



**Community-Campus
Partnerships for Health**
A POLICY AGENDA FOR HEALTH
IN THE 21ST CENTURY



TRACK 3

Promoting Collaborations that Improve Health

written by

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Creating healthier communities and overcoming complex societal problems require collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Community-campus partnerships involve communities and higher educational institutions as partners, and may address such areas as health professions education (i.e. service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. Founded in 1996, Community-Campus Partnerships for Health is a non-profit organization that fosters community-campus partnerships as a strategy for improving health professions education, civic responsibility and the overall health of communities. In just four years, we have grown to a network of over 700 communities and campuses that are collaborating to achieve these goals.

Community-Campus Partnerships for Health's 4th annual conference was designed to broaden and deepen participants' understanding of the policies, processes and structures that affect community-campus partnerships, civic responsibility, and the overall health of communities. The conference also aimed to enhance participants' ability to advance these policies, processes and structures.

This paper – one of nine commissioned for discussion at the conference – played an integral role in the conference design and outcomes and would not have been possible without the generous support of the Corporation for National Service and the WK Kellogg Foundation. On the conference registration form, participants chose a track that interested them the most in terms of contributing to the development of recommendations and possibly continuing to work on them after the conference. Participants were then sent a copy of the commissioned paper corresponding to their chosen track, to review prior to the conference. At the conference, participants were assigned to a policy action team (PAT). Led by the authors of that track's commissioned paper, each PAT met twice during the conference to formulate key findings and recommendations. These key findings and recommendations were presented at the conference's closing session and are reflected in the conference proceedings (a separate publication). These will be considered by CCPH's board of directors as part of its strategic planning and policy development process, and are expected to shape CCPH policies and programs in the coming years.

The complete set of nine commissioned papers is available on CCPH's website at <http://futurehealth.ucsf.edu/ccph.html>

1. Integrating student learning objectives with community service objectives through service-learning in health professions schools curricula – Kate Cauley
2. Working with our communities: moving from service to scholarship in the health professions – Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson
3. Promoting collaborations that improve health – Roz Lasker
4. Public policies to promote community-based and interdisciplinary health professions education – Janet Coffman and Tim Henderson
5. Building communities: stronger communities and stronger universities – Loomis Mayfield
6. Community-based participatory research: engaging communities as partners in health research – Barbara Israel, Amy J. Schulz, Edith A. Parker, and Adam B. Becker
7. Racial and ethnic disparities in health status: framing an agenda for public health and community mobilization – Gerard Ferguson
8. Social change through student leadership and activism – David Grande and Sindhu Srinivas
9. Advocating for community-campus partnerships for health – Charles G. Huntington

INTRODUCTION

As this conference attests, there is a substantial and growing interest in health-related collaboration among people and organizations around the country. In response to grassroots efforts, as well as to foundation- and government-led initiatives, a wide variety of health partnerships are being established (Butterfoss, Goodman & Wandersman, 1996; Kreuter & Lezin, 1998; Israel, Schulz, Parker & Becker, 1998; Lasker & the Committee on Medicine and Public Health, 1997; Zuckerman, Kaluzny, & Ricketts, 1995). These partnerships differ in form, in what they are trying to achieve, and in whom they bring together. Yet they all share a common impetus: the recognition that, in today's environment, most objectives related to health and health care cannot be achieved by any single person or organization working alone (Gray, 1989; Lasker et al. 1997; Mattesich & Monsey, 1992; Zuckerman et al., 1995).

Along with this interest and activity, collaboration is also generating a good deal of frustration. Health partnerships are challenging and costly to run; they have a high attrition rate; and, thus far, it has been difficult to document their effectiveness in improving health (Kreuter, Lezin & Young, 2000; Shannon, 1998; Waddock & Bannister, 1991; Weiss, 1987). It is not surprising, then, that many partnerships are having problems realizing the benefits they seek to achieve through collaboration or that so few of the inspiring examples of collaboration around the country have been successfully mainstreamed.

This paper will explore what can be done to help partnerships and communities realize the full potential of collaboration. It begins with a discussion of the connective power of collaboration — why stronger connections between people and organizations in different sectors are needed and how this connectivity can improve health and the functioning of the health system. It then focuses on factors that are likely to influence the ability of diverse people and organizations

to work collectively: factors related to partners and their relationships, to partnerships as a whole, and to the environments in which partnerships function.

The paper concludes with a set of policy recommendations that address these factors.

THE CONNECTIVE POWER OF COLLABORATION

We use the term “health system” all the time, but on reflection, it appears to be a misnomer. For the last 50 years, the predominant focus of the health system in the United States has been not health *per se*, but the financing of medical care. Very little attention or investment has been directed toward the environmental, social, economic, or behavioral factors that affect health and well-being or to the community-based strategies that are needed to address these factors (Centers for Disease Control and Prevention, 1997; McGinnis, 1997). Equally important, the component pieces of the American health system — its various types of professionals, organizations, services, strategies, and programs — have not really operated as a system. Lacking an infrastructure or policy environment that encourages or enables them to interact, these components have functioned largely independently of each other and independently of a broad range of community groups that can influence health (Lasker et al., 1997).

