OVERVIEW OF URBAN COLLABORATIVE INITIATIVES

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Rather than focusing on priority setting and strategies in a particular urban environment, this paper overviews various types of collaborative strategies that the medical and public health sectors are using in cities around the country to identify and address urban health problems. These strategies were identified as part of a study of 414 cases of collaboration; the study was recently conducted by a group of distinguished scholars and practitioners at the New York Academy of Medicine and was funded by the Robert Wood Johnson Foundation and was supported by the American Medical Association and the American Public Health Association. The results of that study were published as a monograph, *Medicine and Public Health: The Power of Collaboration*, in December 1997.¹

THE COLLABORATIVE IMPERATIVE

Based on what presenters at the New York Academy of Medicine Sesquicentennial Symposium have discussed about determinants of health and the context in which urban health policies are made, collaboration between the two major sectors involved in health—the medical sector and the public health sector—would seem to be an obvious strategy. Yet, for most of this century, medicine and public health have functioned independently of each other and largely independent of other sectors in the community that can influence health.

While this approach may have sufficed in the past, it is no longer a viable option. In today's challenging environment, both health sectors, working by themselves, are having increasing difficulty achieving their missions, addressing health problems, and responding to economic and performance pressures. As was intimated by several speakers at the symposium, the current predicament seems to be due to three forces: (1) the crisis in health care costs and the market response to that crisis—currently managed care; (2) the movement to "reinvent

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government," expressed by downsizing and devolution at all levels; and (3) a changing and increasingly challenging spectrum of health problems.

In this environment, professionals and organizations in both medicine and public health are not only under intense pressure, they also are becoming increasingly dependent on one another. This growing interdependence of medicine and public health can be illustrated by some of the striking shifts that are occurring across the two health sectors: shifts of patient populations, clinical services, perspectives, and financing streams.

SHIFTS OF PATIENT POPULATIONS AND CLINICAL SERVICES

One result of these shifts is that the medical sector is beginning to take over certain activities of public health, such as the care of Medicaid patients and the delivery of clinical preventive and treatment services that are important for the community's health. This is creating a need to make certain services that had been linked to clinical care in public health settings available to mainstream medical practices.

As states move to managed-care contracts and "medical home" initiatives to control costs in their Medicaid programs, increasing numbers of patients who had received care through public hospitals and public health clinics are being shifted to "mainstream" medical settings. Most clinicians acknowledge that it is considerably more difficult to deliver care successfully to Medicaid patients than to the healthier, more affluent patients traditionally covered by medical practices and managed-care organizations. As a group, Medicaid patients are poorer, less well educated, more likely to have multiple risk factors for disease, and more likely to suffer from multiple health problems, including cardiovascular diseases, sexually transmitted diseases (STDs), lead toxicity, substance abuse, and human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS).

Mainstream clinicians attempting to provide effective care for these patients need access to services that traditionally have been linked to medical care in public health settings. They need "wraparound" services such as transportation, translation, and child care to help patients overcome logistical barriers to accessing medical care. They need a way to supplement the care they provide in their offices with services provided in the home. Home visits can be invaluable in identifying patient problems at an early stage; in helping patients and their families deal with complex medical regimens, such as those for diabetes, asthma, or HIV/AIDS; and in promoting adherence with treatment programs for such asymptomatic conditions as hypertension or for problems that threaten the health of the community, such as drug-resistant tuberculosis.

In urban areas, clinicians caring for Medicaid patients also need ready access

to public health services, such as contact tracing, which is essential in controlling the spread of infectious diseases like HIV/AIDS and STDs, and to environmental public health interventions, such as lead abatement in the home. Without a safe home environment, chelation treatment for lead toxicity is ultimately ineffective because children who are treated successfully develop lead poisoning again and again.

SHIFTS IN PERSPECTIVES

The new environment is also making certain perspectives and tools of public health—such as epidemiology and cost-effectiveness analysis—much more relevant to the medical sector. As managed-care organizations and physician networks take on financial risk, they are under increasing pressure to anticipate health service demands and to practice cost effectiveness. In effect, their economic viability is becoming dependent on obtaining information about the health status and health risks of their patient populations and about the efficacy and costs of medical interventions.

