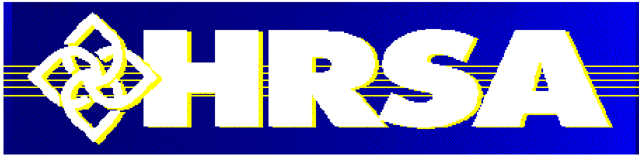

Practice-based Scholarship: Communicating with Stakeholders

3rd Practice Coordinators Workshop
Ann Arbor, MI

April 1999

PUBLIC HEALTH PRACTICE COORDINATORS' WORKSHOP:

Academic Public Health in Communication with Stakeholders

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Ann Arbor, Michigan
July 1998

Sponsored by the Bureau of Health Professions of the
Health Resources and Services Administration
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Final Report

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Executive Summary

The Association of Schools of Public Health (ASPH) Practice Coordinators' Council met in the summer of 1998 in a workshop format to discuss academic public health practice in conjunction with government, community, and student partners associated with the University of Michigan School of Public Health. The Bureau of Health Professions in the Health Resources and Services Administration provided support for this workshop, which is the most recent of three workshops it has funded for the ASPH practice coordinators to examine scholarship, curricula, and faculty issues in schools of public health in terms of practice-based research, teaching, and service.

The workshop participants presented, sought recommendations, and built consensus on a landmark document, *Demonstrating Excellence in Academic Public Health Practice*, which served as a framework for the meeting. For the first time in academic public health history, the document will define the scope of academic public health practice, further illuminate the role of schools of public health in helping to assure the performance of the essential services of public health, and address incentives and rewards for faculty who actually practice public health with vested partners. Furthermore, partnerships between the University of Michigan School of Public Health and the local community were highlighted to bring a "real life" dimension to the issues covered in the paper. These

partnerships were explored in two panel discussion formats, one on practice-based research and the other on practice-based teaching. Each panel discussion was followed by a break out group in which participants discussed the paper, asked tough questions, listened to each other's successes and failures, and made recommendations on the topic of academic public health practice.

This Ann Arbor workshop represents the historic crossroads at which the *school of public health faculty*, who have conceptualized the basic definitions and principles of scholarly public health practice from their own experience, and the *community and agency members and practitioners* of public health, who host students for internships and provide valuable health services to target populations, have met to discuss topics of mutual concern. Both groups are invested in health promotion and disease prevention, yet each group has its own culture and follows its own methods in achieving that goal. The shared perspectives and suggested solutions disseminated in this workshop setting have helped inform all stakeholders on the obstacles to overcome and the enabling factors involved in increasing the quality and quantity of public health academic-community linkages for the health of communities.

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I. BACKGROUND

The Association of Schools of Public Health (ASPH) created the **Council of Public Health Practice Coordinators** in 1992 to provide a mechanism for creating and maintaining linkages with the public health practice community and to establish a forum for exploring innovative ways to incorporate and augment public health practice principles in the research, teaching, and service in the graduate schools of public health. This group performs liaison functions, not only with official public health agencies (e.g., state and local health departments), but also with community-based health organizations, managed care organizations, and the federal government. The group serves as a contact link for practitioners in the field to access resources and to explore collaborative ventures with faculty and administrators in the schools of public health (SPH), and it advises the deans on issues relevant to academic public health practice.

The council is composed of one administrator or faculty member appointed by the dean of each school of public health. Typically, the designated public health practice coordinator is a faculty member who has had significant experience in the practice community and/or who holds a joint appointment in a practice agency.

The council's relationship with the **Bureau of Health Professions** in the Health Resources and Services Administration (HRSA) has allowed this group to examine scholarship, curricula, and faculty issues in the SPH in terms of practice-based research, teaching, and service. Progress has been made toward expanding existing linkages with the community and in bringing those experiences back to the university. In this way, agencies and organizations benefit by receiving technical assistance from the schools, and academic institutions gain from practitioner input in curricula development and field placement programs. This synergy between the SPH and the community results in more relevant training for students preparing for careers in the public health workforce. Furthermore, communities benefit from the immediate service provided to them by the faculty and student interns and from the students who decide to seek employment in these areas upon graduation.

Over the past few years, the council has come together in a workshop format to further define its mission and to discuss topics of common concern. In **February of 1995**, the council met with several practitioners from various regions in the country at the campus of the University of South Carolina School of Public Health in Columbia, South Carolina to participate in a workshop supported by HRSA (see *The Changing Definition of Public Health Practice: South Carolina Practice Coordinator Workshop Final Report*). This first workshop focused on innovative practice activities at three SPH and was followed up by a discussion of the future of public health practice, the definition of what constitutes practice, and the roles of ASPH public health practice coordinators. The group also discussed collaborative research, alternative sources of funding, and multicultural and distance learning issues. The group expressed an interest in meeting again to advance the recommendations made in this first workshop.

In **September of 1996**, HRSA and ASPH convened the full council in a similar forum in Boston, Massachusetts in order to pursue the recommendations made during the South Carolina workshop, such as the need for an examination of the obstacles and successes to public health practice in the SPH. The group created a chart of

"Major Topics, Barriers, and Recommendations" which the council has used to monitor progress on academic public health issues through the years. The council also deliberated new and emerging public health practice issues. Again the council met in **June of 1997**, with a smaller working group of twelve practice coordinators, in Savannah, Georgia to begin development of a paper to define public health practice for the academic community and to recommend strategies for increasing the emphasis on public health practice in research, teaching, and service (see *Overcoming Barriers: Creating Sustainable Academic-Community Linkages* for both the Boston and Savannah workshop summaries).

