crash risks, but the crash responsibility method used is inadequate for determining this. Because control for exposure is partially lost in the responsibility analysis technique, drivers with marijuana who crash, compared with other drivers, may be on the roads at times and places where they are less apt to be responsible for crashes. Or they may drive erratically in such ways that they initiate crashes but are not identified as the responsible driver. The system used in this study for classifying responsibility is oversimplified in assigning 100 percent of the crash responsibility to one driver or the other; however, the use of more sophisticated systems was inappropriate because of the quality of data available from the police reports.

The fact that marijuana was found in more than one-third of the drivers in this study indicates that its role in crashes needs further investigation. Further studies are also needed to determine the incidence of marijuana and other drugs in crash populations other than young California males.

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Technical Assistance Offered to Community Health Programs through a Resource Model

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Synopsis

A multidisciplinary unit in the Department of Community Medicine, Mount Sinai School of Medicine, consists of a core group of specialists who plan, develop, and evaluate community health care programs. The primary

tools used by the staff of the Services Coordination Unit, epidemiology and behavioral and management sciences, result in improved organization and coordination of health services and community resources.

The small unit of specialists functions as a resource group, helping community groups address the complex problems of planning, organization, delivery, and financing of health services. By offering technical assistance rather than day-to-day health care services, the unit has established an education and training program in New York's East Harlem, which surrounds the medical school. Over the last 10 years, that approach has enhanced the administrative and financial viability of existing health programs in East Harlem.

Since the unit's establishment, it has collaborated with a broad variety of community groups. More than 20 programs have resulted.

The income generated by the unit completely covers the expenses and has done so since 1976; "seed money" was used for startup and the first 3 years of operation. The unit is paid for long-term services and for most consultations.

JOHN GRANT, IN THE 1950s, STRONGLY RECOMMENDED "regionalization" of medical care and medical education (*1*). In the sixties, many national and international groups, reflecting the general social unrest of the decade, recommended that universities and their schools of medicine become more responsive to community needs (*2–5*). Medical schools themselves, confronted by rising social expectations, began to identify community health as an area of academic priority.

Throughout the 1960s, many medical schools in the United States did become involved in community issues. Departments were created with a variety of names—social medicine, community medicine, preventive medicine, and community health. New medical schools were established with a primary focus on community health. Innovations in medical education were introduced, and new types of health care service were initiated in response to these new concerns (*6–8*). Similar kinds of departments and programs appeared in many other countries (*9–13*).

In the United States, one of the most difficult tasks faced by the new departments was to define their purpose, operational policy, and the activities in which they would engage. In particular, the appropriateness of direct delivery of personal health services by such departments was a major issue. Under strong societal pressure to provide medical care, most departments ultimately assumed responsibility for some form of medical service delivery, through neighborhood health centers (*14–17*), hospital-based ambulatory care programs (*18–19*), and primary care programs.

The Mount Sinai School of Medicine was one of the few medical schools created in the sixties that had a commitment to community health but with a department of community medicine that did not assume responsibility for providing personal health services in the community (*20*). The school gave substance to its professed community health goal by endowing a Department of Community Medicine, which has become an integral component of the institution. The advisory role of the department in personal health services, identified as community medicine practice, has been described elsewhere (*21*).

We will describe and discuss the role, functions, organization, and operating procedures of the Services Coordination Unit, the multidisciplinary team practicing community medicine in the Department of Community Medicine.

Services Coordination Unit

The department operates in the context of a specific definition of community medicine as that discipline dedicated to the identification and solution of health problems in population groups. This definition is a unifying theme for a broad range of services of the department (*22*). Since 1973, responsibility for those services has been vested in the Services Coordination Unit, which is part of the office of the chairman of the department and coordinated by the deputy chairman.

Composition of the Unit

The Services Coordination Unit comprises faculty from different disciplines, with varied experience, who are trained in health care organization and prepared to serve as a core group of specialists for planning, development, and evaluation of health care programs. In addition to the coordinator, who is a physician-educator, the unit consists of a physician with expertise in planning, an epidemiologist, a community social worker, three organizational sociologists, and two clinicians—a total of nine persons plus support staff.

Purpose and Operational Policy

The unit's overall purpose is to improve health care services in communities where it becomes involved, without assuming direct responsibility for day-to-day administration or for provision of personal health care services. To meet these objectives, the unit's staff serves a broad variety of community groups in a continuing process of problem identification and resolution. The community groups represent consumers (community organizations) and health care providers (hospitals and medical practices). In partnership with these groups, members of the Services Coordination Unit encourage a more rational utilization of existing resources; foster interorganizational linkages, mergers, and agreements; and work toward the unit's goal of the regionalization of health services (*23*).

