Brokerage Professions and Implementing Reform in an Age of Experts

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Forthcoming in American Sociological Review
2014, Vol 79(5) 912-941

Abstract

In this comparative ethnographic case study of the implementation of a reform related to the Affordable Care Act in two community health centers, I find that professionals may not compete to claim new tasks (and thereby not implement reform) if these tasks require them to acquire information unrelated to their professional expertise, use work practices that conflict with their professional identity, or do impure or low-value tasks that threaten their professional interests. In such cases, reform may be implemented if lower-status workers fill in the gaps in the division of labor between the professions targeted by the reform, playing a brokerage role by protecting each profession's information, meanings, and tasks in everyday work. When the new tasks represent professionally ill-defined problems, brokers can be more effective if they use buffering practices rather than connecting practices—managing information rather than transferring it, matching meanings rather than translating them, and maintaining interests rather than transforming them—to accomplish reform. By playing a buffering role in the interstices between existing professional jurisdictions, lower-status workers can carve out their own jurisdiction, becoming a brokerage profession between existing professions that need to collaborate with one another for reform to occur.

Keywords: Brokerage, Law and Society, Professions, Reform, Status

In this age of experts (Brint 1996), when professions are the largest and fastest growing proportion of the labor force in the United States (Gorman and Sandefur 2011), reform implementation increasingly involves different groups of professionals. For example, to implement civil rights reform, human resources professionals need to work with business managers (Dobbin 2009; Kalev, Dobbin, and Kelly 2006). To implement pharmaceutical reform, clinical trials researchers need to work with clinicians (Heimer and Gazley 2012). To implement environmental reform, safety experts need to work with scientists (Silbey, Huising, and Coslovsky 2009). And to accomplish judicial reform related to drug use, probation officers need to work with clinicians specializing in substance abuse (McPherson and Sauder 2013). Sociologists who study a wide range of these reforms find tremendous variation in compliance with the same reform across organizations (e.g., Dobbin, Kim, and Kalev 2011).

Reform targeting professionals is often difficult to implement, because reforms create broad and ambiguous mandates that do not specify clear standards for compliance, and because reforms open up new task areas that spark jurisdictional battles between existing professions (Abbott 1988; Edelman 1992; Kelly and Dobbin 1999). To implement reform, public officials and organizational executives must settle these jurisdictional battles (Dobbin and Kelly 2007; Starr 1982; Timmermans 2005).

The existing literature is critical to explaining how and when reforms involving professionals are implemented, but we must add to it to account for the outcomes I observed in my ethnographic study of two U.S. community health centers (pseudonyms Main and Central). The reform I studied—the medical-legal partnership (MLP) reform—is one of the enabling programs being rolled out across the United States along with the Affordable Care Act (ACA). For the 26 states participating in Medicaid expansion, Medicaid coverage is now provided for most low-income adults to 138 percent of the federal poverty level (Center for Medicare & Medicaid Services [CMS] 2014). Yet, even though the Affordable Care Act increases coverage for low-income patients, expanded coverage does not necessarily translate into increased care.

Public health activists argue that because low-income people's health problems often occur long before they get to their doctor, for the Affordable Care Act to be successful, patients need access to primary care physicians and to enabling programs that address the social determinants of health. Activists across the country have received funding for these programs (American Public Health Association [APHA] 2010). MLP reform is an enabling program designed to improve the health outcomes of traditionally disadvantaged groups by changing the everyday practices of health center doctors and legal aid lawyers. Health center doctors typically treat low-income patients' medical problems; with the implementation of

MLP reform, they also address the social and legal problems that affect patients' health (e.g., if a patient's apartment lacks heat, it will be difficult for the patient to recover from an ear infection). Lawyers, in working with low-income clients, often use individual cases to bring legal reform for large numbers of the poor; with the implementation of MLP reform, they gain new access and treatment points for vulnerable clients by expanding legal screening, and they increase their ability to solve legal problems related to health for large numbers of the poor by getting doctors to assist with reform efforts.

To implement MLP reform, both doctors and lawyers need to change how they screen clients, determine their eligibility for treatment, and treat them. Doctors must learn from lawyers to screen patients for unmet social and economic needs in areas such as income, housing and utilities, education, immigration, and personal and family stability; they must also refer patients with unmet needs to lawyers. Lawyers must learn from doctors how to resolve issues during phone consults, advise doctors about other legal and social services, and schedule patients for intakes and treatment at their legal clinic.

Research shows that MLP reform allows patients to leave medical clinics with comprehensive prescriptions for improved health (Sandel et al. 2010). For instance, asthmatic patients not only obtain prescriptions for inhalers, but also strategies to compel recalcitrant landlords to remove mold and exterminate pests (Zuckerman et al. 2004).

By 2013, top managers at 235 community health centers and safety-net hospitals across the United States had adopted MLP reform, but the success of reform implementation across sites was uneven. In my study, reform succeeded at Central but failed at Main. To explain this difference in outcomes, we need to focus on cross-professional collaboration in everyday work, rather than on jurisdictional battles played out in front of public officials or executives. And, we need to focus on gaps in the division of labor generated by targeted professions claiming some but not all of the new tasks required for reform.

I find that existing professions may fight to claim some new tasks created by reform, but they may not claim all of the required new tasks if these tasks are low status, low value, and do not enable them to use their specialized expertise and express their professional identities. However, unless all of these new tasks are claimed, reform cannot be implemented. In such cases, lower-status workers may help implement reform by protecting each professional group's information, meanings, and tasks in everyday work. By playing a buffering role in the interstices between existing professional jurisdictions, these workers can carve out their own jurisdiction, becoming a *brokerage profession* between two existing professions that need to collaborate with one another for reform to occur.

CURRENT UNDERSTANDING OF REFORM IMPLEMENTATION INVOLVING PROFESSIONALS

Professions, Law, and Organizations

Professions theory and law and society theory each address the question of how and when reform involving professionals is implemented. Professions theory focuses on how important it is for professionals to construct task boundaries between themselves and competing practitioners (Freidson 1970; Starr 1982); because professional jurisdiction is the means of continued livelihood, professionals fiercely guard their core task domains (Abbott 1988). Environmental changes, like new laws, can disturb the system of professions by opening new task areas that spark jurisdictional battles between existing professions (David, Sine, and Haveman 2013; Dobbin and Kelly 2007; Edelman 1992; Fligstein 1990; Galperin 2014; Hafferty and Light 1995; Zetka 2003). Such jurisdictional battles can negatively affect those who are served by professionals (Heimer 1999; Kellogg 2011, 2012; Timmermans 2005).

According to this theory, reforms are implemented when jurisdictional battles end in one of five forms of settlement: full jurisdictional control by one profession; subordination of one profession under another (nurses under doctors); intellectual control of one profession over another (psychologists under psychiatrists); shared jurisdiction with a division of labor by content of work (architects and engineers) or by client (corporate lawyers and legal aid lawyers); or advisory control by one profession over certain aspects of another profession's work (lawyers advise bankers) (Abbott 1988:69-79). Professions theory would lead us to expect that MLP reform should be successfully implemented in situations where one of these settlements is achieved; for example, if doctors and lawyers develop a shared jurisdiction with a division of labor by content of the work.

While professions theory demonstrates that implementing reform involving professionals is difficult because it requires the settlement of jurisdictional battles between professions, law and society theory suggests it is difficult because new laws create broad and ambiguous mandates that do not specify clear standards for compliance (Briscoe and Kellogg 2011; Dobbin and Sutton 1998; Edelman and Stryker 2005; Heimer 1996; Kalev and Dobbin 2006; Kelly 2010; Sine, Haveman, and Tolbert 2005). Here, reform is implemented when actors serve as mediating agents between organizations and their external legal environment (Binder 2007; Edelman and Suchman 1997; Kelly and Dobbin 1999). Reform can open up a space for lower-status workers, like human resources managers, to expand their jurisdictions by developing recipes for compliance based on their arsenal of past remedies and by successfully persuading

top managers that these recipes will be useful (Dobbin 2009;Edelman, Uggen, and Erlanger 1999; Kelly 2003). Law and society theory leads us to expect that MLP reform will be successfully implemented in situations where lower-status workers develop templates for compliance and convince top managers to adopt them.

At Main and Central, lower-status workers did not develop recipes for compliance and persuade top managers to adopt them, and doctors and lawyers did not engage in one of the five forms of settlement such as developing a shared jurisdiction with a division of labor by content of the work. Yet reform was successfully implemented at Central. To explain the difference in outcomes at Main and Central, we need to focus on brokerage and cross-professional collaboration in everyday work.

Barriers to Cross-Professional Collaboration in Everyday Work

Scholars have found three key attributes of professional work that make day-to-day cross-professional collaboration difficult: specialized expertise, strong meanings, and high social status and rewards (for a review, see Gorman and Sandefur 2011). Regarding expertise, all professions draw on a body of specialized knowledge, and professionals' control over that body of knowledge accords them the right to determine what is correct or true within their professional domain (Abbott 1988; Barley 1996). When professionals attempt to work with one another across professional boundaries, information difficulties can occur because professional expertise is embedded in incompatible codes, work practices, or protocols (Kellogg, Orlikowski, and Yates 2006; Timmermans and Berg 2003; Vallas 1998).