The council met most recently in Ann Arbor, Michigan in **July 1998** to discuss developments in advancing the scholarly health practice agenda and to review the first draft of the paper which originated from the Savannah workshop. The paper seeks to: define and demonstrate excellence in academic public health practice; reassess the best scholarly practices in academic public health; and, further explore the dynamic influence community partners have on academia, and vice versa, in the area of practice-based research, teaching, and service. The paper's themes were examined, moreover, through a first-hand look at partnerships the University of Michigan School of Public Health had forged with community organizations in its neighborhood.

II. INTRODUCTION

The agenda for the Ann Arbor workshop [Appendix A] was developed by an advisory committee made up of the chair of the Council of Public Health Practice Coordinators (Dr. Kathleen Wright), the Practice Coordinator from the University of Michigan (Mr. Toby Citrin), the HRSA project officer (Capt. Barry Stern), and ASPH staff (Ms. Alison Wojciak and Ms. Geraldine Aglipay). Conference calls were held throughout the spring of 1998 to discuss the agenda, logistics, and topics for the panel discussions. Additional staff from the University of Michigan (Ms. Saundra Bailey, Ms. Terri Weinstein Mellow, and colleagues) also provided logistical and administrative support. The advisory committee made final decisions regarding the agenda. Each public health practice coordinator from the 28 accredited schools of public health and one community-based public health practitioner was invited to attend [see Appendix B for final participant list].

It was decided that the draft paper, ***Demonstrating Excellence in Academic Public Health Practice*** would serve as the framework for the meeting, so it was presented on the **first day of the workshop**. The draft paper was to serve as a landmark report in the field of academic public health practice and would be the first document of its kind in which definitions and measurements would be applied to academic public health practice in non-university settings.

The paper proposed a definition of academic public health practice and, in support of this statement, sought to enhance understanding of the role of the academy in helping to assure performance of the essential public health services. The document was designed to improve understanding of the issues, alternatives, and common models of scholarship as regards: (a) academic public health practice among faculty, key stakeholders, and the public health community at large; and, (b) promotion and tenure policy in schools of public health.

The paper was broken down into four sections: *(I) Introduction; (II) Conceptual Basis and Rationale; (III) Strategic, Structural, and Policy Issues; and (IV) The Future/Recommendations.* Each section was developed and edited by a team of practice coordinators. A core editing team was assembled to provide coherence to the paper and to ensure that the sections flowed together. One representative from each of the four sections was asked to present his or her respective section at the Ann Arbor workshop, and time was allotted for comments and discussion after each section.

The final section on *The Future/Recommendations,* however, was yet to be formulated and the group was encouraged to play a major part in helping the council come to a consensus on the final recommendations or conclusions of the paper. Before the workshop, each participant had been sent a first draft of sections I through III of the paper, *Demonstrating Excellence in Academic Public Health Practice, Draft Document #1B* [Appendix C]. Section IV, the final section, was to be completed upon Council review in light of discussions resulting from the workshop.

On the **second day of the workshop**, partnerships between the University of Michigan School of Public Health and the local community were also highlighted to bring a "real life" dimension to some of the issues dealt with in the paper. The council was also led on guided tours of various multicultural neighborhoods where students from the school of public health are involved in practica. **Two panel discussions, the first on practice-based research and the second on practice-based teaching,** were held in a community setting with partners of the school of public health. Each panel discussion was followed by a question and answer period. Small break-out groups which followed identical guidelines in terms of topics to be discussed took place after the panel discussions. Each practice coordinator was invited to share relevant experience in the form of abstracts (HRSA case studies, special projects, etc.) in categories of practice-based research, teaching, and service in order to broaden the discussion [Appendix D].

The agenda concluded on the third day with a business meeting by the council of ASPH public health practice coordinators. The members discussed using electronic mail to communicate on the paper and ways to increase the visibility of practice-based and collaborative activities, among other topics.

III. TOPICS/ISSUES

A. The Draft Paper: *Demonstrating Excellence in Academic Public Health Practice*

The workshop began with a working lunch where the group was welcomed and introductory remarks were made by Barry Stern (HRSA), Mike Gemmell (ASPH), Kate Wright (St. Louis), and Toby Citrin (Michigan). Dr.

Wright, Council Chair, then introduced the paper, *Demonstrating Excellence in Academic Public Health Practice*, and set the stage for the discussion.

In reviewing the background for the workshop, Dr. Wright recalled the mandate to the Council of Public Health Practice Coordinators and their efforts to create linkages and provide a forum for public health practice. She noted that trying to define academic public health practice has been difficult, and in order to describe and clarify this topic, the practice coordinators had decided to create a document which would build a consensus on academic public health which they could share with the outside community. The target audience of the paper was, first and foremost, the academic community, but, in a later format also would be directed towards the at-large public health practice community. A traditional journal article would also result from the paper.

Dr. Wright noted that the draft about to be presented was developed for feedback from the group and that all comments were welcome. Before final publication, an expert panel of academic public health practitioners would be asked to review it.

1. Introduction

Presentation

Beth Quill (Texas) began by reviewing the first section of the paper and asserting that its purpose was to set the stage for the *Conceptual Basis* section. Ms. Quill noted that the goal of this section was to create **two separate definitions of public health practice**, the first to serve as a reference definition for public and private "providers," and the second for the academy and its partners. The core functions and essential services of public health were incorporated into the definitions to provide an easy segue into the *Conceptual Basis* section.

Comments

The practice coordinators made several suggestions on this section as follows:

- *Define* scholarship for academic public health, first and foremost, and show who is involved in practice;
- *Show* how practice uniquely fulfills a need and how it can be innovative;
- *Describe* the relative advantage practice brings to research, teaching, and service;
- *Be careful* of the tone of the paper;
- *Reflect* the community context for much of public health practice;
- *Remember* that the current document intends to influence promotion and tenure committees;
- *Include* reference to schools' mission statements which support practice;
- *Explain* the broad range of interdisciplinary public health professions; and,
- *Put* the *Conceptual Basis* section before any definitions.

