COMMUNITY-CAMPUS PARTNERSHIPS FOR HEALTH:
PRINCIPLES AND BEST PRACTICES FOR HEALTHIER COMMUNITIES
CONFERENCE PROCEEDINGS
April 25 – 28, 1998
Pittsburgh, PA

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CONFERENCE OVERVIEW

Over five hundred participants – including health professions faculty, students, and staff of community-based organizations and government agencies – gathered in Pittsburgh, PA on April 25-28, 1998 for the Community-Campus Partnership for Health's second annual conference. The conference, "Principles and Best Practices for Healthier Communities," was co-sponsored and supported by The Pew Charitable Trusts, the Corporation for National Service, the National Area Health Education Centers Program Office of the Health Resources and Services Administration as well as local foundations, academic institutions and health care organizations. The conference focused on the principles of community-campus partnerships and "best practices" for putting these principles into action.

Tyler Norris, executive director of the Coalition for Healthier Cities and Communities, opened the conference by challenging participants to think about innovative models for building healthy and economically viable communities. He stressed the importance of redefining wealth in terms of human and social capital. Tyler also asked participants to identify a vision and the unique stories of their communities, and to see their role as "investment brokers for their communities." Gary Grant, executive director of the Concerned Citzens of Tillery, North Carolina, gave a passionate closing keynote address on how the citizens of Tillery came together with the goal of creating a healthier community through grassroots efforts. In defining its own agenda for the future, the community invited universities to be partners in that effort.

Eight Navigating the Futures (NTF) sessions played an important role in the conference by providing participants the chance to develop a draft set of principles of partnerships and to shape the future agenda of Community-Campus Partnerships for Health nationally, regionally and locally. Several NTF groups are continuing their discussions over the internet or collaborating on a specific project. The outcomes of all of the Navigating the Future sessions were an integral part of the CCPH board's October 1998 retreat and are included in these conference proceedings.

Site visits gave participants a first-hand look at successful partnerships between community-based organizations and Pittsburgh's health professional schools. Theresa Chalich, clinic founder and current director of the Rainbow Health Center, took participants to the historic Homestead, home of the famous steel strike and once-thriving community of 20,000. Since the closing of the steel mill, the population has declined to 4,500. The clinic and its affiliated soup kitchen were established to meet multiple community needs resulting from changes in the neighborhood. Its interdisciplinary programs range from providing food for after-school programs to sponsoring a writing program for teenage girls. Medical and nurse practitioner students from local universities contribute to these programs. One participant noted, "Our visit to the neighborhood, the Clinic and its affiliated soup kitchen provided a rich understanding of how to imaginatively provide health services for a specific cultural context, and how committed leadership can overcome overwhelming odds."

Workshops and mentoring sessions provided a forum for participants to reflect critically on innovative models and stories of community-campus partnerships in education, research, and clinical care. Sessions also provided tools for assessing the impact of service learning and using these measures as a way to strengthen and improve community-campus partnerships.

The conference also celebrated the final year of the Health Professions Schools in Service to the Nation (HPSISN) program, which began in 1995 as a demonstration program of service-learning in health professions education. Tom O'Toole, project director for the University of Pittsburgh's HPSISN program, was asked to share a bit about his experience with the national program: "The HPSISN experience has been a way of defining and redefining community-academic partnerships. Rather than the traditional "farming out" process of sending students away from the campus with diffuse (and sometimes obtuse) expectations, this program provided the opportunity to engage communities on multiple levels. Successful service and learning requires community engagement in all facets of teaching and health care delivery…a sharing of "agendas" between academia and community partners."

**THE CONFERENCE THEME:
PRINCIPLES AND BEST PRACTICES
FOR HEALTHIER COMMUNITIES**

Community-Campus Partnerships for Health's second annual conference, "Principles and Best Practices for Healthier Communities" focused on themes relevant to principles of community-campus partnerships, "best practices" for putting these principles into action, and building and sustaining a growing movement of health-promoting community-campus partnerships. Participants examined community-campus partnerships for health professions education (i.e., service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. The conference was an exciting opportunity to help shape and contribute to the further development of meaningful principles for sustaining community-campus partnerships that improve health. A special track during the conference featured lessons learned from community-campus partnerships in the Appalachian region of the United States.

