Education for Health,
Vol. 18, No. 2, July 2005, 312–314

Taylor & Francis
Taylor & Francis Group

FROM THE LITERATURE

In the News

An opinion

Collaboration with the Community: An Excellent Example

In the January 2005 issue of *Academic Medicine*, a remarkably modest article appeared with a description of a community-based programme in collaboration with an Academic Medical Center in Durham, North Carolina, USA (Lloyd Michener *et al*., 2005).

In the article the authors describe that favourable numbers of hospital beds, nursing home beds, available nurses, doctors and health care services may give a skewed picture of the equity of these provisions for all. In North Carolina, there is a large poor population, black, Latino and white. Among these groups, rates of unemployment, school drop-out, and Medicaid eligibility were constantly high when this was measured in 1980, while health was poor. The authors state that their city "was not a healthy community for poor people".

Exploration of the reasons for this inequity, by members of Duke University Medical Center disclosed that the community viewed characteristics of this very institution as part of the problem. The academic medical center was perceived as largely indifferent to the community's concerns, and interaction was seen to pursue or protect the institution's interest. Community-based programmes were frequently short-term research or service projects which terminated when grant funds ended or with the ending of a semester.

This may sound all too familiar to organizers of community-based courses or programmes, and all of us have struggled with these problems in our own ways.

At Duke's these course organizers arranged a series of meetings with members of health services and departments. These meetings were initially characterized by a guarded atmosphere, eloquently described in the article. The atmosphere changed when a member asked the group to describe the characteristics of a successful programme. At that moment participants began to list these characteristics, quickly deciding that a first effort at a collaborative intervention should be small and carefully targeted, sustained and focused on poor children.

The group then sought members of other organizations needed for the success of the initiative: academic and primary care practices, emergency departments, pharmacists, public schools and other community organizations. A dinner was organized at which guidelines were adopted. One-hundred-and-

Education for Health ISSN 1357-6283 print/ISSN 1469-5804 online © 2005 Taylor & Francis Group Ltd
http://www.tandf.co.uk/journals
DOI: 10.1080/13576280500148254

ninety-one clinicians were trained to use these guidelines. When the actual work with these guidelines started, new solutions were found to problems, for example: providing home-based care to patients not able to access primary care.

This programme became a success. Consequently new programmes were launched by the coalition.

In the article the authors give a set of core values and principles for new community programmes:

- Community needs and stakeholders would determine the services to be developed, not academic needs;
- Programmes would focus on populations that lacked access or faced barriers to primary and preventive health care services;
- Programmes would be designed to be financially sustainable; grant funds would be used to finance research, development and evaluation of the programmes but not to sustain the services provided;
- Programmes would be carefully evaluated, but not with intervention and control groups. This was particularly important to reduce the mistrust of the Academic Medical Center expressed by members of the underserved community;
- Innovative methods of care delivery, but not experimental medical care, would be offered. This was also a key element in gaining community trust;
- Learners would not be included in community-based programmes or train in any community programme until the programme was stable, successful and accepted by the community.

New programmes resulted from the success of the first. A number of critical factors for their success have been formulated in the article in order to assist other Academic Medical Centers in delivering community-based health, health promotion and disease prevention services:

- You need seed money, but not too much, in order to avoid ‘‘grant management’’ becoming the main objective;
- Start small;
- Do your homework: bring in relevant data and analyse them for and with your partners;
- Join the process, don’t lead it;
- Serve something; break bread together, hold meeting at partners’ sites as often, or more often than at the AMC;
- Delay publicity until the partners ask for it;
- Hire faculty and staff with community and public agency experience;
- Focus on the forgotten. By making the vulnerable patient populations the focus of the efforts the coalition has ‘the field to itself’;
- Deal with the cultures of the various partner agencies.

In my view the article is remarkable for a number of reasons: it is modest because the initial difficulties are described, as well as the successes. The projects are characterized by involvement of a team, although the article has been authored by a Chairman of the Department of Community and Family Medicine, a Dean of the School of Nursing, a chief Planning Officer of the University Health Center, a chief Division of Community Health and a research analyst, all from Duke University. They were willing to look back at the work and search for reasons of initial limited success. Moreover, the article is very specific in describing the ''lessons learned'', and finally: it is from the United States, where not many of these descriptions are published.

Jan van Dalen
Associate Editor, *Education for Health*

Reference

LLOYD MICHENER, J., CHAMPAGNE, M. T., YAGGY, D., YAGGY, S. & KRAUSE, K.M. (2005). Making a home in the community for the Academic Medical Center. *Academic Medicine*, *80*, 57–61.