To many people interested in improving health, this narrow, fragmented approach is becoming less and less tenable. In the current environment, virtually all communities in the United States are facing extremely challenging health problems, many of which have prominent socioeconomic and environmental components (Lasker et al., 1997; McGinnis & Foege, 1993). Increasingly, health professionals and organizations are expected to do more with less, and with the growing interest in health outcomes, many of them are being held accountable for achieving results that are beyond their direct control (Alter & Hage, 1993;

Gray, 1991; Lasker et al., 1997). Yet, because of the lack of connectivity in the health system, it is very difficult for people and organizations with complementary resources and skills to support each other in achieving common goals, for functional linkages to be established among potentially reinforcing services and strategies, or for the broader community to participate in a meaningful way in health actions and decision making.

The power of collaboration to improve health and the functioning of the health system lies in its ability to establish these missing but critical connections (Lasker et al., 1997). By bringing people with different perspectives together, partnerships have the potential to identify new and better ways of thinking about health issues. By linking the complementary skills and resources of diverse people and organizations, partnerships have the capacity to plan and carry out comprehensive actions that coordinate a variety of reinforcing services, strategies, programs, and systems (Center for the Study of Social Policy, 1998a; Gray, 1989; Potapchuk, Crocker, & Schechter, 1999).

Illustrations of Connective Power

One way to illustrate this connective power of collaboration is by describing how it can be used to strengthen and combine the basic types of actions that communities use to identify and address health issues (Lasker, 1999a). These actions include **services provided to individuals**, such as:

- *clinical services* (e.g., medical, dental, and mental health services)
- *wraparound services* that overcome logistical and cultural barriers to care (e.g., transportation, translation, and child care)
- *outreach services* (e.g., home visiting and mobile clinics)

- *social services* (e.g., job training, case management, nutritional support, insurance).

The actions also encompass **strategies that focus on populations**, such as:

- *the collection and use of data and other information*
- *public education campaigns* oriented toward particular groups
- *community screening programs* to identify individuals at risk or in need of clinical or social services
- *the development, advocacy, enforcement of laws and regulations*
- *social campaigns* that promote health through non-regulatory means (e.g., Mothers Against Drunk Driving or healthy food choices in restaurants and work sites).

Collaboration can strengthen these actions in several ways: (1) by connecting the fragmented array of health and social services that organizations provide to individuals; (2) by involving additional people and organizations in population-based health strategies; and (3) by linking individual-level health services and population-based public health strategies.

Connecting Individual-Level Services

Clinical care plays an important role in reducing the burden of disease and improving health. Yet, no matter how good the practitioners in a community are, their caring and expertise are of limited value if people have difficulty getting to the places where these practitioners work, communicating effectively with them (due to language or cultural barriers), managing the complex medical regimens that are prescribed, navigating their way through the health system, obtaining or

retaining health insurance, or getting needed food and supplies. In most communities, services that can address these needs are available through an array of government agencies and private sector organizations. But the wraparound, outreach, and social services these organizations provide are frequently disconnected from each other and from the clinical care that is provided by mainstream medical practices. This fragmentation is creating problems in many communities as their populations become older, more culturally diverse, and more chronically ill — and, consequently, have greater need for, and coordination of, such services. Mainstream practitioners need stronger connections to these services because the populations they care for encompass not only these changing demographics but also an increasing proportion of Medicaid patients.

As documented in *Medicine & Public Health: The Power of Collaboration* and the *Pocket Guide to Cases of Medicine & Public Health Collaboration*, collaboration can provide the “glue” to connect these otherwise fragmented services (Lasker et al., 1997; Lasker, Abramson & Freedman, 1998a). In communities around the country, medical practices, groups, and institutions are working with public health and community-based organizations to link the clinical care they provide to wraparound, outreach, and social services. In some cases, connections among services are made by linking public health nurses or community health workers to the people who receive care in particular practices. In others, “one-stop” centers are established that locate a broad range of clinical and support services in one convenient place. Another approach uses coordination offices to link medical practices and their patients to services provided by a broad array of organizations throughout the community.

Broadening Community Involvement in Population-Based Health Strategies

Another way collaboration can strengthen a community's capacity to improve health is by involving additional people and organizations in population-based public health strategies. This type of collaboration is useful not only in bringing together like-minded groups to influence public policy (as advocacy coalitions do), but also in engaging *diverse* perspectives, resources, and skills in efforts to define a community's health agenda and to take action to address that agenda.

