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.