Regarding strong meanings, professionals derive their identities directly from the professional work they do, and these identities are often central to their self-esteem (Anteby 2008; Bailyn [1993] 2006; Rivera 2012; Van Maanen and Barley 1984). When professionals attempt to work with one another across professional boundaries, meaning difficulties can occur because professional knowledge is shaped by community-specific values and norms (Bechky 2003b; Lamont 2010; McPherson and Sauder 2013; Turco 2012).

In terms of high status and rewards, professions create social and legal barriers that raise the material rewards for members by restricting the labor supply and by enhancing demand through creating monopolies over markets for desired services (Freidson 1970; Park, Sine, and Tolbert 2011; Ranganathan 2013; Timmermans 2008). In addition to material rewards, professionals' control over their jurisdiction affords symbolic rewards; within the professional division of labor, some tasks are seen as more

respectable than others, and deference is due to professionals whose work is most professionally pure (Abbott 1981; Phillips, Turco, and Zuckerman 2013; Sandefur 2001). When professionals attempt to work with one another across professional boundaries, task-based difficulties can occur because collaboration requires them to make compromises in the tasks on which their valued material and status rewards are based (Bechky 2003a; DiBenigno and Kellogg forthcoming; Morrill and Rudes 2010; Vallas 2013).

Brokers as Facilitators of Cross-Professional Collaboration in Everyday Work

Such difficulties can be addressed by brokers who use two sets of practices—connecting practices and buffering practices (also called *tertius iungens* practices and *tertius gaudens* practices)—to bridge different groups with disparate expertise, meanings, and status (Burt 1992, 2004; Fleming and Waguespack 2007; Lingo and O'Mahony 2010; Obstfeld 2005). In connecting practices, brokers connect groups by engaging in what Carlile (2004) calls "transferring, translating, and transforming." Brokers transfer information across groups by developing work practices, repositories, specifications, and standards that support communication across boundaries (Fernandez and Gould 1994; Fernandez-Mateo 2007; Hargadon and Sutton 1997; Reagans and McEvily 2003). They translate meanings across groups by enabling community members to acknowledge and appreciate the other community's perspective (Huising and Silbey 2011). And, they transform tasks across groups by facilitating a process of negotiation that allows localized knowledge to be transformed into jointly produced knowledge that transcends each community's local interests (Carlile 2002, 2004). In buffering practices, brokers remove the human complexity from problems to present groups with professionally "pure" problems (Abbott 1981; Barley 1996; Barley and Bechky 1994; Heimer and Stevens 1997), and they clarify the roles of the different groups in the creative process (Lingo and O'Mahony 2010; O'Mahony and Bechky 2008).

In this article, I combine an understanding of reform efforts targeted at professionals with the concept of brokerage and extend this concept to explain the process that accounted for the difference in outcomes at Main and Central. I find that while brokers' connecting practices can be quite useful for facilitating reform in situations where the tasks required for reform are high status, high value, and enable the targeted professions to use their esoteric expertise and display their deeply held identities, connecting practices may not be useful when the required tasks are low status, low value, and do not demand professional expertise and values. In these kinds of situations, brokers' buffering practices—managing information rather than transferring it, matching meanings rather than translating them, and maintaining interests rather than transforming them—can be critical to accomplishing reform. This study describes

how MLP reform failed at Main but succeeded at Central because, at Central, a newly developing *brokerage profession* of community health workers (CHWs) used buffering practices to facilitate reform by protecting doctors' and lawyers' professional information, meanings, and tasks in everyday work.

METHODS

Ethnographic Data Collection

I did preliminary interviews with several doctors at each of the six health centers affiliated with the local safety-net hospital, which provided care to low-income, uninsured, and vulnerable populations; all six centers had adopted MLP reform. I heard about particularly interesting dynamics occurring at Central, so I selected Central for observations. I selected Main to be a comparison site to Central because it was the only one of these health centers similar to Central in terms of its patient population.

I conducted observations and interviews over an 18-month period in the legal office and over a nine-month period in the health centers. I observed the legal and medical staff for two days a week, on average, as they interacted with one another in their daily work.

Doctors' daily work in the health centers involved seeing patients in sick visits, scheduled for 15 minutes, and slightly longer well visits throughout the day. During these visits, doctors who implemented MLP reform asked patients questions to uncover unmet needs in areas such as income, housing and utilities, education, immigration, and personal and family stability. They referred patients with unmet needs to lawyers in the legal office at the local safety-net hospital.

When a referral call came in, the lawyers on duty talked with medical staff to engage in legal diagnosis, resolve issues during phone consults, provide advice about other legal or social services, or schedule patients for intakes at their legal clinic. Lawyers rotated through this manning of the phones throughout the week and fielded calls not only from Main and Central medical staff, but also from medical staff at the other four local health centers. I obtained transcripts from the 206 referral calls that came from Main and Central over a one-year period.

In addition, I conducted 51 background interviews with legal and medical staff; I interviewed all 12 lawyers, all seven CHWs (four full-time positions in the targeted departments of adult medicine and pediatrics), both health center directors, and 30 doctors. In these interviews, I questioned staff about their background and their interpretations of the goals and implementation of MLP reform.

Analysis of Contradictory Outcomes

Once I determined that successful reform implementation was occurring at Central but not at Main, I contrasted the two cases to identify the practices associated with facilitating successful reform. I started by analyzing all interactions recorded in my field notes involving doctors and lawyers at Main and Central, and involving CHWs and doctors or lawyers at Central. My inductive analysis consisted of multiple readings of field notes and interview notes and extensive memo writing, as well as tracking patterned activities and issues related to change in ATLAS/ti, a qualitative data analysis program.

To understand how CHWs successfully implemented reform in their interactions, while doctors and lawyers did not, I analyzed each interaction I recorded to highlight CHW practices. I generated preliminary categories of CHW practices through an analysis of my field notes and then tested and revised these categories by analyzing transcripts of the 206 calls to the legal office.

SIMILAR INITIAL CONDITIONS AT MAIN AND CENTRAL

Main and Central were well-matched on factors associated with reform implementation (see Table 1). The centers had each been independent health centers before affiliating with the local safety-net hospital at roughly the same time. They had the same reimbursement structures, were subject to the same pressures, sought to achieve the same goals, had the same management and organizational structure, and were in the same geographic area. Both centers cared for similar low-income patient populations and had similar staffing costs per patient. Main is larger than Central. While some scholars suggest that larger organizations may have more staff and infrastructure with which to implement reform, organization size cannot explain these findings: Main was larger than Central, but Central successfully implemented reform.

<Table 1 about here>

The same lawyers served both centers. Over the prior decade, lawyers at the safety-net hospital solicited monetary support through grants and private philanthropy, and obtained loaned associates from local law firms to staff a group of in-house lawyers to implement MLP reform. The lawyers were supportive of the goals of MLP reform and interested in gaining new access and treatment points for vulnerable clients by expanding legal screening. They also hoped to get doctors to help patients develop trust in lawyers and so lend legitimacy to their reform efforts.

Doctors at both centers also supported MLP reform. While the doctors at Main and Central were not involved in its development, a doctor at the safety-net hospital had created MLP reform. He came up with the concept after repeatedly seeing low-income patients fail to recover from ear infections because their apartments lacked heat, or fail to control their asthma because their residences contained mold. In addition, doctors at Main and Central self-selected into community health centers because they were interested in social justice. They took "health" in the broadest sense to mean the physical, mental, and social well-being of their patients. One doctor noted:

> Social things are such a huge part of the health and well-being of children. Sometimes the only way we find out if the kid has ADD is by asking how school is going. We also want to know what the parents do, who's watching the kids, do they have enough food. . . . Because of who we are caring for, a lot of what we do relates to social issues.

Finally, top managers at both centers supported MLP reform because they believed it would help them achieve their mission of meeting the social and medical needs of their low-income patients.

DIFFERENCE IN IMPLEMENTATION OUTCOMES AT MAIN AND CENTRAL

Despite these similarities, reform succeeded at Central but failed at Main. To implement MLP reform, doctors and lawyers needed to change how they screened clients, determined eligibility for treatment during referral calls, and treated clients. I measured screening rates for both health centers by analyzing, for the 114 patient visits I observed, the percent of visits in which doctors asked legal screening questions. I measured referral rates by using data collected at the legal office on referral calls between medical and legal staff by center. Finally, I measured resolution rates for Main and Central by analyzing transcripts of the 206 calls to the legal office. Doctors considered a call successfully resolved if the lawyer was able to provide them with expert advice and services; lawyers considered a call successfully resolved if the provider reported a legal need in one of the lawyers' priority areas (i.e., income, housing and utilities, education, immigration, or personal and family stability). I coded a call as successfully resolved if it met the success criteria of both doctors and lawyers. Doctors at Central screened their patients for legal needs at a much greater rate than did doctors at Main, and they had a higher percent of referrals per patient and a higher resolution rate than did Main (see Table 2).