Consider, for example, how collaboration can strengthen a community's capacity to collect and use information. Through Healthy Communities, Turning Point, and a variety of other initiatives, diverse people and organizations are becoming involved in broad-based partnerships to define and assess health (American Hospital Association, 1994; Lasker et al., 1998a). As previously under-represented voices contribute to the dialogue through partnership meetings, community forums, focus groups, and door-to-door surveys, many of these partnerships are beginning to articulate a broad view of health. Moving beyond the biomedical model, they are defining health as well-being rather than the absence of disease. They are embracing the full range of environmental, social, economic, behavioral, and biological factors that contribute to well-being. And they are highlighting the contribution that people and organizations in a variety of sectors — many not traditionally associated with health — can play in addressing these factors.

Along with this change in perspective, communities are identifying indicators that can be used to assess health in this broad way (Lasker, 1998b). These indicators go beyond traditional health data, such as morbidity and mortality statistics, to include measures that can assess behavioral and environmental health risks, key aspects of social well-being (for example, poverty, employment, education, housing, and transportation), and community assets and values. By involving government agencies, private sector organizations, and residents in

their efforts, community partnerships can obtain the broad range of information they need to carry out these types of health assessments. By harnessing the diverse skills and contacts of these partners, partnerships can also enhance their capacity to analyze the information they collect and to use that knowledge to support a variety of activities (for example, making programs more responsive to community needs, setting community health priorities, and identifying people and organizations to involve in collective actions to address these priorities).

Linking Individual-Level Services and Population-Based Strategies

While partnerships that connect individual-level services or that broaden community participation in population-based strategies can be very useful, perhaps the greatest power of collaboration is its ability to combine the services and strategies in these two dissociated “silos”. Traditionally, the people and organizations involved in providing services to individuals and in carrying out population-based strategies have worked independently, with little appreciation of the relevance of the other group’s work to their own mission and goals. Nonetheless, as our study of medicine and public health collaboration has documented, by bridging this “great divide” and combining individual-level services and population-based strategies, partnerships can not only promote access to care and the delivery of needed clinical services; they can also strengthen their ability to identify and address underlying causes of health problems (Lasker et al., 1997; Lasker et al., 1998a; Lasker, 1999a).

To illustrate this type of collaboration, consider the challenge of non-insulin-dependent diabetes mellitus (NIDDM). The prevalence of this disease is increasing rapidly in the United States — currently, it affects 16 million Americans (6% of the population) and accounts for \$44 billion annually in health care costs. Yet NIDDM is even more of a burden in minority groups, reflecting a

significant health disparity. Its prevalence is two to three times greater in African Americans and Latinos and up to five times greater in Native Americans than in non-Hispanic whites. And NIDDM is increasing rapidly in some groups, particularly among recent Asian immigrants and African Americans, where the prevalence has tripled in the last 30 years. Moreover, the complications of NIDDM, including blindness, kidney failure, amputation, heart attack and stroke, are more serious and occur at a younger age in many minority populations, creating an enormous amount of suffering (American Diabetes Association, 1998; National Diabetes Data Group, 1995; Carter, Pugh & Monterrosa, 1996).

Clinical care can prevent or delay many of the serious consequences of NIDDM through services that help patients control their blood glucose levels and that detect and treat complications in their early stages (United Kingdom Prospective Diabetes Study Group, 1998). Nonetheless, in many communities around the country a substantial portion of people with NIDDM do not receive this care, even when the services and supplies are covered by insurance and when the delivery of these services is assessed through reports cards, such as HEDIS. Broad-based community partnerships can enhance the effectiveness of these insurance policies and performance measures by putting in place a comprehensive system of supports that makes high risk groups and health professionals more aware of what can be done to detect and treat NIDDM and actively helps them do it.

These support systems include a number of reinforcing individual-level services and population-based strategies, which have considerably more power when they are carried out together than when any single service or strategy is implemented alone. Elements of these support systems include: (1) *education and media campaigns* oriented toward various types of health professionals and susceptible population groups (and developed with those groups so that the

messages are meaningful to the intended audiences, delivered by spokespersons they find credible, and disseminated in places where they live, work, learn, shop, pray, and play); (2) *screening programs* in high-risk neighborhoods that identify people who do not know they have NIDDM or who are in need of diabetes services; (3) *wraparound services* that help people get to medical practices where they can receive care and communicate effectively with clinicians; (4) *outreach services*, delivered by community health workers, for instance, that help patients manage diabetes treatment regimens; (5) *social services* that help patients obtain or retain health insurance and get coverage for needed medications and supplies; and (6) *information systems* that support practitioners and patients by providing them with information about NIDDM, assessing the rates at which diabetes services are being provided, identifying and generating reminder letters for patients who need such services but have not received them, and billing insurers automatically when services are provided.