2. Conceptual Basis and Rationale

Presentation

Margaret Potter (Pittsburgh) introduced the next section which reviewed the definition of scholarship, presented important public health concepts, discussed how to introduce the scholarship of public health practice within the traditional academic paradigm, and applied the **six criteria common to all forms of scholarship** by using illustrations from public health practice.

Comments

The group suggested that they needed to improve this section as follows:

- *Assert* their professional responsibility as faculty and state that practice is not represented by current categories of scholarship in the existing paradigm;
- *Give* some examples of what an academic who is also a practitioner does;
- *Clarify* the model of an academic public health practitioner and the scholarship required to achieve this goal;
- *Distinguish* responsibilities of the school versus those of faculty;
- *Show* the uniqueness and originality of practice;
- *Affirm* that public health practice is a science that utilizes inter- and multi-disciplinary tools;
- *Demonstrate* examples of what peer review means for public health practice; and,
- *Emphasize* that scholarly goals for practitioners can be applied to students in the form of experiential learning.

There was some discussion by the group on the paper's attempt to elevate the traditional concept of service to a higher professional level. Debate ensued on whether adding a fourth leg (practice) to the traditional three-legged stool of research, teaching, and service was necessary. The decision by the group was to define research, teaching, and service with a practice bent.

3. Strategic, Structural, and Policy Issues

Presentation

Jack Conway (Albany) introduced this section and noted that it includes **mission statements** from only three schools of public health. He offered that all the schools' mission statements should be included and that this section also could be placed earlier in the document. In terms of structure, there are several approaches, he noted, each with perceived advantages and disadvantages, in designing an **administrative structure to support academic public health practice**. Dr Conway listed the different organizational arrangements as follows:

- practice department model;
- school-wide center or program model;
- organized unit model; and,
- departmental model.

Comments

The group talked about the need in the paper to:

- *Show* more examples of mission statements as illustrations from each of the 28 SPH would have merit;
- *Have* practice coordinators align themselves with the existing models and to report on new models;
- *Add* what needs to happen to create these models;
- *Use* revised accreditation criteria to establish administrative models;
- *Look* at other professional schools and how they handle practice;
- *Identify* strategies and linkages needed to reach desirable outcomes or changes;
- *Involve* interdisciplinary teams of students in practice efforts; and,
- *Share* lessons learned in terms of funding for practice work.

There was also discussion of the **four models of practice** and how they can: be *applied* to research, teaching, and service (r/t/s); *represented* in r/t/s; *stand beside* r/t/s; or, *replace* r/t/s. The group suggested demonstrating how practice is contributing to knowledge in the field (use the analogy of music and dance in their respective fields, one participant suggested). Practice coordinators were also asked to consider by one member the University of Michigan model, which is a mixed model between the "organized unit" and "departmental" models. The dean's office unit (Office of Community-Based Public Health) acts as a facilitator for faculty in all departments to promote practice-based research and teaching. See attached mission statement [Appendix E].

4. The Future/Recommendations

Presentation

Lastly, Winnie Willis (San Diego State University) facilitated the final section. Dr. Willis noted that the previous discussion was important to help develop the conclusions of the document. She then reviewed the paper, explaining the strong and weak points as she saw them: pointing out which tables were necessary for mapping out frameworks for teaching and practice, which tables could be replaced by simple text, and which tables needed fleshing out; reaffirming that scholarship is evident in academic public health practice; stating that "training" and "evaluation" needed to be included in the examples of scholarly activities; encouraging alternative approaches to peer review; suggesting less focus on "innovation" and a stronger focus on the dissemination of current knowledge and evaluation thereof; noting the **need for best practices** including why, how, and what fora contribute to this process; and, adding to the suggestion for the inclusion of mission statements that there is a **need for criteria to measure practice** and to look at the **rewards and incentives** in terms of practice in schools' mission statements.

Comments

The assembly had many questions which might influence the paper and/or might require future action, for example:

- What is the role of the schools of public health in responding to the cry from the public health workforce for continuing education?

· Is the CDC's graduate certificate is an acceptable method of linking the schools of public health to the educational needs of employed public health professionals?

· What do managed care organizations (MCO) need to know about the public health system and vice versa? What is the role of schools of public health in meeting MCO needs?

· What are the current and future incentives for individuals to get an MPH?

· Which resources would local and state public health agencies have to support continuing workforce education?

· Does ASPH have a major legislative priority to create and support specific line items to train the workforce, including training students in "teaching health departments"?

· Why do some students seek a professional, as opposed to an academic, public health degree?

· Why do local health officer positions not require graduates from schools of public health?

Discussion of the paper concluded with Dr. Wright's thanks to the participants for their contributions to the review, and an extension of gratitude to the drafters and editors who worked hard to bring the paper to this point. Dr. Wright and the core editing team planned to take the observations of the group into consideration in revising the current draft for council review in the near future.

B. Remarks by Dean Noreen Clark on Public Health Practice and Curricular Change

The dean of the University of Michigan School of Public Health, Noreen Clark, PhD, enthusiastically welcomed the participants at a dinner on the first evening of the workshop. She eloquently articulated her support of academic public health practice and recommended creating stronger partnerships for two reasons: to prepare better practitioners and to enrich the research in the schools of public health.

Dean Clark updated the group on efforts by the University of Michigan School of Public Health to change their public health curricula. The school was focusing on three areas of improvement: **expanding the breadth of curricula, integrating curricula, and enriching the students' capstone experience**. Each department was charged to make the students' capstone experience area-specific and to try to anchor it in an area of the students' interest. These changes were to go into effect in the fall of 1998. Dean Clark spoke positively of this process, and noted that "students have to operate in a different way" from the generation before them to become skilled practitioners in today's workforce.