<Table 2 about here>

DOCTORS AT MAIN DID NOT FIGHT TO GAIN JURISDICTIONAL CONTROL OF NEW TASKS CREATED BY REFORM

We might expect MLP reform to have sparked a jurisdictional battle between doctors at Main and the lawyers, because it opened up a new task area for jurisdiction. However, doctors at Main did not attempt to win jurisdiction of many of the new tasks created by the reform, because doing these new tasks threatened their professional expertise, identity, and interests (see Tables 3 and 4).

<Tables 3 and 4 about here>

Doctors Not Willing to Acquire Legal Expertise

The reform demanded that doctors acquire legal expertise to use legal diagnostic information regarding a patient's social history (e.g., moved into public housing two years ago), current potential legal problems (e.g., landlord's failure to address mice or mold), and social situations (e.g., behind on rent). It also required doctors to learn to use legal eligibility information (e.g., income level, immigration status, housing conditions, or school provision of required educational support) and legal treatment information (e.g., whether a patient's problem fell into the lawyers' priority areas).

But doctors did not want to acquire such legal expertise. One doctor noted with exasperation: "If I had wanted to be a lawyer, I would have gone to law school." Nor did doctors want to hear about information that was irrelevant to their own medical work. "When we call the lawyers, they give us all kinds of legal mumbo jumbo," one doctor related. "We need to have them cut to the chase. . . . [They should give us] a list of buzzwords we can use."

Doctors suggested that the lawyers adapt the program to minimize the amount of legal expertise required, but the lawyers, even though they were passionate about MLP reform, refused to adapt the program in this way. As a result, doctors at Main often failed to refer patients to the lawyers, even when they heard about potential legal needs. One doctor said: "I don't call the lawyers because I know that they will ask me a million questions I don't know the answer to."

Doctors Not Willing to Use Legal Meanings

Doctors also did not want to use legal understandings and work practices. For example, regarding different professional understandings, doctors use the word "consult" to mean the immediate provision of expert advice and services by a provider with specialized knowledge at the request of another provider. But,

when doctors called the lawyers with "consults," lawyers usually took about a week to respond, and for consults that did not fall into their priority areas, they referred the doctors to outside social services or legal services organizations. This infuriated the doctors, one of whom referred to the lawyers as "a bunch of ninnies!"

Doctors were also unwilling to use legal work practices; they saw these practices as outside their professional scope and thought patients would perceive these practices as inappropriate for doctors to engage in. For example, one doctor related her difficulty with using legal diagnosis practices:

> It's not easy asking patients about these kinds of issues. A lot of our families are guarded about talking about legal and financial woes. . . . I'm uncomfortable asking them to spill their guts to me.

The same afternoon this doctor described her discomfort with legal questions, I observed her ask five patients to strip down to their underwear, four patients to expose their genital area, one patient to report the last time she had had sexual intercourse, and three patients to allow her to do rectal exams. Clearly, the comfort level associated with particular work practices varied by profession.

Doctors asked the lawyers to adapt the program to the doctors' meanings, but the lawyers would not do it. As a result, doctors at Main often failed to refer patients to the lawyers. One doctor noted:

> A lot of our families are concerned about going to be helped by lawyers. A lot of reassurance goes into convincing them that it's OK. . . . We don't want to get their hopes up only to have lawyers tell us that they don't cover that.

Doctors Not Willing to Perform Non-medical Tasks

Finally, doctors did not want to allocate the time and mental energy required to do tasks that did not afford them the same high material and status rewards as did their core tasks. The work doctors objected to fell into two categories: routine work related to providing legal services to patients, and tangential work that emerged from the screening, referral, and treatment process.

Doctors refused to do routine work, including calling patients back during the referral process to ask follow-up questions necessary for determining eligibility for legal treatment. One doctor related:

> I've got a patient who's going bankrupt and needs legal advice for banking. I call the lawyers and they ask two questions about the finances that of course I don't know the answer to. . . . So they say, "Okay. Ask the patient that, and then we can figure out what to do." There's no way I'm going to do that!

Doctors were also unwilling to do tangential work emerging from the screening, referral, and resolution process because, as one doctor said:

The problem is that if I ask these questions then I surface problems. If the lawyers say they are not legal problems, then I'm the one who needs to deal with them. . . . I don't want to raise the expectations of my patients and then disappoint them.

The doctors suggested that the lawyers adapt the program to protect the doctors' interests, but the lawyers again refused. In response, the doctors at Main failed to screen patients for potential legal needs, thus defeating the aim of reform:

It's always a Pandora's Box to ask about these questions. So with my last patient of the day if I have a lot of no-shows and no one is waiting, only then I will ask about this.

LAWYERS ALSO DID NOT FIGHT TO GAIN JURISDICTIONAL CONTROL OF NEW TASKS CREATED BY REFORM

Just as doctors at Main did not attempt to win jurisdiction of many of the new tasks created by the reform—because doing these new tasks threatened their professional expertise, meanings, and interests—lawyers, too, for the same reasons, did not want to take on these tasks.

Lawyers Not Willing to Adapt Program to Doctors' Expertise

The lawyers were unwilling to help doctors minimize the amount of legal expertise that doctors needed to acquire, because this would have precluded lawyers from using their own expertise:

We need to ask them [the doctors] legal questions to better understand the legal aspects of the problem. And, it is frustrating when they don't know the answers to these basic questions.

Similarly, lawyers were reluctant to learn to use medical expertise:

[The doctors] are always giving us all kinds of irrelevant information. We don't care about the patient's medical history unless it is related to their legal eligibility.

Lawyers Not Willing to Adapt Program to Doctors' Meanings

The lawyers were also unwilling to adapt the program to medical understandings and work practices. For lawyers, for example, the word "consult" means the provision of expert advice and services for legal problems in their specific priority areas over a period of time. This behavior seemed appropriate to the lawyers because, as one noted: "To do good work, we need to have time to consult with one another. We

need to have time to do research on the latest eligibility rules."

Regarding work practices, lawyers also refused to adapt the program. For example, in response to doctors' request for electronic referral, one lawyer said:

> We need to talk to doctors (rather than allowing electronic referrals) because often the way the doctors define the problem and what has been done about it is not the way we define it. We need to ask probing questions in order to better understand the problem and whether we can help.

Lawyers Not Willing to Adapt Program to Doctors' Tasks

Finally, like the doctors at Main, the lawyers were committed to pursuing their professional interests. Thus, like the doctors, the lawyers were averse to doing routine direct service work. Such work might solve the problem of a single client, but it would not change the policies that affected many clients, and changing policies was the lawyers' ultimate professional goal. One lawyer said:

> There are legal hotlines that people can call into and they run all the time. They will give the best advice given what the person is telling them. We could switch to that model. But then we would turn into just a legal hotline ourselves. If we did that, we'd be able to field several hundred calls. And these patients would get help because we'd talk to them directly. But that's a very traditional route. What's new about our model is that we train the doctors in advocacy skills.

Lawyers were also not willing to help with low-status social problems emerging from the process. For example, when doctors requested that lawyers book an appointment for any patient with a potential legal need, one lawyer responded: "If we did that, what would happen is that the lawyers would show up to do an intake and it would turn out to be a social problem rather than a legal problem!"

The lawyers clearly had material concerns about time, but they also had concerns about status. When I asked lawyers naïve questions about why they prioritized one task over another (e.g., Why do you check patient income level before researching possible legal solutions?), they patiently explained the answers to me, but when I asked why they prioritized other work above this routine and tangential work, they often answered in a disgusted tone of voice and sometimes flushed with anger. The intensity of their annoyance suggested to me that they were not making decisions based purely on time constraints. Instead, they saw this routine and tangential work to be below them.

FAILED DOCTOR-LAWYER REFORM IMPLEMENTATION NOT ONLY AT MAIN BUT ALSO AT CENTRAL

In summary, reform required both doctors and lawyers to do tasks outside of their jurisdictions, collect information from clients that was outside the scope of the specialized information they traditionally used, and develop facility with new professional understandings and work practices. Even though both the doctors and the lawyers supported the overarching goals of MLP reform, and the lawyers themselves had solicited funding to implement it, both groups were unwilling to take on many of the new tasks required for reform, because it would mean compromising their own professional expertise, meanings, and interests. Their avoidance of these new tasks led to failed reform implementation at Main.

So why was reform successfully implemented at Central? Significantly, reform was successful at Central *not* because the doctors or lawyers acted differently than they did at Main. As Table 5 shows, doctors and lawyers acted similarly at the two sites. We thus have two organizations with similar top management support for reform, and similar doctors served by the same lawyers. How, then, can we account for their different outcomes?