In addition to enhancing access to diabetes care and the delivery of such care, collaborations that connect individual-level services and population-based strategies have the potential to address some of the underlying causes of NIDDM. Minority populations in which NIDDM is prevalent have a genetic predisposition to the disease. However, NIDDM is very rare in traditional societies. It is only when susceptible people adopt the Western lifestyle of limited physical activity and high fat/high calorie diets that NIDDM reaches epidemic proportions (National Diabetes Data Group, 1995). The medical sector can help somewhat in this regard, by providing people who have NIDDM, or who are at risk of developing the disease, with nutritional counseling and exercise “prescriptions.” But since the social environment has a substantial influence on people’s behavior, simply counseling them to “eat right” and “be more active” is of limited value.

To make it possible for people to actually follow medical advice, the environment in which they live needs to become more supportive of attempts to adopt healthy behaviors. Clearly, no single organization or group in a community is able to do much on its own to counter the pervasive inducements for the Western lifestyle. By working together, however, partners in broad-based collaborations can put in place a comprehensive set of strategies, creating an environment that makes it much easier for people to eat a healthier diet and to increase their level of physical activity. By leveraging their combined influence, resources, and connections, such partnerships can: (1) develop tasty, healthy variants of foods for different cultural groups; (2) promote the availability of these foods in schools, work sites, vending machines, and fast-food restaurants; (3) make the ingredients for healthy foods more readily available and affordable in local markets; (4) provide instructions for preparing these foods in churches and community groups; (5) reinstate physical education classes and recess in schools; (6) establish incentives and opportunities for exercise at work; and (7) create safe environments for active play and sports for children and adults. In addition to enhancing the effectiveness of medical counseling and treatment for NIDDM, these types of collaborations have the potential to reduce the prevalence of a broad range of other diseases associated with the Western lifestyle, such as hypertension, heart disease, and some cancers.

THE CHALLENGE OF WORKING COLLECTIVELY

Considering the connective power of collaboration, which enables people and organizations to address objectives that are beyond their direct control, it is not surprising that health partnerships are becoming increasingly common. Yet the potential of collaboration to improve health and the functioning of the health system is extremely difficult for many partnerships to realize. Because partnerships face numerous challenges and have problems dealing with these

challenges, their attrition rate is high. Estimates suggest that only a small proportion of partnerships succeed in their initial goals and even fewer evolve and thrive (Kreuter & Lezin, 1998).

Why is collaboration so challenging? Put simply, it is because collaboration is quite different from the way most people and organizations have worked in the past. Moreover, it is extremely difficult for diverse people and organizations to work collectively. Doing so requires an optimal mixture of partners. It requires a process that makes good use of partners' complementary perspectives, resources, and skills so the group as a whole can develop new and better ways of thinking about problems, and can plan and carry out comprehensive actions. In addition, if partners are to sustain their activities, they need to establish procedures and structures that can support their collaborative way of working over time. While rigorous research on partnership functioning is limited, the literature and the experiences of people involved in collaborations suggest that the ability of partnerships to meet these challenges depends on factors related to (1) partners and their relationships, (2) partnerships as a whole, and (3) the environment in which partnerships function.

Factors Related to Partners and Their Relationships

Many health collaborations involve a broad range of partners, including people and organizations from the public and private sectors, from practice and academia, from the for-profit and not-for-profit arenas, from medicine and public health, and from various community organizations not traditionally associated with health, such as schools, businesses, neighborhood associations, churches, police departments, and transportation agencies. This diversity is an important source of strength for health partnerships since it provides the complementary perspectives, resources, and skills that make collaboration work. At the same

time, however, diversity creates significant challenges, especially when partners come from different professional, racial, or ethnic cultures; have little experience working together; are skeptical of each others' motivations; or are not accustomed to sharing resources or power (Chang, 1994; Lasker et al., 1997; Together We Can, 1998).

Building working relationships among such diverse partners is the key, and perhaps most time-consuming, challenge that health collaborations face. **Trust** has been highlighted as a prerequisite for successful collaborative relationships (Goodman, Speers, McLeroy, Fawcett, Smith, Sterling & Wallerstein, 1998; Kreuter, Young & Lezin, 1998; Taylor-Powell, Rossing & Geran, 1998; Waddock, 1998). Unless people and organizations involved in a partnership are confident that other partners will follow through on their responsibilities and obligations and will not take advantage of them, it is very difficult for them to work closely together. **Respect** among partners (i.e., their appreciation of the value of each others' contributions and perspectives) is another factor that is likely to be important in partnership functioning (Kanter, 1994; Mattesich & Monsey, 1992; Taylor-Powell et al., 1998). Levels of **discord** (i.e., the extent to which differences of opinion lead to strained relationships among partners) and **power differentials** (i.e., the variation in partners' influence in partnership activities) have also been emphasized in discussions of partner interactions (Alter & Hage, 1993; Forrest, 1992; Kegler, Steckler, McLeroy & Malek, 1998; Waddock & Bannister, 1991; Weiner & Alexander, 1991). Power inequalities have the potential to seriously undermine collaborative relationships since they can limit "who participates, whose opinions are considered valid, and who has influence over decisions made" (Israel et al., 1998, p.183).