SHIFTS IN FINANCING STREAMS

A particularly disturbing repercussion of today's environment—one associated with the shift in financing streams—is that public health agencies are finding it increasingly difficult to carry out their missions. As managed-care organizations take over much of their Medicaid revenue, public health agencies are having serious problems financing care for the uninsured and maintaining their capacity to provide essential population-based services. Today, this is creating a crisis not only for the public health sector, but also for the medical sector. Private hospitals and academic medical centers face high uncompensated emergency room costs when the uninsured in their areas lack access to timely medical care. In an environment of financial risk, the medical sector is now economically dependent on the capacity of public health agencies to prevent unnecessary disease from occurring in the community. When public health efforts to protect the environment fail, medical practices and managed-care organizations bear the costs of treating patients who come down with foodborne or waterborne diseases.

ECONOMIC AND PERFORMANCE PRESSURES

Although these shifts reveal various ways that the medical and public health sectors are becoming dependent on each other and can reinforce each other in today's environment, the strongest impetus for establishing cross-sectoral relationships comes from the health system's growing emphasis on cost containment and on documenting results. As economic and performance pressures intensify, success is more likely if professionals and institutions in the two sectors work together than if they continue to work alone.

With the pressure to contain costs, both the medical and public health sectors are attempting to find ways to achieve economies of scale, to provide services more efficiently, to reduce duplication of effort, and to increase productivity. When neither sector has the time or resources to do everything itself, closer working relationships begin to make sense, particularly if each sector focuses on areas in which it has special expertise or that would be inefficient for the other to perform. In the medical sector, the shift from fee for service to financial risk is reinforcing this incentive to become partners. Under the old payment structure, medical practitioners and institutions were rewarded financially for doing more themselves. In the current environment, they have an economic incentive to focus on what they do best and to work with others with skills and resources that complement their own.

Another compelling reason to collaborate is that health objectives are beginning to be measured. Whether these objectives relate to improvements in health status for the community at large (as measured by Healthy People 2000 or New York's health priorities) or to the delivery and quality of clinical services in enrolled populations (as evaluated by report cards such as the Health Plan Employer Data and Information Set (HEDIS)), results worth achieving often depend on factors beyond any one sector's direct control.

Immunization is a good example. With increasing coverage of immunization in health insurance programs, the public health sector needs to work with and through the medical sector to achieve its immunization goals. But, to move from simply offering immunizations to delivering them effectively, the medical sector needs support to identify and influence patients who are not seeking out this service and to account for individuals in their practices who are getting immunizations elsewhere.

TREND TOWARD CONSOLIDATION

The final factor encouraging the two sectors to re-examine their relationship is the trend toward consolidation. With market forces and redefined roles of government, professionals and organizations in both sectors perceive the need to become part of larger systems. These systems provide them with mechanisms to avoid being excluded from selective contracting, to achieve economies of scale, to manage risk more successfully, to maintain their patient base, and to provide meaningful training experiences for students and residents.

This move toward integration and consolidation is not only establishing an incentive for professionals and institutions to come together. It also has the potential to facilitate new relationships between medicine and public health. At the very least, the dramatic shift of physicians from solo practices to larger

group practices and networks is reducing the number of independent medical practitioners with which a public health agency needs to interact. At best, fully integrated organizations have the infrastructure to support the coordination of services among a broad range of institutions and personnel.

MODELS OF COLLABORATION

Looking at these factors in the changing health system, it is difficult to avoid concluding that the medical and public health sectors would benefit by working more closely together than they have in the recent past. The 414 cases of medicine and public health collaboration that we have collected from all parts of the country document that the need for the two health sectors to work together, and the support they can provide each other, is more than hypothetical. Although each of these cases is, in some sense, unique and was designed to deal with a particular situation, a set of common, and generally applicable, strategies emerge from analyzing the collaborations as a whole. These strategies are very relevant to urban areas. While the study did not focus exclusively on cities, almost half of the cases describe collaborations in urban areas, and more than 20% take place in the largest metropolitan areas in the country. With only one exception, all of the models of collaboration observed in the study are applicable to urban settings.