<Table 5 about here>

DIFFERENCE IN OUTCOMES AT MAIN AND CENTRAL: A BROKERAGE PROFESSION ENGAGES IN BUFFERING PRACTICES

I argue that the different outcomes at Main and Central were associated with the different availability at the two health centers of a group of community health workers who served as a brokerage profession, playing a buffering role in the interstices between medical and legal jurisdictions.[1]

Community health workers (CHWs) were present at Central but not at Main. At Main, when a doctor wanted to refer a patient with a potential legal problem to the lawyers, the doctor contacted the lawyers directly. In contrast, doctors and lawyers at Central interacted primarily through third-party CHWs. Upon discovering that a patient had a potential legal problem, the doctor sent a message with a brief description of the problem to a CHW. CHWs assessed the referral for eligibility for legal services, and if they thought the patient was eligible, called the lawyers to determine the next appropriate steps.

Background of CHWs

There is no single accepted definition of a community health worker; CHWs are defined broadly as employees from the local community who serve as connectors between health care providers, community organizations, and patients to promote health among groups that have traditionally lacked access to care

(Swider 2002).

CHWs at Central played a role that a layperson might assume would fall to social workers. They helped patients access public benefits and other income supports, performed assessments and coordination of care services, conducted health education with patients and families, worked with patients to achieve quality care and better clinical outcomes, linked families to support services, and offered referrals to financial counseling, job training, and employment programs.[2]

None of the employees referred to as CHWs at Central had any kind of formal training. Each had been working in nonprofit or state-supported organizations to provide support for refugees or to connect low-income people to social services. In that work, they did paperwork to help people fill out forms such as housing applications.

The CHWs at Central had arisen for exogenous reasons unrelated to the reform. In 2005, the Department of Public Health (DPH) sent CHWs to Central to help screen women of reproductive age for health risks unrelated to MLP (not because they judged Central to be the best place for screening, but because it was Central's "turn" to receive support from DPH). The doctors at Central found that CHWs were helpful in other areas, and when Central lost the DPH funding, the doctors persuaded the top managers to gain outside private and public funding to retain the CHWs.

Why Did CHWs Help with Reform Implementation?

The CHWs were not explicitly assigned to implement MLP reform at Central. Instead, they actively took on new work tasks created by the failure of cross-professional collaboration between the doctors and lawyers; they managed their workload by prioritizing MLP tasks over some of their other tasks. For example, one CHW told me that, for a patient who needed help with housing issues that exacerbated asthma, she now explored the potential of legal action before pursuing social services solutions.

The CHWs reported to a head of Community Health at Central, but their tasks and performance were loosely monitored, in large part because there were no established standards of practice for CHWs. By taking on the new tasks generated by the reform, the CHWs began to create a new jurisdiction of their own and increased the justification for their continuing presence in the organization.

Why were CHWs interested in doing routine and tangential work when the doctors and lawyers were not?

Unlike for the doctors and lawyers, these new tasks did not require CHWs to take on tasks of lower value or status than their other tasks. In fact, because their status was low to begin with, contact with medical and legal work and with members of high-status groups of lawyers and doctors increased rather than decreased CHWs' status. One CHW noted:

> Before coming here, I was working at . . . a nonprofit organization providing social services for [newly arrived immigrants]. I worked with other case workers doing paperwork, translation, serving as an interpreter, interacting with agencies around citizenship issues. In this job, it's great because I am working with doctors and lawyers. . . . When I call people, I tell them I am calling on behalf of this doctor at Central health center or this lawyer at (the legal office), and that gets their attention.

<indent here>Why were CHWs interested in managing both medical and legal information, whereas doctors and lawyers were not willing to manage information associated with the other specialty? Managing information required possessing some degree of both medical and legal expertise. Because CHWs, unlike doctors and lawyers, had not undergone formal training, they were excited to develop their own expertise. One CHW said, "I like learning the medical and legal terms for things. It can be hard, but it is also interesting because it is new to me. . . . And, once I learn it, I can use it next time that same issue comes up." Another CHW said, "One of the things I like about working with this program is that I'm always learning new things. I'm getting great training and it's never boring."

Finally, why were CHWs interested in using the understandings and work practices of the group with whom they were interacting? Matching understandings and work practices required acting according to both medical and legal values and identities—feeling comfortable asking patients about their medical problems, or their concerns about not having enough money or food. To use both medical and legal work practices, CHWs needed to feel comfortable giving on-the-spot answers as well as engaging in collaborative consultation processes. Unlike the doctors and lawyers, CHWs had not undergone intensive socialization processes that led them to feel uncomfortable engaging in the activities required by another profession. They were willing to act according to both medical and legal values and identities. In fact, if CHWs had any identity, it was that of helper to other groups, and this was consistent with understanding the meanings of both doctors and lawyers. One CHW said, "I'm the go-between. I make sure the patients provide all the information they need to. There's a lot riding on these forms."

This role of go-between did not come without a cost. CHWs' buffering work included engaging in emotional labor (Hochschild 1983), such as deferential treatment and caretaking, to maintain the emotional stability of the doctors and lawyers with whom they worked. Of the CHWs at Central, 86 percent were female, and their role was a feminized one in which meeting the needs of others was valued

and expected. CHWs felt the need to be reassuring and attentive to the moods and feelings of the doctors and lawyers, and this sometimes led to burnout.

In summary, CHWs took the opportunity created by a reform that required cross-professional collaboration to enhance their own expertise, identity, and interests. As I will describe, buffering the information, meanings, and tasks of the doctors and lawyers was not the CHWs' assigned function, but was a byproduct of their process of carving their own jurisdiction, expanding their own occupational boundaries, and furthering their own interests.

ROLE OF COMMUNITY HEALTH WORKERS IN REFORM IMPLEMENTATION AT CENTRAL

To explore how CHWs facilitated the implementation of MLP reform at Central, I coded the interactions I had recorded between CHWs and doctors and between CHWs and lawyers. I found that CHWs at Central implemented reform by engaging in three kinds of buffering practices between doctors and lawyers: maintaining tasks, managing information, and matching meanings (see Table 6 and Figure 1).

<Table 6 and Figure 1 about here>

Maintaining Tasks at Central

CHWs at Central helped implement the program by doing routine and tangential work so that doctors and lawyers did not need to make compromises in their valued tasks.

Doing routine work. CHWs did the routine work associated with screening, referral, and treatment that was required for administering the program, such as calling back patients during the referral process to ask follow-up questions that lawyers thought necessary for determining eligibility for legal treatment. For example, I saw one CHW contact the lawyers about a child who was having difficulties in school. The lawyers told the CHW that she needed to find out exactly what special education services the school had provided before the lawyers could determine whether this patient was eligible for legal help; the CHW called the patient to find this out.

Doing tangential work. CHWs also maintained the core tasks of doctors and lawyers by doing the tangential work emerging from screening, referral, and treatment—work that was neither medical nor legal. For example, I observed one CHW follow up on a doctor's referral by calling the patient to get

more details. It turned out the patient had a furniture problem (requiring social work), not a housing problem (requiring legal work). Rather than contacting the doctor or lawyers, the CHW told the patient to come to the health center so that she and the patient could fill in a furniture worksheet.

In summary, by doing the routine and tangential work that both the doctors and lawyers refused to do because it was outside their core tasks, the CHWs allowed doctors and lawyers to implement the reform while protecting their jurisdictions and the high material and status rewards associated with them. One Central doctor pinpointed the valuable function CHWs performed when he said:

> We got tired of calling the lawyers and having them say, this is what you should ask this patient. . . . That's ridiculous. Why should we be the ones to do that? . . . So I almost never directly call the lawyers. Instead I refer to the [CHWs].

One could argue that the routine and tangential work done by the CHWs primarily involved doing additional work. To see if their buffering involved more than merely doing additional work, I compared the interactions and outcomes of new versus experienced CHWs. The new CHWs were capable of doing the additional routine and tangential work associated with maintaining the doctors' and lawyers' tasks, because they had been doing this kind of work before coming to Central. However, despite the fact that the new and experienced CHWs were equally skilled at this work, the new CHWs' successful resolution rates were much lower than those of the experienced CHWs. The reason for the difference in resolution rates between the new versus experienced CHWs was that the new CHWs were not yet able to use two other buffering practices, which I describe below (managing information and matching meanings) (see Table 7). One new CHW said:

> You need to know [the lawyers'] guidelines and you need to know when something is actually a legal problem. They don't even want you to call them until you've gathered information on the patient's history. I'm new here, so I don't know how to do this yet. The CHWs who have been here longer know what information the lawyers will need to know and they know if something is even an issue that the lawyers will cover. They know what is legal and what is not.

<Table 7 about here>

Experienced CHWs noted that they received no formal training in these buffering practices but had learned them through trial-and-error over time. One experienced CHW said:

> When I first started, I called [the lawyers] all the time. If you compare the number of times I called then versus now it's completely different. Because now I know that for an SSI [Supplemental Security Income] issue, I need to find out where the patient is in the process before I call the lawyers. So I ask the patient if they have filed an original application or an appeal and have they heard back. I know that there

are certain steps to do before the lawyers will do an intake with the patient and I know what they are.