C. Tours of Arab-American and Latino Neighborhoods

On the second morning of the workshop, the participants were led on a bus tour of ethnic neighborhoods in the Dearborn vicinity of the school of public health, where Master of Public Health (MPH) students were actively engaged in practica and other experiential learning opportunities. Dr. Adnan Hammad, Health Services Director of Arab Community Center for Economic and Social Services (ACCESS), spoke of his center's mission to create "one stop shopping" for all services that local Arab-Americans may need in their quest to become independent and

successful members of society. Kathryn Savoie, Environmental Program Director of ACCESS, informed the group on successful community action in response to concerns about industrial pollution and toxicants in the neighboring areas.

In the afternoon, Mr. Ricardo Guzman, Executive Director of Community Health and Social Services (CHASS), took the group on a tour of the Latino neighborhoods and explained the different forms of assistance that CHASS provides to the largely Mexican Latino population in the Dearborn area.

D. Panel Discussions on Practice-based Research and Practice-based Teaching

Two hour-long panel discussions took place, one in the morning on *practice-based research* and one in the afternoon on *practice-based teaching*. The purpose of these panels was to involve important University of Michigan School of Public Health partners in dialoguing with participants on their professional experiences associating with faculty, practitioners, and University of Michigan MPH students in joint health projects. Emphasis was placed on the barriers, solutions, and successes which accompany the academy-community connection.

1. Practice-based Research Panel Discussion

Barbara Israel of the University of Michigan School of Public Health facilitated the first panel discussion. Dr. Israel opened by discussing the **key principles of community partnering** she and her partners follow as part of the Detroit Community-Academic Prevention Research Center (PRC) which is funded by the Centers for Disease Control and Prevention. The goal of the PRC is to promote and support collaborative, community-based prevention research which strengthens the ability of communities in Detroit to address community and family health concerns and increases their knowledge about those issues. Favoring community priorities over those of the university, she asserts, is important for a successful partnership. The PRC conducts its research in ways which are consistent with the "Community-Based Public Health Research Principles" (see Appendix F) developed by the Detroit-Genesee County Community-Based Public Health Initiative. Following Dr. Israel's introduction, three partners of the PRC and a faculty member from another school of public health addressed issues relative to academic-community partnerships.

The community perspective: Alex Allen, of the Butzel Family Center, said that the first challenge for university researchers is to make sure the pending project would be meaningful to the community. Barriers include: time restraints, a lack of trust, and question of control over the project. In response to academic overtures, the community will always have the question **"so what?"** in mind, and are usually expecting an intervention of some kind. The researchers need to make clear to the community what they will gain from the research and need to have

respect for the multitude of personalities within any given community. Patience for the timetable of the community, as opposed to strict adherence to a university schedule, is also important.

The local health department perspective: Next, Wilma Brakefield Caldwell, of the City of Detroit Health Department, cited concerns over funding, the image of the health department, and the need to **utilize local resources over outside resources** in engaging in research with universities. She explained that all partners need to have a role in data interpretation and to see articles before they are published since researchers are prone to take data out of context.

Another community perspective: Ricardo Guzman, of the Community Health and Social Services (CHASS), warned that academic practitioners were not permitted to work in his community unless they promised to abide by certain principles. Issues of time, flexibility, trust, and confidence are paramount in negotiating a relationship between the community and outside organizations. His negative experience with academic researchers stemmed from his community's involvement in projects in which studies were undertaken without any shared results. Experiences such as these have bred mistrust and led to barriers which take time to break down. **Local resources and shared ownership need to be considered** in any research partnership. CHASS has solved this problem by landing contracts for health activities, such as evaluation, which it then subawards to universities.

The academic perspective: Rachel Stevens, of the University of North Carolina (UNC), shared lessons learned from her work in four North Carolina counties where she partnered with community-based organizations and a health agency. The university began a traditional scientific data-oriented approach to the project, but found "inaccuracies" in the health statistics and, furthermore, heard the community say that their problems were different from those reflected in the data. The university decided to stop talking about the data and to listen to their partner's needs. Dr. Stevens says she learned that flexibility in scheduling was very important in working with the community in order to meet them at times when they were available.

Dr. Stevens added that **"community problems do not stop when the semester ends"** and that her team has learned from the mistakes of not including community-based organizations from the start of their projects. One problem which can be prevented is in the area of funding and overhead. If the university recognizes the overhead costs of working with community groups and incorporates these factors into the budget, then it will not "lose" money in such projects. Furthermore, UNC has developed authorship guidelines with the community that seeks to include all partners in any publications resulting from the partnership, but Dr. Steven noted that shared authorship can create barriers to promotion and tenure for faculty.

The question and answer period which followed the panel discussion allowed participants to interact with the speakers before breaking out into small group discussions. The group then broke for lunch.

Quinton Baker, Executive Director of the Center for the Advancement of Community-Based Public Health, gave a short presentation on his organization over lunch. The Center's ultimate goal is to **foster healthy communities through the promotion of community-based approaches** (Appendix G). Furthermore, Mr. Baker illuminated the distinctions among the following kinds of community programs, services or interventions:

- *community-placed* -- physically located within a given geographic and/or cultural

community;

- *community-focused* -- intended for a specific geographic and/or cultural community;
- *community-oriented* -- primarily intended for a specific geographic and/or cultural community; and,
- *community-based/owned* -- primarily driven by the residents of the community at every stage.

2. Practice-based Teaching Panel Discussion

The second panel discussion took place immediately after lunch. Renee Bayer, University of Michigan Community-Academic Liaison Coordinator, served as the facilitator. Ms. Bayer discussed her work to expand the student internship program and to facilitate the **incorporation of public health problems in curricula**. She uses mini-grants and supplemental funding to help design new public health courses and to cover honoraria for outside speakers to address students on timely public health problems.