The cases that we have collected bring together a broad range of partners that include, but extend beyond, the confines of medicine and public health:

- medical practices and community-based clinics
- laboratories and pharmacies
- hospitals and health systems
- managed-care organizations
- health departments and other governmental agencies
- academic institutions
- professional associations
- voluntary health organizations
- community groups, such as businesses, labor organizations, schools, and religious organizations
- the media
- foundations

These partners bring an impressive array of resources and skills to collaborative enterprises:

- 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 patients, the public, and policy makers
- data and information systems
- buildings and space
- financial support

By combining these resources and skills in six ways, partners in collaborative enterprises are able to achieve benefits not only for themselves, but also for the patients and populations they serve:

1. Improve health care by coordinating services for individuals.
2. Improve access to care by establishing frameworks to provide care for the uninsured and underinsured.
3. Improve the quality and cost effectiveness of care by applying a population perspective to medical practice.
4. Use clinical practice to identify and address community health problems.
5. Strengthen health promotion and health protection by mobilizing community campaigns.
6. Shape the future direction of the health system by collaborating in policy, training, and research.

COORDINATING SERVICES FOR INDIVIDUALS

One type of collaboration enhances the success of medical care—and addresses determinants of health that go beyond medical care—by coordinating a broad array of services directed at individuals, such as clinical, wraparound, outreach, and social services. This coordination is accomplished in one of three ways. Some of the collaborations bring new services to existing practice sites, for example, by linking public health nurses with pediatric or obstetrics/gynecology practices. Others create “one-stop” centers that locate a broad range of services in one convenient place. Another approach uses an integrated systems model that links clinical and support services provided in various locations throughout the community. This model often incorporates a broad array of social services provided by community groups. It ensures 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.

ESTABLISHING FRAMEWORKS TO PROVIDE CARE FOR THE UNINSURED AND UNDERINSURED

A second type of collaboration 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. When the medical sector takes the lead in these collaborative activities, clinicians deliver care through free clinics or referral networks. The latter model allows them to provide services where they usually work. Interestingly, and possibly because of the role of public hospitals and academic centers in the care of the uninsured in inner cities, free clinics and referral networks are the only type of collaboration that is not well represented among the urban cases of collaboration in our database.

In indigent care activities organized by the public health sector, contractual arrangements are made that shift patients from public health clinics to mainstream medical settings. Alternatively, medical practitioners are recruited to enhance clinical staffing at public health facilities. 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.

APPLYING A POPULATION PERSPECTIVE TO MEDICAL PRACTICE

A third type of collaboration 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 some of these collaborations, the two health sectors work together to make population-based information more useful in clinical decision making. They do so by making the content and format of health information more relevant to medical practice and by helping it reach a wider professional audience.

Other cases use community-wide screening programs to identify patients who can benefit from medical care and then “funnel” these patients to appropriate providers for needed treatment. By doing so, they not only provide medical practitioners with new patients, but also enhance the cost effectiveness of public health screening. In yet another model, population-based methodologic tools, such as clinical epidemiology, cost-effectiveness analysis, risk assessment, and performance measurement, are used to support quality improvement activities and to enable medical practices and organizations to take on and manage financial risk.

USING CLINICAL PRACTICE TO IDENTIFY AND ADDRESS COMMUNITY HEALTH PROBLEMS

A fourth type of collaboration takes advantage of what can be accomplished through clinical practice to achieve clinically oriented public health goals. These collaborations are especially important as clinical preventive services increasingly become covered health insurance benefits and as patients move across practices and managed-care organizations. They are also valuable in achieving Healthy People 2000 and HEDIS performance goals.

Some of these cases use clinical encounters to build community-wide databases such as immunization registries. When the medical and public health sectors design information systems together, the systems often incorporate innovative features that make them more useful to professionals and organizations in both sectors. For example, some immunization registries provide practitioners with information about vaccines, with automatic reminder and recall letters personalized to the clinician's practice, with patient flowcharts, and with practice management software.

Other collaborations build on clinical encounters to identify and address underlying physical and social causes of health problems. In one of these cases, savings achieved by moving lead treatment from inpatient to outpatient settings were used to finance environmental strategies that reduced the need for chelation therapy.