In addition to maintaining tasks, two other buffering practices—managing information and matching meanings—were required for successful reform implementation.

Managing Information at Central

Experienced CHWs at Central helped implement the program, not by trying to persuade doctors and lawyers to acquire one another's expertise, but by managing information—blocking irrelevant information and constructing relevant information—so that neither doctors nor lawyers needed to acquire new professional expertise.

Blocking irrelevant information. In the interactions I observed between doctors and CHWs, I rarely saw CHWs press the doctors to provide either legal diagnostic or eligibility information, even though they knew the lawyers would need to know this information. For example, one doctor sent a message to a CHW noting a patient's medical and social information: "Mother in for 3-mo visit needs help with housing." Although the CHW required further information to identify whether the problem was legal or social, she did not question the doctor further, saying: "If [doctor] had any information about this, she would have put it in the note so I know that she doesn't know any more than this."

Similarly, CHWs did not press lawyers to discuss medical information that was irrelevant to the lawyers. Doctors often passed along to CHWs medical information, such as a patient's medical symptoms and their prior history with particular medical conditions and treatments, but in the interactions I observed, I never saw an experienced CHW pass this information along to lawyers. For example, one CHW showed me a message from a doctor that included a lot of medical jargon. She explained: "When I call the lawyers, I only tell them the things that they [the lawyers] need to know. . . . I get rid of everything else."

Constructing relevant information. In addition to blocking irrelevant information, CHWs constructed relevant information by soliciting from patients information that the doctors and lawyers would each need to know. For example, doctors often wanted to know whether the lawyers had helped the patients the doctors had referred to them, but lawyers were unwilling to pass this information along because of attorney-client privilege. CHWs addressed this problem by going directly to patients and outside agencies to gather the relevant information for the doctors.

Similarly, CHWs constructed relevant information for the lawyers. (Constructing relevant information is

distinct from the routine work described earlier, because it required case managers to use medical or legal expertise). Because doctors usually passed on very brief social or economic information to CHWs, CHWs questioned patients further. For example, regarding a housing case, the CHW needed further information to provide the lawyers with the information they would need to do their legal work. The CHW told me:

I will call the mom and say, "Can you give me more detail?" And the mom will say that she's got housing through [City Housing Authority] and that she put a request in October to fix the apartment and that she's put in a few requests since then. I will ask her what housing she is in and tell her that if she has any of the letters that she put in with the requests, please bring it to me. I will do as much of this as possible to get things ready before calling the lawyers about this.

<indent here>In summary, the CHWs facilitated reform by blocking irrelevant information and constructing relevant information, thus allowing doctors and lawyers to collaborate with one another without compromising their own professional expertise. One Central doctor summarized the important role of CHWs' information management in implementing the reform:

The first time I called the lawyers it was about a family who needed help around educational services. I called and the lawyers said, "Did they do an evaluation yet?" . . . In another case, it was that the landlord was not addressing infestation. The family thought the house was infested and had talked to the landlord with no response. I called the lawyers and the lawyers said, "Did the family call the city inspector yet?" I didn't know enough to ask [the families] all of this! So now I send it to one of the CHWs.

Matching Meanings at Central

Finally, CHWs at Central helped implement the reform by matching understandings and work practices so that doctors and lawyers did not need to make compromises in their own professional values and identities to implement the program.

Matching understandings. CHWs matched their diagnostic, eligibility, and treatment understandings to the group with whom they were interacting at the time. For example, in one interaction I observed between a doctor and a CHW, the doctor was furious because the lawyer (who was trying to help a patient qualify for Social Security Disability Insurance [SSDI]) had asked the doctor to write a letter confirming that the patient was disabled. The word "disabled" meant something different to doctors than it did to lawyers. The CHW was able to smooth things over by saying to the doctor: "Do you think she is emotionally disabled? This patient has an emotional stress disorder related to real physical trauma, right?" The doctor agreed. The CHW said, "So just say that in your letter." The experienced CHW knew that "emotional stress disorder related to real physical trauma" met the legal criteria for qualifying for SSDI. By matching the doctor's medical understandings rather than trying to get the doctor to understand the

legal meaning of the term disabled, the CHW was able to get the doctor to write a letter that the lawyer could use in her advocacy.

CHWs also matched medical to legal understandings when interacting with the lawyers. My field notes regarding a call from a CHW to the lawyers highlight how the CHW communicated the patient's problem by noting the patient's legal history (a history of housing issues), her current legal problem (mold in the apartment that had not been addressed despite prior requests), and the legal classification category (mold infestation in an apartment where two children have asthma):

CHW: This patient is having housing issues and problems with mold. . . . The patient has not contacted the ISD [inspection services department]. The living room has a huge leak in the ceiling. People from [housing complex] have been in to look at the leak. The last time was January. They keep saying that they will fix it but they have not done anything. . . . There are two kids with asthma in the house.

Lawyer: I think it is worth booking them in the clinic. They would benefit from a referral to Breathe Easy [a program that ensures that housing inspections are fast-tracked for families with asthma and that substandard conditions are resolved]. I usually say let's wait for ISD, but this sounds pretty advanced. I will schedule them for an intake next week.

Matching work practices. CHWs also matched work practices to the group with whom they were interacting at the time. For example, they allowed doctors to provide them with high-level screens (doctors' preferred screening form), and then met with patients to do in-depth screens (lawyers' preferred screening form). CHWs also allowed doctors to refer via electronic message (doctors' preferred referral practice), and they allowed lawyers to manage referrals via phone over several days. One CHW noted:

When you page the lawyers, they call you back to discuss what the problem is. But, it may take them a week to get back to you with an answer. By the time lawyers [research the patient's eligibility and] call back, the doctor doesn't remember [the issue] and the doctor gets annoyed. . . . But, I don't mind, so it's easier for them to call me.

Finally, CHWs allowed doctors to use their preferred treatment practice of one-time referral to a specialist, while also allowing lawyers to protect attorney-client privilege by not contacting patients until they had been accepted as clients.

In summary, both the lawyers and the Central doctors refused to use one another's understandings and work practices, in part, because doing so required them to make compromises in their own valued ways of working. The CHWs helped solve the problem by matching understandings and work practices between the two groups. One Central doctor summarized the important role of CHWs' meaning matching in

implementing the reform:

> We complain about not having time, but even if we did have time, it is not a traditional part of our activities so we're uncomfortable doing it. . . . The CHWs are a huge help with this. They don't mind talking to patients about these kinds of issues. In fact, that's exactly the kind of work they like to do.

Under What Conditions Can Brokerage Professions Successfully Use Buffering Practices?

My findings suggest that when the tasks required for cross-professional collaboration are low status, low value, and do not enable the targeted groups to use their specialized expertise and express their professional identities, brokers can successfully facilitate reform by using buffering practices rather than connecting practices—managing information rather than transferring it, matching meanings rather than translating them, and maintaining interests rather than transforming them.

While the CHWs at Central engaged in buffering practices and successfully implemented reform, a different set of brokers, present at both Main and Central, attempted to implement reform using connecting practices, but they failed. The safety-net hospital affiliated with Main and Central had applied for and received philanthropic funding to hire a doctor from a health center affiliated with the hospital (not Main or Central) and a legal aid lawyer to act as brokers between the lawyers at the legal aid office and the doctors at Main and Central.

These brokers tried to connect the groups by transferring information between them— communicating the needs of each group to the other and creating new shared routines that supported communication across boundaries. But the doctors at Main and Central and the lawyers were not interested. For example, the broker lawyer tried to communicate to the lawyers in the legal office that the doctors in different health center departments wanted training tailored to their specialties (pediatrics versus adult medicine), but the lawyers refused to provide this. The brokers also developed a manual with rules for screening and referral, but neither the doctors nor the lawyers agreed to review it.

These brokers also tried to connect the groups by translating meanings between them—getting doctors and lawyers to appreciate the perspective of the other group, and developing new shared language and work practices between the two groups. But, neither group was willing to engage. For example, the brokers invited the doctors and lawyers to shadow one another, so the lawyers could see why doctors valued immediate answers to their queries about patients, and the doctors could appreciate why it was difficult for the lawyers to provide quick responses. But, the doctors and lawyers did not agree to the

shadowing.

Finally, the brokers tried to connect the groups by transforming interests between them— settling competing claims and negotiating new global agreements. For example, the brokers engaged in back and forth dialogue with doctors and lawyers around an area of common concern—screening—and tried to get the doctors and lawyers to reach a compromise about the joint screening process, but both refused to budge.