Partners bring not only their perspectives to the partnership, but also much of the financial and "in-kind" resources that support partnership activities. In addition to

money, these resources include various types of skills and expertise; space, equipment and goods; data and information; connections to decision makers, organizations and groups; endorsements that give the partnership legitimacy and credibility; and convening power (Center for the Study of Social Policy, 1998a; Goodman et al., 1998; Israel et al., 1998; Lasker et al., 1997; Taylor-Powell et al., 1998). A partnership's ability to carry out its work depends, at least in part, on its ability to recruit and retain partners who can provide the resources it needs.

One of the factors that appears to influence partners' decisions about participating in a partnership is their perception of the **relative benefits and drawbacks** involved (Alter & Hage, 1993; Chinman, Anderson, Imm, Wandersman & Goodman, 1996; Goodman et al. 1998). The benefits that partners seek from collaboration often relate as much to their own mission and "bottom-line" as to the partners' joint goals. As mentioned above, collaborations that bring together individual-level services and population-based strategies are as valuable to people and organizations involved in the delivery of medical care as they are to those who care about the health of the community. But the benefits that can be achieved through collaboration extend to a broad range of other partners as well. These **benefits** include an enhanced ability to address an issue that is important to the partner; the acquisition of new knowledge/skills; heightened public recognition; the acquisition of additional funds to support the partner's own activities; increased utilization of the partner's services or expertise; the acquisition of useful knowledge about services, programs, or people in the community; an enhanced ability to affect public policy; the development of new, valuable relationships; an enhanced ability to meet performance goals; and an enhanced ability to meet the needs of the partner's clients or constituency (Alter & Hage, 1993; Butterfoss, Goodman & Wandersman, 1996; Chinman et al. 1996; Lasker et al. 1997; Weiss, 1987).

Participation in health partnerships entails potential **drawbacks** as well. These drawbacks include the diversion of time and resources away from other priorities or obligations, reduced independence in decision making about the partner's own activities, a loss of competitive advantage (e.g., in obtaining funding or providing services), insufficient influence in partnership activities, conflict between the partner's work and the partnership's work, negative exposure due to association with other partners or the partnership, frustration and aggravation, and insufficient credit for the partner's contributions to the partnership (Alter & Hage, 1993; Bardach, 1996; Kegler et al., 1998; Lasker et al., 1997; Weiss, 1987). Minimizing a partner's drawbacks may be just as effective as providing additional benefits in enhancing a partner's participation in the partnership (Chinman et al., 1996).

The **support that representatives receive from their own organization** may also be critical to partnership functioning. Individuals who represent organizations in partnerships have multiple and competing demands placed on them; thus, it is difficult for these individuals to devote the necessary time and energy to the work of the collaboration (Israel et al., 1998). These representatives may be more effective if they have the authority to commit organizational resources or staff to the partnership and if their organization gives them adequate time and resources to fulfill their obligation to the partnership (Kanter, 1994; Selin & Myers, 1995; Waddock & Banister, 1991).

Factors Related to the Partnership as a Whole

The capacity of partners to make the most of their diversity so they can achieve objectives that none of them could accomplish alone, depends not only on the relationships among partners and the benefits and drawbacks that they experience as a result of participating in the collaboration, but also on

characteristics of the partnership as a whole. **Leadership** may be the most important of these partnership characteristics. One of the key challenges of collaboration is that the type of leadership needed in this context is not the type of leadership that most sectors and professions are producing. Traditional leaders frequently have a narrow range of expertise, speak a language that can be understood only by their peers, are used to being in control, and relate to the people with whom they work as followers or subordinates rather than partners. Collaborations, by contrast, need boundary-spanning leaders who understand and appreciate different partners' perspectives, can bridge their diverse cultures, and are comfortable sharing ideas, resources, and power (Alter & Hage, 1993; Lasker et al., 1997; McKinney et al. 1993).

Often in collaborations, a number of people provide leadership, in both formal and informal capacities. Partnership functioning may depend on the leaders' ability to take responsibility for the partnership; inspire, motivate, and empower people involved in the partnership; bridge and combine the different perspectives, resources, and skills of partners; help partners be creative and look at things differently; develop a common language among partners; foster respect, trust, inclusiveness, and openness among partners; create an environment in which differences of opinion can be voiced; resolve conflict among partners; and communicate the partnership vision (Center for the Study of Social Policy, 1998a; Chrislip & Larson, 1994; Gray, 1989; Lasker et al., 1997; Shortell & Kaluzny, 1994).