The academic perspective: Patricia Wren, adjunct faculty and senior researcher in the school of public health, detailed her course on materials and methods in health education programs. She has arranged for seed money in the amount of $250 per student group (each with three or four members) which is assigned to a public health agency to apply health education theory through developing health education materials. The students hire graphic consultants, buy supplies, run focus groups, prepare materials, and negotiate in-kind resources and labor to supplement their seed money. Ms. Wren noted the **barriers** to her efforts: **money, time** (ten months of preparation is required to launch a fifteen-week course), **commitment requirements**, the bearing on **course evaluation** (especially the possibly negative impact on promotion and tenure for instructors) and the **challenge to institutionalize the program**. Particularly problematic is determining how to create a mechanism to sustain funding for the products created in the programs. Cultural and linguistic barriers also pose minor difficulties.

Ms. Wren shared several strategies for success, which include: developing a source book of agencies and a short-term and long-term wish list for goals, and avoiding the temptation to compare results among students. Ms. Wren considers an important role of the professor is to coordinate the students to make certain that they are not replicating each other's work. Rewards include: *lasting relationships* with community partners, as Ms. Wren has access to preceptors who are willing to serve as guest lecturers in her courses and she has been asked to join community advisory boards; the *tangible outcomes* that students see in their work which increases their confidence in their ability to practice public health and that preceptors have programs and products created by the students for their use in teaching others; and, the *positive impact on the agencies* and in the lives of their clients.

The community perspective: Adnan Hammad, Health Services Director of ACCESS, introduced the agency's philosophy and explained its outreach efforts through the medical practice and public health programs. Dr. Hammad described the Studying and Improving Minority Health in Michigan (SIMHIM) project which is funded by the Health Resources and Services Administration. The program enables first year students at the school of public health to organize preventive programs such as cancer screenings in health fairs and during health education home visits. He noted that language and cultural differences can be a barrier with some populations, but the students have

learned to be flexible. An important strategy is that **outcomes must be tangible**. Students have been known to stay in touch with their clients and the agency in a consulting or other capacity even after the project has ended.

The student perspective: Ann-Gel Palermo, student at the University of Michigan School of Public Health and an intern at CHASS as part of SIMHIM, related her experience with practice-oriented student programs. She came to the university as an undergraduate in a summer enrichment program and after enrolling at the Michigan SPH began recruiting other minority students to join the MPH program. Her active involvement in minority student health groups and working with school of public health administration has taught her and her fellow **students** that they **can be effective advocates within the SPH**. Ms. Palermo has observed that many students are willing to fight for the education they want and know they need.

Another community perspective: Yvonne Lewis, of Flint and Vicinity Community and Economic Development (FACED), was the last speaker. Ms. Lewis believes that health plus education equals improved economic opportunities for citizens. She explained the motto of FACED, which is to work with universities and other partners to improve health. One example is the health team concept that a SIMHIM student designed with the churches. People of faith are now being mobilized to help change and modify poor health behaviors. Barriers include: time and energy required to involve students and faith communities, the lack of training some students have, and the shortage of materials and resources in small agencies. **Facilitating factors revolve around an agency's readiness to offer students a meaningful practice experience**, but students also need to learn the details of running a small organization, including handling the menial tasks, Ms. Lewis noted.

This panel discussion was also wrapped up by a question and answer period.

E. Break Out Discussions

After both panel discussions, participants gathered in small groups to examine the issues involved in both practice-based research and practice-based teaching. A list of **cross-cutting questions (Appendix H) was provided to guide the discussions**, and volunteer student note takers were assigned to each group to record the comments of the members. Participants were also asked to draw from their own scholarly practice-based activities, to share information from the projects they submitted in the abstract compendium (Appendix D), and to highlight items that emerged in connection with the paper *Demonstrating Excellence in Academic Public Health Practice*, which at the time went by the acronym *DEPHP*. The questions are outlined and responses have been collated as follows:

1. Describe similar or related community-based (research/teaching) activities in which your institution/organization played a role, highlighting their relationship to the paper, "DEPHP". (Practice Coordinators should discuss examples from their own schools)

The challenge, one practice coordinator said, is to build a real working relationship with an organization outside of the university since "collaboration [between SPHs and the community] is an unnatural act." Nonetheless, participants shared numerous activities they were undertaking in practice-based research and teaching in their SPHs.

The major contributions to the discussion follow:

a. Research Activities

(1) The University of California - Los Angeles has developed a reputable **advisory committee** which networks with public health providers on various projects. This technical assistance group makes itself available to community-based organizations to conduct evaluations and other activities. The 14-member group includes faculty and is run by a non-faculty technical coordinator who has experience working with the county. The practice coordinator reporting on this arrangement conveyed the importance of the dean's support for this project, especially in terms of his ability to make appointments;

(2) The Prevention Research Center at the University of South Carolina has an important role in providing **research-to-practice updates for practitioners**;

b. Teaching Activities

(1) **Field seminars** in which students work at non-traditional sites in the summer, conducting health promotion at a corporation or presenting nutrition education with a municipal school system, for example, is a way that the University of North Carolina - Chapel Hill expose students to practice;

(2) A **multidisciplinary four credit course** taught by four faculty from four different disciplines has been designed in conjunction with community partners at the University of Texas - Houston. The community has laid out the agenda which seeks to identify environmental health problems and community capacity in problem solving;

(3) Tulane University is seeking to unite the practice and the research pathways at its school by **reorganizing curricula** and filling in the gaps. Student input into the process and linking with community-based organizations is helping bridge the practice-research divide;

(4) A Kellogg-funded project in which five to six faculty meet on a regular basis to **review community-based content in the SPH courses** is underway at the University of North Carolina - Chapel Hill. The faculty has considered the taxonomy of community-based content, and Kellogg is putting together a book of the results.