To understand the conditions under which brokers' connecting practices *are* useful to reform implementation, it is useful to consider a counterfactual case. Doctors and lawyers did allow the brokers to use connecting practices around one set of new tasks—provision of novel legal services in areas of high need for doctors, including immigration services, early-intervention services for patients in culturally diverse groups, and DNR/DNI (Do Not Resuscitate/Do Not Intubate) services. The majority of tasks required for cross-professional collaboration in these areas were high status, high value, and enabled both doctors and lawyers to use their specialized expertise and express their professional identities.

Implementing reform in the new task area of early-intervention services to culturally diverse groups is a good example. Families from particular ethnic groups had difficulty answering questions on the standard early-intervention screening form. Lawyers were willing to allow the brokers to connect them with doctors to help revise the screening form because, since this legal service had not previously been provided, it offered an opportunity for creating and writing about innovative approaches to identifying and treating poor patients' legal problems: "This is very interesting to us because it is a new service that MLP has never provided before."

Doctors were willing to allow the brokers to connect them with lawyers to help revise the form because revising it would allow all doctors at their health centers to more effectively care for their individual patients. One doctor explained: "The wording on the form says 'Do you have concerns?' Some families from particular ethnic groups answer, 'Yes, Yes, Yes,' because they think it means do they care for their children, not are they worried about these particular problems. We are hoping that the lawyers can help us with making changes to the form so that we can better serve these patients."

The brokers successfully connected the groups by transferring information between them, describing to the lawyers in great detail the current medical process for early-intervention screening. While the lawyers had been unwilling to develop the medical expertise necessary to tailor their trainings to health center

departments, they were willing to develop the medical expertise necessary to understand patients' problems with the doctors' current early-intervention process.

The brokers also successfully connected the groups by translating meanings between them, explaining to the doctors why the lawyers wanted to "step back and take a comprehensive and strategic approach rather than taking a piecemeal and tactical approach" by considering how all of the different ethnic groups (e.g., Dominican and Cape Verdean) served by Main and Central could benefit from redesigned forms. Initially, the doctors were maddened that the lawyers "wanted to delay and make the whole thing into a theoretical exercise." But the doctors allowed the brokers to help them appreciate the lawyers' preferred work practice of deep research, despite the fact that doing so demanded that the doctors compromise their preferred work practice of providing immediate solutions.

Finally, the brokers successfully connected the groups by transforming interests between them, getting them each to make concessions to reach a settlement—the lawyers would work first on the early-intervention form, and then the doctors would help them identify other medical forms that could be changed to help this same set of culturally diverse families.

In summary, brokers were able to successfully use connecting practices rather than buffering practices in this situation because the majority of the tasks required for cross-professional collaboration were high status, high value, and enabled both doctors and lawyers to use their professional expertise and identities.

DISCUSSION

Contributions to Professions Theory

These findings contribute to our understanding of professions in several ways. First, prior studies show that implementing reform among professionals is difficult because reforms open up new task areas that spark jurisdictional battles between existing professions; these battles must be settled for reforms to be implemented (Abbott 1988; Dobbin and Kelly 2007). I find that reform implementation difficulties can stem not only from jurisdictional battles between professions competing to claim new task areas, but also from jurisdictional voids created by professions not doing so. Because professionals have hard-won expertise, deeply held values and identities, and strong material and status interests related to performing the core tasks of their profession, they may not compete to claim a new jurisdiction (and thereby not implement reform), if new tasks represent professionally ill-defined problems that require them to acquire information unrelated to their specialized expertise, use understandings and work practices that conflict

with their professional identity, or do impure or low-value tasks that threaten their professional interests. While scholars have not previously explained this, it is consistent with current cases in the literature. For example, in Dobbin and Kelly's (2007) article about sexual harassment, the lawyers were not willing to adapt their traditional work practices to win the new jurisdiction created by the reform. The findings presented here suggest that perhaps this was because doing so would have forced them to take on professionally ill-defined tasks that threatened their expertise, identity, and interests.

Second, while Abbott (1988:118-119) highlights that professions may vacate unattractive jurisdictions that then become the province of paraprofessionals, he does not focus on cross-professional work, so he describes these paraprofessionals as doing only the low-status work of interacting with clients. Likewise, prior research on buffers highlights how low-status workers protect the status of professionals by doing the frontline service work with clients required to present groups with professionally "pure" problems (Barley and Bechky 1994; Heimer and Stevens 1997). In contrast, my research shows that paraprofessionals who step into jurisdictional voids may do not only frontline service work with clients—what I call maintaining tasks—but may also facilitate cross-professional collaboration by managing information and matching meanings to protect existing professional groups' expertise and identities.

Third, the current literature shows that professionals can win new jurisdictions by demonstrating their expertise and knowledge to state officials or by offering a bureaucratic solution to organizational executives (Abbott 1988; Dobbin and Kelly 2007; Freidson 1970; Starr 1982). My findings show that professionals can also win new jurisdictions by maintaining tasks, managing information, and matching meanings between two groups of existing professionals. The rise of cross-professional reforms may create new brokerage professions, which fill in the jurisdictional gaps between existing professions by acting as professional safeguards and coordinators.

While no prior research highlights the concept of brokerage professions, my findings are consistent with empirical examples in the literature. For example, managed care reform opened up new tasks related to coordinating the specialist care of acutely ill patients from their admission to the hospital until their discharge to recuperative care facilities or their community. Neither hospital specialists nor primary care physicians in the community were willing to take on the new tasks created by the reform (Wallace and Schneller 2008). This created space for hospitalists—what I call a brokerage profession—to play a buffering role between hospital specialists on the one hand and community primary care physicians on the other and, in turn, to carve out their own jurisdiction in the interstices between these existing professions.

Contributions to Law and Society Theory

This article also makes several contributions to our understanding of law and organizations. First, in terms of barriers to implementation of reform involving professionals, prior studies show that implementation is difficult because new laws create ambiguous mandates that do not specify clear standards for compliance (Edelman 1990; Heimer 1996; Kalev and Dobbin 2006; Kelly 2010). The findings presented here demonstrate that reform implementation difficulties can stem not only from reform's ambiguous mandates, but also from its threat to professional expertise, identity, and interests.

Second, in terms of when reform involving professionals can be successfully implemented, the current literature demonstrates this can happen when lower-status workers seeking to expand their jurisdictions serve as mediating agents between organizations and their external legal environment, developing recipes for compliance and persuading top managers to adopt them (Dobbin 2009;Edelman, Uggen, and Erlanger 1999; Kelly 2003). The findings presented here demonstrate that lower-status workers can also successfully implement reform by serving as mediating agents between different groups of professionals targeted by reform, filling the jurisdictional void between two existing professions by protecting each professional group's information, meanings, and tasks in everyday work.

These findings are consistent with Morrill's (2009) finding that court-based alternative dispute resolution (ADR) programs arose in the interstices between the fields of law, social work, and therapy. But, my findings differ from Morrill's in a substantive way: his study demonstrates how reform can be implemented over time through the processes of innovation, mobilization, and structuration, whereas my study points to how reform can be implemented in day-to-day work when a brokerage profession plays a buffering role in the interstices between existing professions that need to collaborate with one another for reform to occur.

Contributions to Theory of Brokerage

Finally, this article contributes to our understanding of brokerage. Current literature suggests that brokers use two sets of practices to coordinate across groups: connecting practices (also called *tertius iungens* practices) and buffering practices (also called *tertius gaudens* practices). While this literature shows that brokers in the same structural position can act differently (Burt 2012; Fernandez-Mateo 2007; Lingo and O'Mahony 2010; Powell, Packalen, and Whittington 2012), I demonstrate the conditions under which we can expect brokers to successfully use connecting practices versus buffering practices.

I find that connecting practices—transferring information, translating meanings, and transforming interests between groups—can be quite useful for facilitating cross-group collaboration in situations where the majority of the tasks required are high status, high value, and enable the targeted groups to use their specialized expertise and display their deeply held identities. However, when the tasks required for cross-group collaboration are low status, low value, and do not enable the targeted groups to employ their expertise and identities, buffering practices—managing information rather than transferring it, matching meanings rather than translating them, and maintaining interests rather than transforming them—can be critical to accomplishing cross-group work (see Table 8).

<Table 8 about here>

Generalizability and Future Research

To what extent is the concept of a brokerage profession generalizable to other cases of reform implementation? I expect it would be most important in situations where reform requires cross-professional collaboration in everyday work, and the actual work of implementing the program requires professionals to engage in professional dirty work.

To generalize this argument to other situations, when reforms open up new task areas, some of these tasks may be threatening to the expertise, identity, and interests of existing professions. However, unless all of these new tasks are claimed, reforms cannot be implemented. For example, to accomplish civil rights reform, industrial psychologists needed to work with business managers to change their screening and promotion practices (Dobbin 2009; Stryker, Docka-Filipek, and Wald 2012). To implement environmental reform, safety experts needed to work with scientists to change their research practices (Silbey et al. 2009). And to implement microfinance reform, international development experts needed to work with bankers to change their lending practices (Canales 2014).