Another factor that is likely to play an important role in partnership functioning is the **administration and management** of the partnership. This "backbone," and the support staff that comprise it, is the "glue" that keeps partnerships together and that enables multiple, independent people and organizations to work with each other (Israel, 1998). Unlike bureaucratic forms of management, which are

often rigid and structured to control what people do, many health partnerships need administration and management systems that are flexible and supportive. Particular aspects of administration and management that may be critical to the functioning of partnerships (particularly those involving large numbers of diverse partners) include coordination of communication (both among partners and with people and groups outside the partnership); coordination of partnership activities, including meetings and projects; preparation of materials that inform partners and help them make timely decisions; management and distribution of funds; application for and management of grants; performance of secretarial duties; maintenance of databases; orientation of new partners as they join the partnership; and evaluation of the progress and impact of the partnership (Israel, 1998; Lasker et al., 1997; Selin & Myers, 1995; Waddock & Bannister, 1991; Wandersman et al., 1997). The effectiveness of a partnership's administration and management may depend on having paid staff to carry out this work rather than relying on volunteers.

The **governance** of the partnership is likely to be another important predictor of partnership functioning (Axner, 1999; Center for the Study of Social Policy, 1998a; Chaskin & Gang, 1997; Flower, 1994; Flower & Norris, 1994; Kramer, 1999; Mitchell & Shortell, 1999; Potapchuk et al., 1999; Taylor-Powell et al., 1998; Weiner & Alexander, 1998). By establishing procedures and structures that determine *who* is involved in partnership decision making and *how* the partnership makes decisions and does its work, governance has a profound impact on the extent to which diverse perspectives, resources, and skills can be combined. By formalizing its procedures and establishing a sound organizational structure, the partnership, the relationships among its partners, and the collaborative way its partners work with each other and with the broader community, can be sustained beyond the tenure of any particular leader or staff person. One of the key challenges of governance is that the most effective

procedures and structures at one point in time may not be optimal later. Consequently, partnerships that seek to maximize their functioning may need to re-evaluate on a regular basis the people and organizations involved in decision making, the procedures by which decisions are made, and the legal status of the partnership.

Factors related to the external environment

The ability of diverse people and organizations to work collectively is likely to be influenced not only by factors related to partners and the partnership, but also by factors that are beyond the ability of the partnership to control. One such factor is the **conduciveness of the community to the work of the partnership** (Israel et al., 1998; Goodman et al., 1998; Jewiss & Hasazi, 1999; Mattesich & Monsey, 1992; Taylor-Powell et al., 1998). Recruiting and retaining partners, and building working relationships among them, may be considerably more difficult in communities in which there is little history of cooperation and trust, significant competition for resources or clients, resistance of key people and organizations to the goals and activities of the partnership, problems bringing partners together due to crime or lack of transportation, and/or a plethora of categorical partnerships involving many of the same partners.

Going beyond geographical issues, many health collaborations, regardless of where they are located or what they are trying to achieve, are facing a number of common **public and organizational policy barriers**. Some of these barriers relate to *funding and program requirements* (Center for the Study of Social Policy, 1998b; Finance Project, 1998; Gardner, 1994; Newachek, Halfon, Brindis & Hughes, 1998; Orland, Danegger & Foley, 1995). For example, categorical program requirements may make it difficult for partnerships to take comprehensive approaches to health problems. Funding streams oriented

toward service delivery may make it difficult for partnerships to obtain adequate financial support to develop and maintain their administration and management infrastructures. Government and foundation initiatives that support the development of new partnerships, rather than building on the relationships and administration and management infrastructures of existing ones, may encourage a plethora of fragmented partnerships.

Other policy barriers relate to *incentives* (Cortes, 1998; Friedman, 1997; Karlin & Sullivan, 1999; Lasker, 1999b; Melaville, 1997). Currently, it is difficult to motivate some people and organizations to participate in partnerships because they are either not rewarded or are actually penalized for doing so. For example, hospitals, community-based organizations and health departments may be reluctant to participate in collaborative community health assessments if the products do not satisfy their own reporting requirements. Not-for-profit hospitals and managed care organizations may not be willing to channel their community benefit funds and activities to support the work of broad-based community collaboratives unless they have a legal incentive to do so. Heads of programs in government agencies may not consider working together if they are not held accountable for achieving the same performance measures. Faculty at academic medical centers may not work with partnerships in the community if the time and effort involved in doing so does not satisfy their institution's criteria for promotion and tenure. Health professionals may have little interest in working collaboratively if they are not exposed to collaborative practice during their training that demonstrates how people and organizations in other sectors can help them achieve their goals.