(5) **Required student practica** at Ohio State University, which has arranged 2,600 medical student placements domestically and internationally, is another way to give students practice experience. Guest speakers are often used in courses at this school;

(6) Saint Louis University is **reassessing the curriculum** in behavioral science and becoming more aware of the need to get students into practica earlier in their SPH experience. Students also need to be involved in the assessment process. For example, this practice coordinator has been involved in a one-year process with the archdiocese to develop an assessment

tool and make recommendations in a project with the elderly. The student has been seeking to identify agencies and groups, and churches in particular, to support the elderly; and,

(7) One of the University of California - Los Angeles practice coordinators reported on a $100,000 gift from an outside donor to support student internships. The representative encouraged practice coordinators to be aware of **local resources** of this kind.

c. Other Activities

(1) Mobilizing the university to **empower communities** is another practice achievement of the University of California - Los Angeles. The partnership's integrated strategy includes the use of public service announcements and working with the school system and health departments to support informed citizens who can advocate for themselves; and,

(2) **The Leadership Ladder of Learning model** [Appendix I], which illustrates a life-long process of scholarship in which public health students and early career professionals move up a "career ladder" and become more abstract in their expertise, is used at the University of Illinois - Chicago to help guide public health leadership activities from the bottom up. A public health think tank is needed to play a role as the "top rung" of the ladder and can serve as a "learning community" for leaders in public health. The Robert Woods Johnson Foundation is supporting the "lowest rungs" of the ladder through *Turning Point* projects and management training and leadership development with state health departments and other practitioners.

2. What benefits or rewards has your institution/organization realized through participation in these activities? How have they enhanced academic public health practice, as defined in the "DEPHP" paper?

a. Faculty Benefits

(1) Junior faculty have profited from the relationship they have built with CBOs to **build their careers**;

(2) Community-based work brings **faculty "out of the woodwork"** and reduces their isolation;

(3) Faculty's **minds are opened**; and,

(4) One's **credibility and value as an instructor** are positively influenced by linkages with agencies.

b. SPH Benefits

(1) The SPH increases its **visibility** in the community; and,

(2) **Teaching is enriched** by community exposure.

c. Community Benefits

(1) The **health** of the community **is improved**; and,

(2) **Stereotypes** of CBOs as "poor small agencies" are **broken down**.

d. Student Benefits

(1) When students are able to provide agencies with a product, they are actually practicing in a **real world setting**, but can still retain their status as students;

(2) Much **learning** can take place outside of the classroom. Students, for example, learn that they can and need to go directly to the community to learn; and,

(3) Students have changed from considering themselves "students" to **"technical assistants,"** and this has improved educational outcomes.

3. What are the barriers to participation for members of your institution such as the faculty, students, practitioners, staff members, and community members (e.g. extra time needed, developing partnerships, costs, transportation)?

a. Funding Issues

(1) **Federal funding drives research** and, thus, can direct grantees' activities which may be inappropriate for the community;

(2) **Faculty perceptions of the prestigious funding agencies** may not include the organizations that are likely to fund practice-based work. Tenure-track, non-NIH (National Institutes of Health) funding is perceived as the "gold standard" for practice faculty. Although there was not a consensus on the image of HRSA (Health Resources and Services Administration) funding, some members agreed that it is seen as less prestigious. However, the group said funding status perceptions vary by school, structure, dean, leadership, size of the department, etc;

(3) **Sustaining funding** is problematic. Starting work with a CBO and having to "pull out" after the money is depleted is the kind of situation that breeds distrust;

(4) The **high cost of case studies**; and,

(5) **Additional tuition costs** for summer course work, which often includes internships.

b. Control Issues

(1) Academic **freedom in publishing** is jeopardized in partnering with some CBOs. For example, the local Detroit health department noted that they reviewed all papers before they go to the publisher, and that the health director makes final decisions on whether information in the paper is appropriate;

(2) Faculty need to get over their **desire to control situations**. One member warned that communities view "partnership" as a euphemism for "we're here to help you!"; and,

(3) Faculty can have difficulty in grading student groups because of the **power struggles** that can occur in groups.

c. University-Community Disconnect

(1) The **traditional model** in which universities engage in scientific research for their own interests, as opposed to involving the community in the definition of their health problems, is counterproductive to partnering with outside groups;

(2) The bureaucratic **challenge of defining community interests** is difficult even for the community itself, as the definition of "community" is subject to interpretation. Furthermore, in working with communities, some locals have their own realities and agendas, and it often becomes clear that "our [SPH] public health isn't their [community] public health";

(3) The legitimacy of **an academic functioning as citizen** is questionable;

(4) Some **professors feel "unwanted"** by the community;

(5) The bulk of **SPH work is irrelevant** to the community;

(6) The possibility that **SPHs can be coopted** or manipulated by the community to take on a "bad idea" is a concern;

(7) There is a **perception "out there" that universities have unlimited resources for public consumption.** Furthermore, people do not understand the faculty culture and that resources are needed to compensate faculty for their efforts;

(8) The professionalism and expertise of faculty can make it difficult for them to learn from others. A **sense of arrogance**, moreover, is inherent to faculty;

(9) The **lack of communication** is a major problem and this issue is tied to a lack of trust;

(10) Academicians tend to send students out, but **neglect to involve** themselves in the community;

(11) It is often the **preceptors who "get" the students**. Community members are not involved in what the students are learning; and,

(12) Sometimes agencies just need a student to do **clerical work**.

d. Intra-university Disconnect

(1) There is a **"culture gap"** in which practice is not valued in the SPH, in addition, faculty who conduct practice-based teaching are not properly rewarded;

(2) The **narrow perspective of science faculty** was discussed. Many scientific faculty feel that their job is not to work with the community, but to provide a knowledge base;

(3) The problem of **coordinating efforts** in large universities is legion;

(4) The **lack of staff support** to handle students needs hamper practica;

(5) The perception exists that there is **no place for community-based research** in research universities; and,

(6) There are a **limited numbers of faculty who are truly interested** and engaged in the

internship process.

e. Time and Resource Limitations

(1) The **amount of time and energy** required to properly supervise a student in a community project is more intensive than in lecture courses;