The argument presented in this article suggests that if many of the tasks required by these reforms were non-core tasks that threatened the professional interests, expertise, and identity of the targeted professions, reform would likely have failed unless members of *brokerage professions* (e.g., compliance officers, occupational health and safety officers, or microfinance loan officers) played a buffering role in the interstices between existing professional jurisdictions. In the process, these workers may have carved out their own jurisdiction between these existing professions that needed to work with one another for

reform to occur.

This study raises several questions for future research. First, one might ask whether Central really was a successful case of reform implementation. Prior research shows that, to persuade organizational executives of the usefulness of their remedies, mediating agents often dilute the law by attending to managerial concerns (Edelman, Uggen, and Erlanger 1999; Kelly and Dobbin 1998), and MLP reform was diluted at Central. This raises a more general problem with brokers' buffering practices—there is little reform-oriented learning on the part of the targeted professions. Without learning, there is no way to improve the implementation process. Future research could explore alternative mechanisms for reform in situations where reform requires cross-professional work but threatens the expertise, identities, and interests of the target professions.

Second, if these tasks were given to CHWs at Central, why were they not given to other workers, such as nurses or medical secretaries, at Main? More generally, when will professions targeted by reform "hive off" (Hughes 1958:135) reform work to subordinate professionals rather than using a brokerage profession to help accomplish it? Future research could explore whether this is most likely to occur in cases where only a handful of tasks required for reform threaten target professionals' specialized expertise, identity, and interests (Kaplan, Milde, and Cowan 2014).

Third, it is unclear from this study whether CHWs will become a successful brokerage profession. I did observe the CHWs engaging in practices that Nelsen and Barley (1997) argue are associated with a professionalization project—legitimizing the worth of their work, portraying themselves as experts, denigrating the practices of their rivals, setting standards of practice, and establishing the boundaries of their emerging jurisdiction—but analysis over a longer period of time is necessary to determine whether CHWs successfully professionalize.

Fourth, while CHWs helped with reform implementation at Central, the funding used to support them could have been applied in other areas, such as hiring additional social workers to assist patients with behavioral health needs. Because neither group gathered data on program efficacy, I could not compare the two models of reform implementation beyond assessing their impact on MLP screening, referral, and resolution rates. Future research could provide more comprehensive assessments of staffing effectiveness. Finally, because medicine and law are both long-standing professions with strong interests, expertise, and identities, future studies of reforms requiring collaboration between less established professions is needed to determine the conditions under which brokerage professions are useful.

In summary, in this age of experts (Brint 1996), reform increasingly demands interaction among multiple groups of professionals. When the tasks required for reform are primarily low status, low value, and do not enable the targeted professional groups to employ their professional expertise and identities, reform implementation is likely to fail unless a brokerage profession is available to play a buffering role by managing information, matching meanings, and maintaining tasks between the targeted professions. By buffering existing professionals' "real work," members of brokerage professions can help implement the reforms that activists fight so hard to win.

Acknowledgments
Thank you to Lotte Bailyn, Roberto Fernandez, Sarah Kaplan, Ray Reagans, Susan Silbey, Cat Turco, John Van Maanen, and Ezra Zuckerman for insightful comments on multiple versions of the paper. This article also benefited from the thoughtful feedback of Larry Isaac and Holly McCammon and the *ASR* reviewers and Steve Barley, Ron Burt, Rodrigo Canales, Julia DiBenigno, Lauren Edelman, Roman Galperin, Cal Morrill, Siobhan O'Mahony, Wanda Orlikowski, Vicki Parker, Woody Powell, Aruna Ranganathan, Vinnie Roscigno, Mike Sauder, Robin Stryker, Sameer Srivastava, KVEJJ group, WOW group, and seminar participants at MIT Organization Studies, MIT Economic Sociology Working Group, University of Chicago/Booth, Northwestern University/Kellogg, University of Michigan/Ross, Boston University, and Ohio State University. This article would not have been possible without the time donated by the legal staff in the MLP office and the medical staff at Main and Central.

Notes

1. In the online supplement (http://asr.sagepub.com/supplemental), I address two alternative explanations to my argument that it was the CHWs' buffering work that led to successful reform implementation at Central by showing that (1) Central did not simply have more resources than Main, and (2) there was no underlying difference between Main and Central in support for reform.

2. Social workers at Main and Central no longer do this work, because new reimbursement plans allow social workers to bill for behavioral health counseling but not case management services.

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Table 1: Comparison of Main and Central Health Centers

	Main	Central
Location	U.S. urban center	
Alignment with public sector	High	
Patient population served	Low-income patients	
Prior organizational performance	Full accreditation every year for which data are available	
Organization type	Federally qualified health center that receives government funds	
Director background	MD with long career in community health	
Doctor background	Four years of medical school and four years of residency training (including rotations in community health)	
Conditions treated in units studied	General pediatric, adult medicine	
Work organization	Doctors provide medical care to a panel of patients Doctors work during 4-8 3-hr "clinics" seeing 10-20 patients per clinic in 15-minute increments	
Staffing Cost per Patient	$58.71 at Main versus $58.28 at Central	
Support from Lawyers	Same group of lawyers worked with doctors at both centers	
Timing of Study	2010-2012	
Size of health center	2.6X patients*	X patients

*To disguise which centers are studied here, actual number of patients is not recorded.

Table 2: Difference in Outcomes between Main and Central

	Main	**Central**
Screening Rate* (Patients screened)	13% of well-patient visits 4% of sick patient visits (N=66 observed patient visits)	92% of well patient visits 56% of sick patient visits (N = 48 observed patient visits)
Referral Rate (Patients referred to lawyers)**	0.18% of patients in targeted departments (N= 24,000 patients in targeted departments)	1.71% of patients in targeted departments (N= 9,550 patients in targeted departments)
Resolution Rate* (Cases successfully resolved)**	23% of referrals (N= 43 referrals)	64% of referrals (N= 163 referrals)
Example	A boy whose family had just been told that they would be evicted from their apartment the following week came in for his annual check-up. Being evicted would impact the boy's health and development because the special education services he was receiving from his local public school would be disrupted if the family moved. Dr. Green, the boy's family doctor, did not screen for legal needs during the check-up and so did not identify the housing problem. At the end of the visit, the mother mentioned that the family would soon be evicted. Dr. Green ignored this information and did not refer the family to the legal office for help. This family did not get assistance with their housing problem.	A boy whose family had just been told that they would be evicted from their apartment the following week came in for his annual check-up. Being evicted would impact the boy's health and development because the special education services he was receiving from his local public school would be disrupted if the family moved. Dr. O'Brien, the boy's family doctor, screened for legal needs during the check-up, identified the housing problem, and referred the family for legal services. The lawyer who took the call accepted the case.

*I measured screening rates for both health centers by analyzing, for the 114 patient visits I observed, the percent of visits in which doctors asked legal screening questions.
**I measured referral rates by dividing the number of referral calls between medical and legal staff by center (206 referral calls came in from Main and Central over a 1 year period) by the total number of patients in the targeted departments by center.
***I measured resolution rates for both Main and Central by analyzing the transcripts of the 206 calls to the legal office. Doctors considered a call successfully resolved if the lawyer was able to provide them with expert advice and services; lawyers considered a call successfully resolved if the provider reported a legal need in one of the lawyers' priority areas (income, housing and utilities, education, immigration, and personal and family stability). I coded a call as successfully resolved if it met the success criteria of both doctors and lawyers.

Table 3: Taking on New Tasks Created by Reform Required Doctors and Lawyers to Make Compromises in their Interests, Expertise, and Meanings

	Traditional Jurisdictional Tasks	**Newly Created Tasks**
Interests	Doctors Gain material rewards and status by pursuing the quick and effective identification and treatment of individual patient's medical problems Lawyers Gain material rewards and status by creating innovative ways to provide direct legal service and by winning policy reform to help large numbers of the poor	Doctors Take time to do routine work required to administer MLP program Take time to do tangential work emerging from the process Lawyers Take time to do routine work required to administer MLP program Take time to do tangential work emerging from the process
Expertise	Doctors Use medical diagnostic, eligibility, and treatment information and processes Lawyers Use legal diagnostic, eligibility, and treatment information and processes	Doctors Learn to use legal diagnostic, eligibility, and treatment information and processes Lawyers Learn to use medical diagnostic, eligibility, and treatment information and processes
Meanings	Doctors Use medical understandings Use medical work practices of high level screening, and electronic, in-the-moment referral Lawyers Use legal understandings Use legal work practices of detailed screening and phone-referral over several days	Doctors Become comfortable with using legal understandings Become comfortable with using legal work practices of detailed screening and phone-referral over several days Lawyers Become comfortable with using medical understandings Become comfortable with using medical work practices of high level screening, and electronic, in-the-moment referral

Table 4: Doctors and Lawyers Were Not Willing to Make Compromises in their Interests, Expertise, and Meanings