Some of the questions explored during the conference included:

- What are the principles underlying successful partnerships between communities and higher education? How do they reflect, incorporate and balance community, student and college/university perspectives?
- How can the strengths and assets of communities and of higher education be effectively mobilized to improve health and quality of life?
- What can leaders in health professions education (faculty, students, deans, etc.) do to help promote and integrate the principles of partnership into community-based education, research and service?
- What can community leaders do to engage health professional schools in their efforts to build healthier communities?
- What are the best practices for developing, implementing and evaluating community-campus partnership efforts?
- How can these best practices be effectively implemented in the context of today's managed health care system?

Principles of Good Community-Campus Partnerships

The conference was a valuable opportunity for participants to gain the skills, tools, and leadership to ensure the success of their programs and partnerships. The conference built upon the successes of CCPH's 1997 conference, "Building Sustainable Futures Together," where participants began to identify meaningful principles for community-campus partnerships. With input from CCPH members and attendees of the 1997 and 1998 conferences, the following draft set of principles were developed as guiding benchmarks for successful community-campus partnerships. These principles were adopted by the CCPH board of directors as organizational policy in October 1998.

1. Partners have agreed upon mission, values, goals and measurable outcomes for the partnership.
2. The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.
3. The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.
4. The partnership balances the power among partners and enables resources among partners to be shared.
5. There is clear, open and accessible communication between partners, making it an on-going priority to listen to each need, develop a common language, and validate/clarify the meaning of terms.
6. Roles, norms, and processes for the partnership are established with the input and agreement of all partners.
7. There is feedback to, among and from all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.
8. Partners share the credit for the partnership's accomplishments.
9. Partnerships take time to develop and evolve over time.

What do we mean by community-campus partnerships?

CCPH believes that community-campus partnerships are mutual, reciprocal relationships between communities and educational

institutions that build on each other's strengths and encompass a range of community-responsive activities. These partnerships might address such issues as how health professional are educated (i.e.,service-learning), how health care is delivered, how research agendas are defined and implemented; how the health of an entire community is improved; and how a community's economic situation is improved.

CONFERENCE GOALS

- **Provide an inclusive and dynamic forum** for networking, information sharing and skill-building among all stakeholders involved in community-campus partnerships.
- **Identify "best practices"** for meaningfully integrating these principles into community-campus partnerships.
- **Promote principle-centered partnerships** between communities and educational institutions.
- **Explore community-campus partnerships** in the context of today's changing health care system.
- **Showcase regional community-campus partnerships** consistent with the conference theme.
- **Build and sustain a growing network** of health-promoting community-campus partnerships.
- **Further the mission** of Community-Campus Partnerships for Health.

CONFERENCE FORMAT

The conference included plenary sessions; workshop and story sessions, 'navigating the future' sessions, poster and exhibitor sessions and site visits highlighting community-campus partnerships in Pittsburgh.

An opening evening reception, exhibition and performance featured the West Virginia Rural Health Education Partnerships (WVRHEP), WVRHEP consortia and other community-campus partnerships from the Appalachian region of the United States. As part of the event, a one woman, one act play, *Coal Camp Memories*, was performed by Karen Vuranch. This performance presented the life of a young woman aging through time in the coal fields of West Virginia.

In selecting among the session and poster proposals, the Conference Planning Committee had the following objectives:

- To encourage collaborative proposals among program partners, including staff of community-based organizations and community/civic members, faculty and students;
- To encourage interactive group discussion, where session presenters function more as facilitators than as speakers and use of audiovisual aids is kept to a minimum;
- To encourage peer-based technical assistance- that is, minimal focus on individual program descriptions and emphasis on successful strategies and skill-building to sustain community-campus partnerships and education;
- To encourage the involvement of community partners, community-based organizations and community members involved in health professions education; and
- To encourage student leadership and involvement in health professions education.

PLENARY PRESENTATIONS

LOREN ROTH
Loren Roth is associate senior vice chancellor for health sciences at the University of Pittsburgh, senior vice president of medical services at the University of Pittsburgh Medical Center Health System, and professor of psychiatry at the University of Pittsburgh School of Medicine.

"If there is knowledge, it is where the book meets the street."