CONCLUSION AND RECOMMENDATIONS

Considering the daunting challenges involved in realizing the benefits of

collaboration, one might reasonably ask whether the current interest in health collaboration in the United States is justified. In spite of the limited evidence documenting the effectiveness of partnerships in improving health, we believe the answer must be “yes”. The most compelling reason for pursuing collaboration is that there is no other way to achieve the health objectives people in communities care about; very little can be accomplished by any person or organization working alone. Another reason is that the connective power of collaboration has the potential to create a real health system in this country – one that focuses on health and well-being as well as the financing of medical care; one that actively involves people most affected by health problems in decisions and actions related to their health; and one that enables communities to take innovative and comprehensive actions to address the full range of environmental, economic, social, behavioral, and biological factors that influence health.

Collaboration is unlikely to lead to improvements in health and the functioning of the health system, however, unless the pioneering people and organizations involved in health partnerships are supported in addressing the multiple challenges they face. This support entails far more than financial assistance. Partnerships around the country are seeking strategies that can help them establish working relationships among diverse partners and make the most of what these partners bring to the table. They are looking for procedures and structures that can help them engage a broad range of stakeholders – including community residents who are not health professionals or service providers – in collaborative action and decision making. They are trying to find ways to make public and organizational policies more conducive to collaboration. Additionally, partnerships are seeking methods that can help them determine how well their partners are working together and how well their partners’ collective efforts are succeeding in achieving their goals.

What can be done to provide the people and organizations involved in collaboration with meaningful assistance? Many centers and consultants around the country are currently working with partnerships, and each of these is taking a somewhat different approach to providing assistance. Our experience leads us to make the following recommendations.

First, we believe there is a need to **develop instruments that can be used to assess partnership functioning (i.e., how well diverse people and organizations work collectively) and to conduct studies to identify the factors that have the greatest influence on partnership functioning.** With such tools, partnerships would have a way to determine how well they are functioning, to identify their particular strengths and weaknesses, and to take appropriate steps to improve their functioning. Funders would be able to identify partnerships that are functioning well but need more time and investment to achieve their goals. Researchers studying the impact of collaboration on health would be able to target their investigations on functional partnerships, which may be most likely to succeed.

Second, there is a need for effective **tools and training programs that can help health collaborations improve the ability of their diverse partners to work collectively.** The development of such tools and training programs should be informed by the results of the studies mentioned above so that they focus on factors that are documented to have a substantial impact on partnership functioning (rather than on factors that seem important, but actually are not). To assure that the tools and training programs are useful in the field, the types of partnerships that will be using them should be actively involved in their development.

Third, there is a need for **tools that can help health partnerships establish effective procedures and structures for broadening community participation in their work.** Currently, many health partnerships around the country are grappling with issues of community governance, often independently of each other and without the benefit of the experience that has been gained in other areas, such as comprehensive community initiatives focusing on children and families. While tools need to be developed with the particular types of partnerships that will be using them and oriented toward their needs, the process by which they are developed should build on the relevant lessons learned in other partnerships and initiatives.

Fourth, there is a need for **coalitions to develop and advocate options for addressing public and organizational policy barriers to collaboration.** Currently, numerous partnerships and collaborative initiatives around the country are facing similar public and organizational policy barriers, yet none of them, working alone, has the capacity to develop feasible options for addressing these barriers or the power to change existing policies. By joining together, however, they may have the influence, resources, and skills to do so. Community-Campus Partnerships for Health could stimulate productive discussions about forming such coalitions, since it brings together people involved in a broad range of collaborative initiatives.

Finally, there is a need to develop **new and better methodologies to assess the impact of partnership actions on the health of the community and the functioning of the health system.** Difficulties documenting the impact of collaboration on health and the health system relate as much to the challenges of, and limited investment in, this type of research as to the problems partnerships face in achieving their outcomes. As increasing attention is focused

on evidence for effectiveness, this lack of documentation has the potential to seriously undermine future financing for collaborative community health interventions. Since so many researchers involved in evaluating community health partnerships are associated with Community-Campus Partnerships for Health, this organization could play an important role in stimulating the development of new methodologies.

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APPENDIX OF RESOURCES

Academy for Educational Development (<http://www.aed.org>)

Annie E. Casey Foundation (<http://www.aecf.org>)

Aspen Institute Roundtable on Comprehensive Community Initiatives for Children and Families (<http://www.aspenroundtable.org>)

The California Center for Health Improvement (<http://www.cchi.org>)

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<http://www.nyam.org/pubhlth/>

Center for Applied Research and Educational Improvement

<http://carei.coled.umn.edu>

Center for Assessment and Policy Development (<http://www.capd.org>)

Center for Community Change (<http://www.communitychange.org>)

Center for Policy Alternatives (<http://www.cfpa.org>)

Center for Regional and Neighborhood Action (<http://www.crna.net>)

Center for the Study of Social Policy (<http://www.cssp.org>)

Center for Substance Abuse Prevention
<http://www.samhsa.gov/csap/index.htm>

Chapin Hall Center for Children; University of Chicago
<http://www2-chc.spc.uchicago.edu>