Barriers to Reform	Doctors	Lawyers
Interests		
Not willing to sacrifice interests by doing routine work required for reform implementation	"The lawyers don't like to call patients… they like to use me as the intermediary…I refuse to do that."	"When people first start out, they like doing direct service work. It's very tangible, and there's a client on the other end saying: 'Thank you so much, if it hadn't been for you helping me with this utility shut off protection, I would not have been able to have my family here for Thanksgiving, and now I can.' That was an actual call that I got. But, then you begin to see that you have an opportunity to help so many more people by doing policy work…The people who are leaders in the field are the ones who are doing policy work."
Not willing to sacrifice interests by doing tangential work emerging from the process	"It would be so much easier for the patient to get an appointment with the lawyers right there (for anything that might turn out to be legal) instead of having to reconnect later. If the lawyers couldn't help them, they could still talk to them and advise them."	"We take care of legal problems, not social problems!"
Expertise		
Not willing to hear about one another's diagnosis, inference, and treatment expertise	"I don't want to hear about all of the legal details…I'd like to have a short list of screening questions to identify potential legal issues."	"We don't want to give doctors a narrow screening tool because, even if we are not going to be able to help a particular patient, we want the doctors to call. The way we learn about what doctors need is to hear what they ask about. Then, if we don't provide that service, we can try to move that way in the future. The reason we are now beginning to take on immigration cases is because we heard a lot of inquiries about immigration from the doctors."
Not willing to learn to use one another's diagnosis, inference, and treatment expertise	"I buy into the model of wellness and that these things are critical to a patient's health. But we…don't understand the ins and outs of the law and we don't know the appropriate resources for referral. Even if I wanted to learn all of this, I wouldn't have the time to invest in it."	"I don't have an MD and I'm not interested in getting one… I just need to know in simple terms, can I call it asthma or can't I?"

Meanings		
Not willing to adapt to one another's meanings	"We should be able to just ask lawyers when the patient is in the room and get the answer right there."	"We could give on-the-spot answers (to the doctors) but they would be wrong…Many of these problems are complex and we can't just make snap judgments."
Not willing to use one another's work practices	"What happens when I refer to other specialties is I put in my referral and I say 'Five-year-old child with asthma, please evaluate.' I expect that the specialist will meet with the patient and may send me some kind of letter or e-mail in return saying 'Dr. (X), I met with your patient and here is what I did.' We should be able to do that with lawyers."	"We can't accept every referral….We limit our areas because, with limited resources, we can't provide service in every area. Even with housing, we can't fully cover it. So we can't do things like home ownership and averting foreclosure. Instead, we focus on things like mice and mold in the apartment."

Table 5: Frequency of Buffering Practices at Main vs. Central

	Doctor-Lawyer Interactions (Main)	**Doctor-Lawyer Interactions (Central)**	**CHW-Lawyer Interactions (Central)**	**CHW-Doctor Interactions (Central)**
Brokerage Profession Available	No	No	Yes	Yes
Maintaining Tasks				
—Doing routine work required for administering program	5%	3%	82%	81%
—Doing tangential work emerging from process	0%	5%	87%	90%
Managing Information				
—Blocking information between groups	7%	5%	76%	72%
—Constructing information to meet interaction partner's needs	23%	25%	75%	66%
Matching Meanings				
—Matching understandings to interaction partner	24%	20%	73%	72%
—Matching work practices to interaction partner	8%	5%	75%	76%
Successful Resolution Rate*	23%	20%	70%	73%
Number of Recorded Interactions	43 (Doctor-Lawyer)	20 (Doctor-Lawyer)	143 (Case mgr-Lawyer)	67 (Case mgr-Doctor)

* I measured resolution rates for each center by analyzing the transcripts of the 206 calls to the legal office over a 1 year period. Lawyers considered a call to be successfully resolved if the provider reported a legal need in one of the lawyers' priority areas. Doctors considered a call to be successfully resolved if the lawyer was able to provide them with expert advice and services. I coded a call as successfully resolved if it met the success criteria of both doctors and lawyers. Resolution rates for CHW-doctor interactions were measured differently because my IRB did not allow me to gather the patient-identifying information required to tie back each interaction to a specific patient case and track it through the lawyer's database. Therefore, I assess these resolution rates by analyzing each interaction according to whether or not the immediate task required for program implementation was accomplished.

Table 6: Community Health Worker Buffering Practices

Barriers for Doctors and Lawyers	**CHW Buffering Practices**	**CHW- Lawyer Interactions**	**CHW- Doctor Interactions**
Interests	**Maintaining Tasks**		
Not willing to sacrifice interests by doing routine work required for reform implementation	Doing routine work required for reform implementation	Reporting on work with outside agency to complete steps required for making this a legal case Reporting on communication with patient regarding patient's treatment options	Reporting on whether or not lawyers accepted the patient's case and whether is patient received the needed treatment
Not willing to sacrifice interests by doing tangential work emerging from the process	Doing tangential work emerging from process	Accepting non-legal work emerging from screening Accepting non-legal work emerging from eligibility evaluation Accepting non-legal work emerging from treatment	Accepting non-medical work emerging from screening Accepting non-medical work emerging from eligibility evaluation Accepting non-medical work emerging from treatment
Expertise	**Managing Information**		
Not willing to hear about one another's diagnosis, inference, and treatment expertise	Blocking information between groups	Blocking irrelevant medical diagnostic, eligibility, and treatment information	Blocking irrelevant legal diagnostic, eligibility, and treatment information
Not willing to learn to use one another's diagnosis, inference, and treatment expertise	Constructing information to meet interaction partner's needs	Constructing info on specific legal violations (mice, mold, $ values) Constructing info on initial legal steps taken (ISD, IEE) Constructing info that helps determine if in lawyers' priority areas	Constructing info from work with patient and outside agency
Meanings	**Matching Meanings**		
Not willing to understand one another's meanings	Matching understandings to interaction partner	Using legal problem category (behind on rent, heat, electric, notice to quit) Using legal eligibility category (asthma diagnosis, disability diagnosis) Using legal treatment category (SSI appeal, IEP)	Using non-legal problem category (housing, immigration, bankruptcy) Using non-legal eligibility category (not disabled) Using non-legal treatment category (needs legal advice for banking)
Not willing to use one another's work practices	Matching work practices to interaction partner	Providing in-depth screening to lawyers Communicating by phone with lawyers Allowing lawyers to get back to them at later date	Accepting hi-level screening from drs Communicating electronically with drs Giving on-the-spot answers to drs

Table 7: Buffering is not Just Doing Additional Work

Buffering Practices	**Central New CM-Lawyer**	**Central Experienced CM-Lawyer**	**Central New CM-Doctor**	**Central Experienced CM-Doctor**
Maintaining Tasks				
—Doing routine work for administering program	75%	85%	78%	82%
—Doing tangential work emerging from process	94%	85%	94%	88%
Managing Information				
—Blocking information between groups	11%	97%	22%	90%
—Constructing information to meet other group's needs	27%	91%	33%	78%
Matching Meanings				
—Matching understandings to interaction partner	22%	90%	28%	88%
—Matching work practices to interaction partner	33%	88%	41%	89%
Successful Resolution Rate	31%	82%	44%	84%
Number of Cases*	35	108	18	49

*35 is the number of referral calls between lawyers and Central new case managers over a one year period and 108 is the number of referral calls between lawyers and Central experienced case managers over this period;
18 is the number of MLP-related interactions observed between Central doctors and new case managers over the nine months I conducted observations at Central and 49 is the number of MLP-related interactions observed between Central doctors and new case managers over this time period

Table 8: Under What Conditions Can Brokers Successfully Use Connecting Practices versus Buffering Practices?

	Brokerage: Connecting Practices	**Brokerage: Buffering Practices**
Facilitating Conditions	Majority of tasks required for cross-group collaboration are high-status, high-value tasks that enable the targeted groups to use their specialized expertise and express their identities	Majority of tasks required for cross-group collaboration are low-status, low-value tasks that do not enable the targeted groups to use their specialized expertise and express their identities
Different Interests Between Groups	**Transforming Tasks:** Communicating competing claims between groups Negotiating a new shared settlement between groups	**Maintaining Tasks:** Avoiding competing claims between groups by doing routine work not included in either group's tasks Avoiding the need for settlements between groups by doing tangential work not included in either group's tasks
Different Expertise Between Groups	**Transferring Information:** Communicating information to allow each group to acquire the expertise of the other Creating a new shared data repository or communication genre to allow each group to use the expertise of the other	**Managing Information:** Avoiding the need for each group to acquire the expertise of the other by blocking information between groups Avoiding the need for each group to use the expertise of the other by constructing new information to meet each group's needs
Different Identities and Values Between Groups	**Translating Meanings:** Assisting in appreciating the perspectives of other group Developing new shared artifacts, language, and demeanors	**Matching Meanings:** Avoiding the need to appreciate the perspectives of the other group by matching understandings to those of the interaction partner Avoiding the need to use shared work practices by matching work practices to those of the interaction partner

Figure 1: Brokerage Profession and Reform Implementation at Central and Main