



GUEST EDITORIAL

## **Toward a Policy Agenda for Community–Campus Partnerships**

January 2000 marked the launch of the Healthy People 2010 Objectives for the Nation, which set the United States' public health goals for the next decade: to increase quality and years of healthy life; and to eliminate health disparities that are associated with race, ethnicity and socioeconomic status ([www.healthypeople.gov](http://www.healthypeople.gov)). Achieving these goals will require community partnerships that involve ordinary citizens, grassroots organizations, community agencies, hospitals and health systems, businesses, government, philanthropy and other partners. The US Surgeon General has specifically called upon health professional schools to be essential partners in achieving the Healthy People 2010 objectives (Lurie, 2000). Indeed, higher educational institutions as a whole can make significant contributions to advancing health—through their roles as educators, researchers, service providers, employers, campuses, community assets and citizens (Seifer, 2000).

Creating healthier communities requires collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Many positive outcomes can be achieved through partnerships between communities and higher educational institutions (Seifer & Maurana, 1999). Community–campus partnerships can:

- improve the preparation of health professionals as community-responsive providers and as agents of social change;
- level the playing field between universities and communities;
- recognize community assets and community contributions to teaching, research and the development of knowledge;
- foster civic responsibility; and
- improve health and increase access to high quality health care.

Despite these significant potentials, communities and higher educational institutions face numerous challenges to developing sustainable, mutually beneficial partnerships. Community–Campus Partnerships for Health's 4th annual conference, 29 April–2 May, 2000 in Arlington, Virginia, USA, convened over 500 community and campus leaders, including participants from Bangladesh, Canada, New Zealand, South Africa, South Korea and Sweden, to explore the policy issues affecting community–campus partner-

ships. The conference, *From Community–Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century*, was co-sponsored and supported by the Corporation for National Service, the WK Kellogg Foundation and over 15 national organizations in health and health professions education. With its emphasis on policy, the conference was designed to broaden and deepen participants' understandings of issues that affect community–campus partnerships and the overall health of communities. Enhancing participants' advocacy skills for change within communities, academic institutions, government and the philanthropic sector was an explicit aim of the conference. Ultimately, the conference sought to shape a policy and advocacy agenda for community–campus partnerships. Nine policy papers were commissioned for discussion at the conference.<sup>1</sup> Edited and peer-reviewed versions of these papers appear in this issue of the journal. In widely disseminating these papers, we hope to bring the voices of those involved in community–campus partnerships at the grassroots level to the attention of international, national, state, organizational and institutional decision-makers. Although the policy context for the conference was the United States, we believe the resulting ideas and recommendations are relevant to a global audience and can inform the deliberations and decisions of our colleague organizations around the world, including The Network.

Our conference participants generated the major policy recommendations below. Achieving them will require the efforts of many individuals and organizations. For its part, Community–Campus Partnerships for Health's board of directors is prioritizing the recommendations into a policy agenda we can begin to implement. Our roles will include educating key stakeholders and our members about the policy issues; educating our members to be more effective advocates; serving as an information clearinghouse on policy issues, legislative and regulatory initiatives; collecting data that may be helpful to policy makers in making decisions; and participating in coalitions that do some or all of the above.

As you review the recommendations below and the commissioned papers in this journal issue, we hope you will reflect on your roles and responsibilities as an advocate for health within your family, community, organization and profession. We hope you will consider the range of policy issues that affect the ability of communities and higher educational institutions to develop strong and sustainable partnerships that promote health. Do these recommendations resonate with your observations and experiences? Please share your comments and reactions with us. Finally, we invite you to join with Community–Campus Partnerships for Health in taking specific actions to advance this policy agenda. Together, we can create a more supportive environment for communities and higher educational institutions to form and sustain partnerships for health and education—in the United States and around the world.

## **A Policy Agenda for Community–Campus Partnerships**

### *General Policy Recommendations*

- Advocate for policies at the national, state, local and institutional levels that support community–campus partnerships.
- Advocate that national, state and local funding be used to support community–campus partnerships and to promote community-based and interdisciplinary health professions education.

### *Recommendations for Academic Institutional Policy*

- Adopt a mission statement that explicitly supports community engagement and its connection to teaching, research and service.
- Adopt promotion and tenure criteria and processes that recognize and reward faculty for community scholarship and expand their assessment of reputable journals in which community scholarship can be credibly published. Ensure that faculty members receive credit for the role they play in grants submitted by community-based organizations, and their involvement in training and technical assistance to community partners.
- Adopt job performance criteria and processes that recognize and reward staff for community partnerships.
- Treat community participants as equal partners, with access and input on important issues, such as the budget.
- Offer incentives for community participation, such as stipends, travel money, adjunct faculty status. Include service learning as a core component of health professions education.
- Significantly involve students in decision-making. Student-driven projects should be supported by their institutions in a way that fosters student leadership. Support includes but is not limited to:
  - funding a service-learning coordinator;
  - utilizing senior level students as mentors and teachers;
  - faculty development programs;
  - leadership development for students through formal programs; and
  - ensuring the appropriateness of student projects with the community.
- Establish policies regarding the capacity of community-based organizations to have fiduciary responsibility for grants or the university's fiduciary responsibility to community partners.
- Establish policies regarding allocation of indirect funds to the community or the partnership.
- Adopt principles of partnership and principles of community-based participatory research.
- Affirm and support faculty involved in community–campus partnerships, especially as programs are getting started, through such mechanisms as

continuing education credit for faculty development seminars and faculty mini-grants.