(2) **Getting practica accomplished** in a ten-week (one semester) project is challenging;

(3) Difficulty in **coordinating schedules** among academic and community players dampens partners' enthusiasm;

(4) The amount of **time required to build trust** among vested groups is a barrier as entrance into a community is a long-term process;

(5) The **exhausting nature of practice-based work,** including preceptor burn out, is a human resource limitation; and,

(6) The community's desire for a **time-limited interaction** with the university, while the faculty are invested in a bigger agenda, creates frustration among agendas.

f. Student Barriers

(1) Students are sometimes **burdened** with a heavy workload that could limit their commitment to an internship or practicum;

(2) Student **safety** in entering some communities is a concern;

(3) Students who **do not understand the scope of public health** nor how their practica fits into public health have trouble understanding practice-based work;

(4) The **lack of experience by students** entering SPHs do not give them a context in which to place their education; and,

(5) Students are **not getting the theory** they need in the classroom before they are placed with agencies, so some students are not able to draw on information to apply to their practice-based learning.

g. Other

(1) The **liability** inherent in some of the information that students provide from agencies is problematic; and,

(2) The **variation in degree requirements** among schools (some require internships while others do not) create students with differing skills and expertise;

4. What solutions have you found to facilitate participation in community-based research or teaching at your institution/organization? What would need to be in place to facilitate increased participation? (e.g. promotion and tenure/rewards system, funding agencies). What strategies might bring about these changes?

In spite of these barriers noted above, a member noted that more faculty are coming forward to work on

related issues at the community level and are building on these experiences. A proper focus is on the community and not a particular topic, a practice coordinator suggested. A colleague added that one needs to keep in mind that the "partnership is more important than the project", but **the reality is that "projects drive partnerships"**. Some solutions and strategies follow:

a. Faculty Solutions

(1) Internships should not be started by faculty who are not truly committed to them because the arrangement could backfire. A faculty member mentioned that his school conducted a study of internships at the university and that the successful ones included **distinct faculty involvement**;

(2) Instructors need to leave the "hallowed halls" of the university and **"get dirty"**;

(3) In a spirit of **concern for junior faculty** who are more vulnerable to "punishment" for practice-based work, the members suggested that less senior faculty could establish themselves in their first year with research, documentation of this research in their writing, and good teaching in order to secure tenure before launching any community work. If junior faculty are working in the community in lieu of publishing, that is not alright. Each school should have core senior faculty to serve as mentors or "point people" to junior professors;

(4) Practice-oriented faculty need a **different set of skills** to deal with practice-seeking students; and,

(5) Practice coordinators must **make themselves advocates** for public health.

b. Partnership Solutions

(1) The **triad of student, agency preceptor, and faculty** is part of the mechanism of training and serves as a successful model;

(2) Partners need to understand that **relationships are between people** and not between organizations or agencies;

(3) **Make partnerships real** and more than writing on paper;

(4) In order to build long-term relationships with CBOs, faculty need to avoid the traditional route of obtaining funds before seeking to partner with CBOs. Faculty need to **ascertain CBO's needs first**, then seek funding;

(5) Bring good faith through **"trading" skills**;

(6) Recognition of the time needed to respond to requests for proposals (RFAs) and the **time required to build trust** with partners is vital;

(7) Develop a **"joint statement"** between the university and community groups; (8) Create as many environments as possible to **train and teach what public health is**, as projects can strengthen agencies, and training builds the public health infrastructure;

(9) **Faculty need to listen** to what communities have to say and understand that two-way

communication encourages motivation; and,

(10) It may not be necessary to have the entire community in agreement as long as their **"voice is heard."**

c. Funding Strategies

(1) **Community lobbying** needs to be coordinated;

(2) **Multiple sources** of funding are needed;

(3) **Foundations** can be approached as a good source of funding, however they can be inconsistent; and,

(4) Consider the possibility that **students should pay to perform internships**. In this scenario, objectives would be clarified and the quality of the placement would increase. Furthermore, the burden would be increased for faculty to devote more time to the students involved in internships.

d. University Strategies and SPH Administrative Structures

(1) Form an **institutional structure** in which CBOs and the university (SPH in particular) are able to build relationships that exist over time in spite of the departure of key faculty members;

(2) **Leverage SPH faculty skills and talent**: their role as negotiators or decision-makers, the credibility that universities bring to the table, and the knowledge that universities can offer to CBOs are kinds of things the schools can offer partners;

(3) A way for universities to avoid being "used" is to **outline objectives** during the relationship-building period;

(4) **Institutional commitment** by the university, in general, and academic departments, in particular, supports practice relationships the SPH forges with the community. Institutional commitment is also useful to help gain the trust of communities;

(4) Clear and defined **criteria for measuring scholarship** can assist in raising the mantle of academic public health practice;

(5) One angle to use in approaching communities can be that of **"community service"**. The SPH can then offer to follow up with community research;

(6) **Build a cadre of practice faculty** in order to sustain leadership in practice;

(7) Create an **incentive structure** for a faculty partnership;

(8) Realize that it's not necessary to have a school-wide consensus on practice, but move ahead if there are **a few committed people** who are willing to begin the process;

(9) Tenure and promotion committees need to be convinced that **applied research is legitimate**. One practice coordinator reported that the tenure and promotion committee has changed at his school of public health. External reviewers are now involved and publications from anywhere are accepted. The dean and departments chairs have good communication with the

committee. Junior faculty, moreover, are better prepared and they have more positive attitudes and a greater willingness to match methods to problems. These faculty, nonetheless, need to be protected through the review process;

(10) **More rigor** in "write-ups, methodology, and replicability" is required for practice work;

(11) A **"template" for community-based research**, research models, and a model of practice were suggested in order to guide faculty in practice;

(12) Develop a **practice-based teaching workshop** for deans of SPHs;

(13) Locate people to **house students for summer internships**;