Working with the community on a day-to-day basis, the unit's staff members are in a position to enhance the perceived and actual ability of the community to meet its own problems and needs. By providing technical assistance rather than direct care, the Department of Community Medicine establishes an ongoing education-training process. By transferring valuable technical skills to community members, the department creates a situation from which it will be able to withdraw when its expertise is no longer necessary, leaving community groups in complete and capable control of the program. Over the past 10 years, this approach has enhanced the administrative and financial viability of several health care programs located in New York's East Harlem, the medical school's surrounding community.

This team of community medicine practitioners actively plans, develops, and evaluates programs in concert with community groups (*24*). Unlike the clinical providers, the primary tools used are epidemiology and the behavorial and management sciences; the impact of intervention is seen in the improved organization and coordination of health services and community resources.

Operating Procedures

The staff of the Services Coordination Unit meets weekly to review ongoing planning, to analyze emerging problems, and to discuss new requests for technical assistance. These requests, which come from health services organizations or consumer organizations in the community, are reviewed with respect to the nature and priority of the problem and the availability of human resources from the Services Coordination Unit or other sections of the department or the medical center.

When a problem is particularly appropriate to the unit, personnel in the group assume responsibility in one of two ways. Unit staff members can act either as short-term consultants to the consumer or health care organizations or as long-term participants in the planning, development, or evaluation of service programs. Long-term participation is limited to the provision of particular kinds of expertise, information, or specialized intelligence and recommendations. The Services Coordination Unit does not take over responsibility for a project from its parent agency, but it does provide a knowledge base on which the responsible agents may act.

'The overall purpose is to improve health care services in communities without assuming direct responsibility for day-to-day administration or for provision of personal health care services.'

Every decision to respond to a request is based on priority-setting guidelines and careful consideration of the amount of time available for staff members to meet the commitment. Once a project is assured of funding, appropriate staff members are selected from the disciplines represented in the department and assigned to work with the community group on a part-time basis for as long as necessary.

When members of the unit assume long-term responsibility for a particular project, their ongoing work is discussed periodically in the weekly meetings and reviewed with the entire planning team.

Priority-Setting Guidelines

Each community-based group requesting technical assistance for health care issues has its own set of priorities and long-term goals, and most requests for cooperation could easily absorb all the technical resources and time available to the unit. In this environment, a services unit that did not have a clear notion of its goals and objectives could disperse its resources so widely as to become nonfunctional. Assigning priorities to the multiple requests for technical assistance and selecting those most compatible with the unit's orientation help it avoid excessive and counterproductive fragmentation of its efforts. The following criteria are used to identify high-priority projects.

Community leadership capacity. Because the Department of Community Medicine is committed to the

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notion that the community should have a strong voice in shaping and monitoring its own health care, the existence of community leadership is a condition of first priority. The Services Coordination Unit is unwilling to enter into a project if its members will have to assume direct responsibility for the administration or actual provision of services.

Population-based planning. The unit gives priority to requests that address the needs of defined groups in the community and to provider groups that are willing to assume full responsibility for maintaining the health of well-defined population groups. Thus, the services unit attempts to avoid working entirely in the existing institutional framework.

Regionalization. Recognizing the need for a better and more efficient use of resources, members of the unit promote increased coordination and integration of existing health care services in a region while respecting the pluralistic nature of American society.

Provider teams. Convinced of the desirability of health professionals working in interdisciplinary groups, members of the services unit encourage the delivery of health care by organized group practice health teams that include not only a variety of medical specialists, but other health professionals and paraprofessionals as well.

Prepayment. Because resources are always limited and the form of payment to providers for professional services influences their behavior, priority is given to programs that promote the financing of health care by prepayment and capitation.

The five issues outlined provide a rational framework for establishing priorities and deciding which opportunities to pursue. The department participates primarily in programs and projects that share a set of common concerns; since its establishment, it has collaborated with a broad variety of community groups. More than 20 programs that resulted have been described elsewhere (*25–30*).

The following descriptions of two of these programs give some sense of the range of groups with which the Services Coordination Unit has been involved.

- In 1975, at the request of the East Harlem Council for Human Services (EHCHS), a Puerto Rican community organization, the Services Coordination Unit participated in an analysis of alternative approaches to the problem of providing primary care to the East Harlem community. These discussions led EHCHS to establish two neighborhood health centers and to assume responsibility for their governance. The two programs, which now offer primary medical and dental care to more than 17,000 registered patients (*29*), were planned and implemented with the department's cooperation.
- At the request of the Mount Sinai Department of medicine, the Services Coordination Unit provides ongoing technical assistance for development of a primary care group practice. This practice, which has replaced Mount Sinai Hospital's traditional general medical clinic, serves more than 4,000 registered adults from all socioeconomic levels. Two social scientists from the services unit are responsible for concurrent policy research designed to provide a regular flow of information for modifying patient services and evaluating the delivery of health care to the practice's population (*27*).