Studs Terkel

First of all, welcome to Pittsburgh. We've very proud of Pittsburgh. We're proud of Southwestern Pennsylvania. We have a very unusual environment here. You're in a large, obviously, metropolitan city, but this is also population-wise, the largest rural state in the United States. In other words, once you leave Philadelphia, Pittsburgh, Harrisburg and Erie, you're in rural territory. So we have quite a diverse environment here to learn from and to participate in. My favorite quote in the world is from Studs Turkel and it basically goes this way: "if there is knowledge, it is where the book meets the street." I think that's an absolutely great remark that goes to the heart, and I

believe symbolizes what your partnerships are all about.

Several years ago when I was interested in increasing the amount of interdisciplinary training for our students, I wanted to know what the perspectives of the deans of the schools of the health sciences would be on this, since I was supposed to lead and organize this effort. We got together in a meeting and reviewed the strengths and weakness of all of our programs in the teaching area. There was a uniform concurrence from all of the six schools of the health sciences, that the one thing the students really didn't understand in any of the schools when they left their training was what the health care system was about, what was their role in it and how did it work. In other words, they had learned something about professional roles, they had learned something about the disease process, they had learned something about how you intervene as a professional and as a scientist/humanist. But the students did not get it with respect to what they going to do with that knowledge, and how to best apply it. And I would say that if the students did not fill that particular hole in their education, they actually lacked a conceptual understanding of what they were supposed to do with that knowledge to begin with. Because ultimately the medical professions are service professions. They use science but they are service professions.

So I'm extremely excited about our conference, your activities, what we can learn from you, what you can learn basically from us. I think the parallel point is simply that every health care economist makes-that health care is eventually local. And to understand the delivery of health care and the roles of professionals within it, you have to understand the local scene. You will not understand the local scene by localizing your body and your mind in some particular building where that scene comes to you. You can only understand the local scene and ultimately what opportunities it presents for you by being out there, by participating, by learning. And to me what this is all about is structuring the kinds of opportunities for students and working with communities to make sure that the conceptual definitions of what our health care professionals do once they graduate - meets the needs of those communities. So, with this, I welcome you very much. Thank you for coming to Pittsburgh. Bring more conventions here. This is a great convention city! Thank you.

CONNIE CIBRONE

Connie Cibrone is executive vice-president and chief operating officer of Allegheny General Hospital in Pittsburgh.

"Let us build wisely, let us build surely, let us build faithfully, let us build not for the moment but for the years to come."
Winston Churchill

Benjamin Franklin who lived most of his adult life in Pennsylvania once said: "We must all hang together or most assuredly we shall all hang separately. To me that statement is the essence of what Community-Campus Partnerships for Health is all about." In particular, it captures the spirit of the conference, on principles and best practices for healthier communities that bring all of you here together for the next several days.

Good morning. As Sarena has mentioned, I am the Chief Operating Officer of Allegheny University Hospital's Allegheny General, which is a member of Allegheny Health Education and Research Foundation. Allegheny is an academic health center based in Pittsburgh and Philadelphia, Benjamin Franklin's adopted home town. This mission shared by Allegheny General and its member institutions is to deliver the highest quality health care to people who come to us for healing and for hope and to help conserve the health of future generations. Ben Franklin and his fellow founding fathers understood the value of partnerships. So do our community-campus partnerships for health.

Collectively and individually our partnerships provide a connection between the health care needs of the undeserved populations and the academic medical community. These partnerships also serve as a bridge to institutions that can help educate people about prevention and treatment options. As cost and reimbursement issues force many health care organizations to struggle to maintain the breadth and depth of their services, the challenge that we all have together undertaken become evermore important.

During the next several days, you'll be discussing how to muster the resources to insure that all of our young people and those who are responsible for the well-being of young people have access to health care services so many of us take for granted. And that we do our part to encourage careers in health professions

and provide opportunities for continuing education. Like its sister institutions in Eastern and Western Pennsylvania, Allegheny General is involved in a variety of community partnerships toward this end. In last fiscal year we directly touched nearly 200,000 people in our community through close to a hundred vital programs. I'd just like to name a few:

- scholarship programs with local universities and community colleges to help people from disadvantaged backgrounds obtain skills to become registered nurses, physical therapists, surgical technicians and nursing assistants
- educational programs to teach senior citizens, expectant mothers and others with special health needs to meet those requirements successfully on their own and how to use the health care system effectively when they need outside assistance
- vital life support training for more than 1000 people in bachelor's and master's degree programs in emergency medical services to help paramedics sharpen their pre-hospital care skills and further their education
- family growth centers to help young mothers and fathers learn valuable parenting skills and acquire confidence they need to nurture their children and build a successful future
- domestic violence and injury prevention programs for more than 150 people through our university's Center for Violence and Injury Control which helps channel state, municipal and county resources to prevent these injuries
- a mobile mammography program that brought this life saving test to more than 5000 women last year who would not have otherwise had access to early breast cancer detection.