Civic Practices Network (<http://www.cpn.org>)

COMM-ORG: The Online Forum for Community Organizing and Development
<http://comm-org.utoledo.edu>

Community Building Resource Exchange (<http://www.commbuild.org>)

Community Tool Box (<http://ctb.lsi.ukans.edu/tools>)

Community Voices (<http://www.communityvoices.org>)

Community-Campus Partnerships for Health
<http://futurehealth.ucsf.edu/ccph.html>

The Edna McConnell Clark Foundation

<http://fdncenter.org/grantmaker/emclark/index.html>

Electronic Policy Network | Links: Democracy & Civic Participation

<http://epn.org/links/civiclincs.html>

Family Investment Trust (<http://www.mofit.org>)

The Finance Project (<http://www.financeproject.org>)

Ford Foundation (<http://www.fordfound.org>)

Health Forum (<http://www.hhnmag.com/default.html>)

Health Research and Educational Trust (<http://www.aha.org/hret>)

Healthy Start National Resource (<http://www.healthystart.net>)

Illinois Violence Prevention Authority (<http://www.IVPA.org>)

Institute for Educational Leadership (<http://www.iel.org>)

International Healthy Cities Foundation (<http://www.healthycities.org>)

Iowa Empowerment Initiative (<http://www.empowerment.state.ia.us>)

Local Initiatives Support Corporation (<http://www.liscnet.org>)

Local Investment Commission (<http://www.kclinc.org>)

MacArthur Foundation (<http://www.macfdn.org>)

Maternal & Child Health Policy Research Center (<http://www.mchpolicy.org>)

Medicine and Public Health Initiative (<http://www.apha.org/ppp/medicine.htm>)

National Academy for State Health Policy (<http://www.nashp.org/home.html>)

National Center for Public Productivity

<http://www.andromeda.rutgers.edu/~ncpp/ncpp.html>

National Civic League (<http://www.NCL.org>)

National Community Building Network (<http://www.ncbn.org>)

National Governors' Association (<http://www.nga.org>)

National Network for Collaboration (<http://crs.uvm.edu/nnco>)

National Partnership for Reinventing Government (http://www.npr.gov_

New York AIDS Coalition: The Collaboration Project

<http://www.nyaidscoalition.org/collaboration/collaboration.html>

North Central Regional Education Laboratory (<http://www.ncrel.org>)

Oregon Commission on Children and Families (<http://www.ccf.state.or.us>)

Partnerships for Health (<http://www.health.gov/partnerships>)

Pew Partnership (<http://www.pew-partnership.org>)

The Rockefeller Foundation (<http://www.rockfound.org/frameset.html>)

Russell Sage Foundation (<http://www.russellsage.org>)

Ryan White Comprehensive AIDS Resources Emergency (CARE) Act
<http://www.hrsa.dhhs.gov/hab/care.html>

Surdna Foundation (<http://www.surdna.org>)

Sustainable Communities Network (<http://www.sustainable.org/index.html>)

Together We Can Initiative (<http://www.togetherwecan.org>)

Turning Point Initiative (<http://www.tpnet.org>)

Urban Health Initiative (<http://www.urbanhealth.org>)

Urban Institute (<http://www.urban.org>)

Urban Partnerships Project (<http://www.thenationalcenter.org/upp/index.htm>)

Urban Strategies Council Web Site (<http://www.urbanstrategies.org>)

W. K. Kellogg Foundation (<http://www.wkkf.org>)

Wisconsin Cooperative Extension (<http://www.uwex.edu>)

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Dr. Lasker has spent her professional life at the interface of medicine, public health, and health policy. For the last four years, she has directed the Division of Public Health at The New York Academy of Medicine. Among her many projects at the Academy, Dr. Lasker led a major study on the relationship between medicine and public health, which culminated in the publication of *Medicine & Public Health: The Power of Collaboration*, and *The Pocket Guide to Cases of Medicine & Public Health Collaboration*. This year, she established a new arm of the Division — the Center for the Advancement of Collaborative Strategies in Health — to enhance the capacity of communities to initiate and sustain effective health collaborations.

Prior to joining the Academy, Dr. Lasker served as Deputy Assistant Secretary for Health (Policy Development) in the U.S. Department of Health and Human Services, where she received the John W. Gardner Award for excellence and outstanding achievement in public policy, population health, and public service. From 1987 to 1993 she served as Principal Policy Analyst for the Physician Payment Review Commission, a Congressional body created to reform the way physicians are paid under the Medicare program. Dr. Lasker was Assistant Professor of Medicine at the University of Vermont College of Medicine, where she received the Teacher of the Year Award. Trained in endocrinology at the National Institutes of Health, Dr. Lasker is an alumna of the University of Pittsburgh School of Medicine, Cornell University, and the High School of Music and Art in New York City.

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