Although East Harlem remains the primary focus of the services unit, the unit is also involved in programs outside the immediate geographic area, as well as in other countries (*30*).

Financing

In keeping with the department's commitment to community participation, the services unit is paid for the long-term services provided and for most consultations. Because the community groups assisted by the services unit may be in either the public or the private sector, the unit derives income from a variety of sources. For example, during 1981, it received $425,000 through technical assistance agreements with nine different organizations, among them the two community-run neighborhood health centers, two voluntary hospitals, three clinical departments in the Mount Sinai School of Medicine, a multinational corporation, and a foundation. The latter was supporting the group practice planning effort in the Mount Sinai Hospital's Department of Medicine.

The long-term viability of the services unit depends on its ability to stay within the limits of the resources available. To this end, the number of core personnel is pur-

posely kept to a minimum. Core personnel and nonpersonnel expenses are projected at the beginning of each fiscal year and compared with anticipated revenues. As the year progresses, actual income and expenditures are carefully monitored. Since new activities may be initiated at any time during the year, actual income and expenditures often exceed early projection.

The income generated by community medicine practice completely covers the expenses of the unit and has done so since 1976. Initially, "seed money" was needed for creation of the unit and for its first 3 years of operation. These funds were provided between 1973 and 1976 by the Robert Wood Johnson Foundation.

Education and Research Activities

In addition to the training inherent in technical assistance, the Services Coordination Unit contributes to knowledge through its involvement in departmental education programs. The unit's members participate in the undergraduate teaching program in community medicine as preceptors and lecturers. These courses are designed to help medical students enhance and refine their clinical learning by expanding their knowledge and understanding of the population dimensions of health problems and their solutions. Unit members also participate as preceptors and consultants in the department's teaching program.

During the 1960s academic research became unpopular among community groups that found its inclusion in collaborative medical school-community projects to be a strain on limited resources and its products of uncertain utility. As a result, the services unit de-emphasized traditional research in its projects and limited its research to activities essential to program planning and implementation. The critical role of ongoing evaluation in successful program planning made it inevitable that unit members would become deeply involved in evaluative research (*31*), while the need for population data for initial planning assured unit members of their involvement in community surveys.

Similarly, organizational research efforts have focused on resolving conflicts within institutions and facilitating successful program operations. The evaluation carried out in conjunction with unit projects has been applied research and has been described in terms of its centrality to program development rather than in research terms per se. The unit's efforts have concentrated on experimental model-building rather than on the acquisition of new knowledge. Because of the community agencies' positive experience with the research conducted to date, they are now more favorably disposed to research in general, and it should be possible for unit members to expand the range of their research in the future.

'The income generated by community medicine practice completely covers the expenses of the unit and has done so since 1976.'

Discussion

Several previous articles have defined the department's approach to the practice of community medicine. The extent to which the department's approach has been replicated in the United States or abroad is unknown to the authors. Although the role, functions, and organization of the Services Coordination Unit would appear relatively simple to adapt, we offer the following caveats to departments that may be interested in reproducing the model.

A department that decides to work with the community at its initiative, to act as liaison for the medical school, and to contribute to planned change in an urban setting can expect to receive more requests than it can possibly handle. To be successful, such a department must be firmly rooted and have a strong enough sense of itself to establish its priorities and stick with them. Failing this, the complexity of urban health issues and the variety of ways the community may request intervention may overwhelm the best of intentions. The department, based on its working guidelines, must be able to identify and pursue the most appropriate opportunities among those available in order to avoid overextending its resources.

To succeed and endure, it is also of utmost importance that the planning team have a well-developed sense of patience and recognize that, in a democratic and pluralistic society, change usually occurs slowly. Technical assistance will only be sought and accepted when the need for it is recognized by a community group. Progress in the way health care is organized and delivered will occur at a pace set by the community group. Conscious recognition of the need for patience by a technical assistance team will reduce the frustration and disillusionment experienced by any group anxious to effect change.

For a true partnership to develop between the community group and members of the services unit, reimbursement for technical assistance should cover the true cost of efforts. A peer relationship will occur naturally only if the economic transactions between the working groups appropriately cover the time invested in program activities. Nonprofit community groups with limited, and often diminishing, revenues may be tempted to delay or

forgo payment of the services unit in order to use the funds set aside for planning and coordination to pay for the delivery of services. Again, only a strong enough sense of self will permit a technical assistance team to persist in claiming full reimbursement. Under the best of circumstances, delays in payment are frequent and require the medical school to invest funds up-front for cash flow maintenance.

In addition to the volume of requests, delayed reimbursements, and the slow pace of change encountered in this approach to community medicine practice, a team should be aware of other problems. Prominent among them are local politics, interagency rivalries, competition among ethnic groups, the academic goals of the medical school, and the high turnover among team members.

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