During the next several days you'll hear more compelling stories from your colleagues and their efforts to build long term relationships with community-based organizations. To borrow the words of another wise statesman, Winton Churchill: "Let us build wisely, let us build surely, let us build faithfully, let us build not for the moment but for the years to come." In doing so we'll help to insure that the ever changing health care delivery system has a place for everyone who needs medical services, health education or skills to enter the labor force. May this conference exceed your expectations in every way. Thank you.

TYLER NORRIS

Tyler Norris is executive director of the Coalition for Healthier Cities and Communities, senior associate of the National Civic League and president of Tyler Norris Associates.

"Health is not an intervention. Health is a by-product of a community working."
Tyler Norris

I have, to start, a short history of medicine that I thought might be useful to begin with today. Doctor, I have a stomach ache. In 2000 BC the doctor said here, eat this root. In 100 AD the doctor said, ah, that root is heathen, here, say this prayer. In 1850 AD, that prayer is superstition, here, drink this potion. In 1940 AD, the doctor says, ah, that potion is snake oil, here swallow this pill. 1985 AD, that pill is ineffective. Take this antibiotic. In 1998, that antibiotic, here take this root. (Applause).

I think that that provokes us a bit about our sense of knowledge and our sense of action. And in fact I'd like to engage us on a bit of a journey about what it is we actually know and don't act on, and what it is we actually don't know and pretend we do.

Beginning with a basic question: what approaches build and sustain health in communities?

My own personal and professional journey has centered on a basic question which is: What actions, what investments, what work, what caring, what, what approaches actually build and sustain the health and vitality in communities? What actually supports children and families in thriving and having access to the resources they need to realize their futures for themselves? What actually creates a vital and productive work force? What actually builds dynamic local economies? What actually builds the vitality of a local democracy? What actually helps communities work?

I was tempted on waking up very early this morning to ask God: why do you allow poverty, dislocation, disparity of affluence and privilege, of access to what can create and support health? And on that little prayer I realized that he would be asking me that same question. How

can you allow this? I'm going to suggest this morning, whether you see yourself here as an individual, a young person launching on a career, an institutional leader thinking about what your most appropriate role is or whether your thinking strategically about your institution, to think about your role as a leader. So this two tract conversation this morning from me is in part, what works out there in building communities? What are the lessons, what are the stories, what are the principles, what are the tools and what are the practices? Because we are part of a vast movement in this country that goes by a lot of different names but they are the same people working for the health and vitality of the community and we actually know a lot as a country.

And secondly there's a tremendous domain of what we don't know and what we can't explain. My wife is an artist and a painter and one of the greatest teachers I know and my closest friend. And she's a painter and an abstract artist, and I'm not (laughter). And I don't always understand what she does, which is a little challenging when she says, What do you think? I sort of struggle to understand it, and one time I sort of found the right question and it was, Where did you start that one? (laughter). She said, You know, I started by not knowing, that to create this painting I had to find a part of myself that didn't know. Because that was where my creativity came from. That was the place of starting - by not knowing.

About a year and a half ago, I had the opportunity to go to the city of Ephesus which was built by the Greeks in 1000 BC and is on the western coast of what is now Turkey. It's an extraordinary place. You enter the oldest part of the city and find these marble walkways and columns and pillars and statues, and its grandiosity is overwhelming. The Greeks built one of the first fresh water systems that brought the water from the mountains down through conduits and pipe out underneath the marble walkways and then out through fountains where people would have access to it for drinking and bathing and their household needs. And perhaps just as important, the Greeks built one of the first underground sewage systems that actually took the waste water out underneath these marble walkways and out through pipe, through the natural wetlands where the water was naturally treated, and the wastewater was naturally treated before it went into the bay.

They built one of the first great libraries - it's a three story library built in about 800 BC. They had one of the deepest ports in the world that connected their markets to the rest of the world and they had one of the richest economies for centuries.