Other cases engage a broad range of partners in the community—and a broad range of strategies—to achieve clinically oriented health objectives such as immunization and prenatal care. Often they involve:

- education and media campaigns, to increase awareness of the problem among the public (effectively funneling patients in need of immunizations to medical offices);
- outreach, tracking, and follow-up services, to address logistical barriers that some patients face in obtaining clinical services;
- community-wide information systems, such as immunization registries.

MOBILIZING COMMUNITY CAMPAIGNS

A fifth type of collaboration moves away from clinical care and demonstrates how diverse groups in the community can work together around population-based strategies. Often, these collaborations address underlying causes of health problems in inner cities: tobacco, drug, and alcohol abuse; injuries; and violence. All substantially strengthen the capacity of health departments to carry out their essential population-based functions. Working together, partners in these collaborations:

- identify important health problems through community assessments;
- make people aware of these problems through health education campaigns;
- make the environment more conducive to improving health by advocating health-related laws and regulations;
- make it easier for individuals to translate health promotion messages into healthier behaviors by mounting voluntary community initiatives such as bicycle helmet campaigns.

Some urban collaborations of this type evolve into Healthy Cities projects and address issues that are important to health but go beyond the traditional purview of the health sectors, such as education, jobs, and housing.

COLLABORATING IN POLICY, TRAINING, AND RESEARCH

In the last type of collaboration identified through the study, the medical and public health sectors work together to shape the environment in which they work. They do this through collaborations that:

- influence health system policy (around such issues as access to care, provider payment, insurance benefits, quality of care, and the organization and financing of public health programs);
- promote cross-sectoral education and training (through initiatives that involve curriculum change, dual-degree programs, the establishment of functional connections between schools and programs in the two health sectors, and linkages among academia, medical and public health practice sites, and the broader community);
- foster cross-sectoral research.

CONCLUSION

Taken together, collaborative strategies substantially enhance the capacity of medical and public health professionals to deal with urban health problems. For example, in the case of asthma, which is a serious health problem in many inner cities, the skills and resources of various partners can help clinicians address the nonbiologic determinants of health that influence the success of their medical treatment. Cross-sectoral collaborations can:

- enhance childrens' access to medical care, drugs, and supplies;
- improve their health-seeking behavior and adherence with medical regimens;
- ensure that they are referred to programs that eradicate precipitants in the home.

For public health officials responsible for developing programs to address the rising epidemic of asthma among inner-city children, collaborative strategies can help their agencies achieve greater impact with limited funds. These strategies can:

- inform clinicians in practice of the most effective approaches to asthma therapy;
- link children identified as having asthma in school screening programs with medical practitioners who provide appropriate asthma treatment;

- help health departments implement more-effective surveillance systems for asthma and obtain valuable support for their public education campaigns and environmental policies.

Where does this leave us? Clearly, medicine and public health collaboration has documented, as well as potential, benefits in urban areas. By looking not only at what external forces are doing to them, but also at what they can do for each other, professionals in medicine and public health can become considerably more effective in addressing urban health problems. At the same time, these collaborative strategies can enhance their own effectiveness and economic stability.

Yet, much more needs to be done. In spite of the relevance of collaboration to current challenges, these strategies are not the norm. The study documents a striking dichotomy between health professionals involved in collaborative enterprises and those who participated in a series of focus groups that we conducted around the country. For partners involved in collaborative enterprises, working together seems obvious. By reshaping the relationship between medicine and public health, they have found proactive ways to deal with current challenges. The majority of health professionals in the focus groups, on the other hand, are overwhelmed with the changes that are occurring in the health system. They are unaware of the role that medicine and public health collaboration can play in helping them deal with the pressures they face.

If collaborative strategies are to become more widespread, substantial efforts will be required to make health professionals more aware of them and to support them in their efforts. Equally important, more research will be needed to understand leadership and partnership issues, to develop valid and measurable indicators of success and failure, and to understand the factors that lead to productive outcomes. The work alluded to herein is only the beginning of this effort. With the continued commitment of the partners involved in this effort—and the active involvement of “pioneers” around the country—collaborative strategies in urban areas may someday become the norm.

REFERENCE

1. Lasker, RD, Committee on Medicine and Public Health. *Medicine and Public Health: The Power of Collaboration*. New York: New York Academy of Medicine; 1997.