery and insurance issues. Their Public Policy Action Project has built relationships among state and local government, community groups, and public health organizations in rural areas to improve community health and economic stability. The Center for Community Health Resources Development is a joint venture of UAB, the Alabama Cooperative Extension Service (Auburn University) and the Alabama State Health Department that has been active over 20 years. With a nurse as its director and a staff of public health professionals and social workers, this Center has developed community-based, health education initiatives, held conferences to educate consumers and physicians about public health approaches to illness and wellness, and provided technical assistance that has established County Health Councils in over half of Alabama's counties.

Osterweis, M, and Eichhorn, SF. 1993. Community-based health promotion activities. In *Promoting community health: the role of the academic health center*. Skilton, WD and Osterweis, M, eds. Washington, DC: Association of Academic Health Centers.

Case Abstracts

The narrative abstracts are intentionally brief—designed to give readers just enough information to determine whether the collaboration is relevant to their interests and needs. (A key to the acronyms used in the abstracts can be found on page 325.) While space limitations precluded us from telling the “whole story” of each case, we tried, to the extent possible, to include key elements of each collaboration: why it started, when it took place, which partners played major roles, how it illustrates particular collaborative models, and what it accomplished. As mentioned earlier, these narratives are based on information obtained through two surveys, published reports, and, not infrequently, clarifying telephone conversations. Nonetheless, it should be noted that, in most cases, all of this information was provided by a single case reporter. Because of the large number of cases included in the *Pocket Guide*, it was not possible to validate these reporters’ descriptions by obtaining multiple partners’ perspectives of each collaboration.

Characterization Codes

To the left side of each abstract, readers will find the unique identifier for the case, as well as additional coded information that characterizes the case according to the framework described earlier. These codes, which also are used for indexing purposes, provide information about:

- the types of organizational partners involved in the collaboration
- the particular synergy model(s) by which the partners combine their resources and skills
- the structural foundation(s) that undergird the partners’ relationship

For easy reference, definitions and abbreviations for these codes are provided in a set of tables at the end of this book (Keys to Abbreviations on pages 313 through 326). In the Internet version of the *Pocket Guide*, expanded information about each coding term is provided through automatic “hot-links” to relevant sections of *Medicine & Public Health: The Power of Collaboration*.

It is important to point out that the coding of cases in the *Pocket Guide* is not completely uniform. To a large extent, this relates to the evolving nature of many collaborations, which makes it difficult to specify clear boundaries for the enterprise in which partners are engaged. Over time, collaborations commonly develop offshoots or new collaborations, which may complement or replace the original partnership. Consequently, the coding of partners, synergy models, and structural foundations varies depending on whether the case reporter took a broad or narrow view. Other causes of coding variation include differences in the interpretation of certain terms (for example, some case reporters considered funders of collaborations as partners while others did not), and limitations in available information about certain cases, which sometimes made determination of involved synergy models or structural foundations difficult.

Sources of Additional Information

Below the codes, on the left side of the case entry, readers will find an additional source of information for each collaboration. Usually this source is a person—one of the key individuals involved in the case who is willing to be contacted about it. (Due to space constraints, it was not possible to print the names of all knowledgeable and willing contacts for each case.) The case entry includes the name, postal address, and (if available) E-mail address of the contact. The Internet version of the *Pocket Guide* facilitates E-mail communication with these contacts. In cases in which a suitable contact could not be located, did not wish to be listed, or was not directly involved in the partnership, a citation for the case (referring to a journal article, organizational report, or Internet address) is provided instead. (Due to space constraints, it was not possible to list citations other than books for the remaining cases.)

SEARCH TOOLS

Searching cases in the print version of the *Pocket Guide* is facilitated by a series of indexes that follow the case entries. These indexes allow readers to identify all cases in the database that:

- take place in a particular state, a multistate region, at the national level, or in another country (Index 1, p. 271)
- involve a particular type of organizational partner (Index 2, p. 285)
- illustrate a particular synergy model (Index 3, p. 299)
- utilize a particular type of structural foundation (Index 4, p. 309)

The Internet version of the *Pocket Guide* has special features that allow users to search the database through multiple index terms simultaneously and to search the text of the case entries. Through these means it is possible, for example, to identify cases in which particular combinations of partners work together, cases that involve particular models of collaboration in certain parts of the country, cases that are associated with particular health problems or program initiatives, and cases that are reported by particular individuals.

In searching the database—in either print or electronic form—one caveat should be kept in mind. While the database is illustrative of the different types of medicine/public health collaboration occurring around the country, it is *not* a representative sample. Therefore, searches should not be used to estimate the relative frequency of collaborations occurring in different parts of the country, involving different types of partners, or utilizing different types of models.

ADDING NEW CASES TO THE POCKET GUIDE

In the course of developing the *Pocket Guide*, we have become aware that considerably more medicine and public health collaborations are occurring around the country—and the world—than are represented in the current data-

base. It is not surprising, then, that many people have expressed interest in the database, not only to obtain information from it, but also to contribute their own cases to it. Individuals interested in participating in this expansion of the *Pocket Guide* can obtain materials to submit their cases in two ways:

- through the *Pocket Guide* Web site (<http://www.nyam.org/pubhlth>)
- by contacting
Center for the Advancement of Collaborative Strategies in Health
Division of Public Health
The New York Academy of Medicine
1216 Fifth Avenue, Room 452
New York, NY 10029
Phone: 212-822-7250
Fax: 212-426-6796
E-mail: pubhealth@nyam.org

New cases of collaboration will be added continually to the Internet version of the *Pocket Guide*. By doing so, we hope to create a “living database” that will become increasingly useful, both as a networking tool and as a sampling frame to study key questions generated by collaboration partners, funders, researchers, and policymakers.