- Adopt accreditation policies that require community-based education, research and service.

### *Recommendations for Community Agency Policy*

- Policies within community-based organizations and other partner organizations need to be established that recognize the contributions that participants from their organization make to the partnership (e.g. release time, include partnership responsibilities as part of one's job description, pay raises).
- Identify collaboration as a clear part of job descriptions.

### *Recommendations for Funder Policy*

- Use grant making criteria to make the community an equal partner in partnerships (i.e. insist on community participation in the budget process, direct funds to community organizations).
- Fund the dissemination of models that are developed through their funding.
- Provide sufficient resources for an evaluation component right from the start of the project (process and outcome evaluation).
- Make greater use of 1-year planning grants that focus on creating the relationships and infrastructure necessary for developing and maintaining long-term community-campus partnerships, especially as part of a longer-term funding initiative with up to 5 years of additional funding.
- Provide long-range funding for community-based participatory research projects that focus on physical, mental and social well-being, as well as on enhancing understanding of and addressing the biomedical, social, economic, cultural, behavioral, historical and political determinants of health and disease. Such broad-scale determinants of health require at least 10 years for changes to be adequately discernable.
- Recognize that the burden for change should not be limited to residents of marginalized communities (community level interventions) but that these initiatives need to include specific links to broader policy change efforts.
- Support initial and continued funding for the infrastructure necessary for developing and maintaining community-campus partnerships. These funds should not be project-specific or project-related.
- Fund community-based organizations as well as universities directly. Require, as appropriate, that community-based partners be the direct recipient and fiduciary of community-campus partnerships grants.
- Fund comprehensive approaches that extend beyond categorical perspectives and traditional research designs (i.e. recognize diverse methodologies and the validity of multiple approaches to research).

- Provide technical assistance and pre-application consultation for organizations that have little experience completing application forms.
- Incorporate principles of community–campus partnerships in grant requests for proposals.
- Review the criteria for judging applications. Also, the persons involved in the review process need to be consistent with the principles themselves (i.e. including academicians with expertise in community-based participatory research and community members who have been involved in CBPR endeavors).
- Provide an equal number of planning grants and subsequent intervention support.

### *Recommendations for National Policy*

- Increase funding for national grant programs that support community-based and interdisciplinary education and for programs aimed at increasing the number of health professionals from disadvantaged backgrounds.
- Ensure that methodologies used to award these grants provide incentives for health professions schools to offer education for students in community-based sites.
- Provide health professions schools with greater flexibility in implementing community-based and interdisciplinary educational initiatives supported by federal grants, as well as initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds.
- Expand eligibility for federal grants, especially for allied health disciplines and community-based organizations.
- Decrease grant periods to permit funding for a greater number of new initiatives.
- Fund leadership development programs based in educational institutions and non-governmental organizations. A demonstration project in a subset of schools would offer an opportunity to evaluate specific curricula developed in diverse settings.
- Consider giving block grants to replace or supplement categorical funding.
- Encourage community health centers, migrant health centers and other federal health care grantees to participate in health professions education.
- Educate federal health care grantees about revenue streams for community-based health professions education.
- Expand the range of community-based sites that are eligible for direct medical education reimbursement (where costs of community-based training are not covered by teaching hospitals).
- Develop a methodology for reimbursing community-based sites for indirect medical education costs. Once a methodology is developed, amend the Medicare statute (or equivalent, as needed) to permit reimbursement of

community-based sites that incur both direct and indirect medical education costs.

- Require or encourage states to link Graduate Medical Education payments (or the equivalent, outside the US) to performance, specifying that a significant portion of medical school and residency training occur in out-of-hospital settings known to be in short supply of health professionals or are related to achieving better service for underserved or uninsured populations.
- Expand eligibility for and distribution of Medicaid Graduate Medical Education payments to certain out-of-hospital providers of graduate medical, nursing and allied health education programs that are qualified to receive these payments directly.
- Create a National Institute of Community Health within the National Institutes of Health or equivalent in other countries.

### *Recommendations for State Policy*

- Target or weight state appropriations to initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds.
- Target or weight state appropriations to undergraduate and graduate training programs that stress community-based and multidisciplinary education.
- Develop incentives to expand community-based and interdisciplinary training by using general fund appropriations to institute a requirement (e.g. a third-year family practice clerkship for medical students) that stresses significant experience in out-of-hospital community settings.
- Mandate rural and urban underserved service-learning experiences in state health professional schools.
- Use general fund appropriations to increase per-capita spending for training in primary care and public health.
- Use general fund appropriations to locate more primary care residency and graduate nursing training in community-based underserved areas.
- Institute an inner city or rural rotation option that stresses significant experience in out-of-hospital community settings for all graduate health professions students.

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## Note

1. The full text and appendices for the commissioned papers are available on Community Campus Partnerships for Health’s website at <http://futurehealth.ucsf.edu/ccph/guide.html#CommissionPaper> > .

## References

- LURIE, N. (2000). Healthy people 2010: setting the nation’s public health agenda. *Academic Medicine*, 75, 12–13.
- SEIFER, S.D. (2000). Engaging colleges and universities as partners in Healthy Communities initiatives. *Public Health Report*, 115, 234–237.
- SEIFER, S.D. & MAURANA, C. (1999). Health professions education, civic responsibility and the overall health of communities: realizing the promise of community–campus partnerships. *Journal of Interprofessional Care*, 12, 253–256.