(14) A stronger **orientation towards students** would represent a positive cultural change that would influence their practice experiences;

(15) Since practice-based education and research are not separate entities, it would serve practice well to **better integrate the theory of research, teaching, and service**;

(16) Create a **year-long practicum**, as one SPH has, to train public health students; and,

(17) Practice-based faculty need to learn how to **"play by the school rules"** and still achieve their practice goals.

e. Curricula Solutions

(1) Create **longer-term internships**;

(2) **Community-based program evaluation** must be written into interventions and integrated into courses with students;

(3) **Developing case studies** are valuable, but they are difficult to create and hard to keep updated. Sharing these case studies over the Internet, or otherwise, would be useful. Furthermore, the positive results of creating a generation of materials which influence later curricula and the looping effect of this continuous process far outweigh the amount of work involved;

(4) **Writing up students evaluations** would help constitute a feedback system that could help current students understand the complexity of working with communities;

(5) Have **ASPH serve as the venue** for exchanging and sharing case studies and in helping locate internships for faculty and students;

(6) **Field practice** has to have the same weight as a credentialed course;

(7) Think about **moving "beyond the practicum"** and viewing practice as more than a "capstone experience". Practice-based work should be incorporated into all coursework;

(8) The **problem-based learning** or case study approach which is used by The Allegheny University of the Health Sciences' was acknowledged as useful in approaching practice work. Critical thinking and analytical skills are important to a practice-based approach;

(9) Courses which include **communication and writing** improve competency in practice and can include technical skill building, such as report writing and administrative skills;

(10) Increasing the **"community competency"** of students through a specific course helps sensitize students to work outside of the university, as students do not necessarily come prepared with these skills.

f. Student Solutions

(1) Give students involved in group projects the **power to "fire"** any member of the group;

(2) **Student demand for practice experiences** can result in a greater supply of practice opportunities and practice-based learning in the classroom;

(3) Individual student and student organizational **feedback** is important; and,

(4) Students need to maintain humility until they gain experience working in the "real world";

5. In what ways has this panel and discussion influenced this meeting's discussion about scholarly practice and the "DEPHP" paper?

a. What is Missing from the Paper

(1) The practice coordinators' **role in training** the next generation of health professionals is absent from the paper; and,

(2) The paper needs to **address partners in non-health fields,** such as faith, law enforcement, education institutions, Rotary and business clubs as they are part of a "natural constituency."

b. Ideas on the Paper's Audience(1) The group needs to agree on a **core constituency** regardless of the audience; (2) The constituency should be **inclusive and broad-based**; and,

(2) The **target audience** should be the deans and the Committee on Academic Personnel, which are interdisciplinary and cut across university departments.

c. Important Points to be Made in the Paper

(1) Academic public health practice is a field of **research** which:

sets out and defend its methods;

identifies contributions to the field;

supplies creativity and new knowledge, such as meta-analyses; and,

is not apologetic.

(2) The paper should also characterize how **peer SPH** promote and advance the academic public health practice agenda in order to positively influence other schools which have not come on board.

IV. Conclusions

There has been tremendous progress in the level of understanding and sophistication of what constitutes academic public health practice in the six years since the ASPH Public Health Practice Coordinators were created in 1992. The draft paper *Demonstrating Excellence in Academic Public Health Practice* shouts out that there is achievement in practice in the schools of public health and it includes suggestions on how to bolster, evaluate, and measure successes in this area. This paper will serve as a valuable document in promoting and advocating for greater visibility and recognition for the real practice of academic public health.

Community practitioners and students in SPH are important contributors to discussions of academic linkages with non-university partners. The practice coordinators heard loud and clear at this workshop that CBOs and health agencies are likewise tempted to "follow the money" in research areas. Academic public health has the means, clout, and responsibility to help alter this equation and can do so in conjunction with community and agency partners. The student representatives also reminded the group of their power as advocates within the SPH to fight for the practice-based education they want and know they need.

The participants honestly discussed issues of control and ownership in collaborative ventures and how to build trust and sustain partnerships among invested parties. A radical change in "business as usual" needs to occur to bridge the mutual suspicion among university representatives, community organizations, and health agencies, including government. The practice coordinators have come a long way in this area by involving their partners as equals and taking their concerns into account in discussing scholarly public health practice.

Academic public health is contributing to the discovery and application of new knowledge through special fora, such as this workshop, and everyday, in building and maintaining partnerships among students, faculty, community groups, and other agencies. There is momentum in the field and the practice coordinators are taking advantage of this energy to move the practice agenda forward in the paper *Demonstrating Excellence in Academic Public Health Practice.* Furthermore, highlighting successful liaisons between the SPH and non-university organizations, such as those shared in Ann Arbor, Michigan, permits others to enlist similar strategies to replicate and adapt successful collaborative ventures in their own universities and communities.

Much in the same way *The Future/Recommendations* chapter of the paper *Demonstrating Excellence in Academic Public Health Practice* had yet to be written at this workshop, the future of academic public health practice has yet to fully manifest itself. The field of academic public health is ripe for the tough questions and bold statements that came out of this workshop. As we look to the future, we can keep in mind one participant's question: Do students trained in practice-based programs perform better than others? Despite the lack of indicators of success in this area, and until we can quantify the effects of academic-community linkages, we can intuitively say "yes", that academic-practice linkages and partnering with valuable stakeholders will only enhance the current and

future public health workforce and make it more relevant to the public health needs of US society.

In spite of differences in strategy, orientation, history, and culture, schools of public health, such as the University of Michigan, are creating, preserving, and leveraging partnerships with groups such as CHASS and ACCESS to: become more informed on the reality of public health in their neighborhoods, increase students' chances of becoming more relevant practitioners, and improve the health of the communities around them. To meet the needs of the next generation, we must build on the best practices shared in this workshop in order to construct a shared future of effective academic public health practice with our schools and communities.

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