One of the first things you see on entering Ephesus] is a theater that holds 2000 people, and a young Turkish historian said that the Greeks believed that at any one given time, at least one tenth of the city's population ought to be able to be in discourse with each other, ought to have a forum or a place where they can discuss the great issues of the day. And she went on to say not only did they have their theater and their music and presentations of the arts, but they came together here to discuss the future of their community. And I thought, oh, that's amazing, can you imagine this, citizens coming together! And in the relatively newer part of the city, still a few centuries before Christ, you will see a theater that holds 25,000 people, at a time when there were a quarter of a million people in Ephesus. She said, and here too, they had the great discourses of the day. My friends and I looked at each other and said, Yeah, right. A theater of 25,000 people. You couldn't even hear each other. Then we decided to do a little acoustical test - I went low to one corner of this theater and my friend went high to another corner and we started whispering to each other. And sure enough you could hear each other speaking in a very, very modest voice. We were amazed and trying to imagine this. Well, you all know what happened around the time of Christ and the first great ecumenical conference? This was no longer a Greek city. It became a Roman city and citizens were no longer actors or governors in relation to the future of their state. They were subjects in relation to the rulers from Rome. Some of you actually have experience in what they faced. There was no fresh money coming from Rome anymore, and they said, How will we continue to built and sustain our community? Well, unfortunately their fresh water system started to break down and soon after that their sewage system broke down. Their sewage system backed up in the wetlands. They literally fouled their nests. The wetlands became malarial, and it killed off a huge percentage of the population. Ephesus was abandoned within two or three generations to never again be inhabited, after a millennium and a half of being on the richest cities in the world.

The meaning of a healthy civic life

I was so struck by this story because it told the story of what I think we're learning from American communities today. And that is that a healthy civic life, the way people come together to deal with their issues on their turf in their ground with their assets is the means to a healthy people and to a healthy economy. Not the other way around. A healthy civic life, an effective governance, the way people function with each other in their communities, is the precursor to healthy people and a healthy economy. You don't somehow get rich as a community and get the money and become healthier. Now we know that and there's a lot of studies out to show us. For example, a story from Chicago that I thought was most compelling involved looking at what do we know about neighborhoods that have lower crime and violence rates? This study from Chicago in 1995 of 87,000 residents in 343 communities, tells us in some ways what we already know but it's important to sort of back this up. And here's what they said, and they correct it for income in all these different neighborhoods. They said: The ability of neighborhoods to realize the common values of their residents and to maintain effective social controls is the major source of neighborhood variation in violence. They went on to say this: the willingness of local residents to intervene for the common good depends in large part on conditions of mutual trust and solidarity among neighbors. You can't buy that. There's no program for that. And in fact, we don't really even know what it means except that it means we need to be neighbors. That seems to be what creates the variations in violence in urban Chicago neighborhoods as they said.

Redefining health

Now in a minute we're going to redefine health, but I'm going to challenge you this morning to redefine wealth as well. And I'm going to start with redefining wealth. We think we all know what it is, but wealth is not simply about monetary worth. But it's about different kinds of capital that taken together that make up the real riches of a community and a region and a nation. We know we could talk about natural wealth, the air, the water, the soil. We know the impacts of toxins on those, for whom environment justice places them close to toxins. This is very important to the vitality of our community. We know about social capital, the skills, the processes, the relationships, the leadership emerges, the way people work together across lines of race and class, or how they don't. That's social capital upon which the issues of our communities rest. About which the Ephesus story addresses. Human capital, the beliefs, the skills, the attitudes, the psychological, emotional, spiritual and physical health of people, as well as economic wealth. All four forms of that wealth-natural, social, human and financial-must be built and must be sustained. And the diminishment of any one of those forms of capital will eventually devalue the others.

And I bring this up because I'm going to encourage you where ever you find yourself, as a student emerging into your promise, into your career, or an institutional leader looking at your role, or a non-profit or a neighborhood leader, to say that our goal is not to run better programs, although that may be part of it, or to start or manage another project, although that may be part of what you need to do, but to think about yourself not as some recipient of some grant but about an investment, about being an investment broker for your community. That is to say, to ask the questions, What investments in family, in children, in housing, and access to care, in transportation, in education, actually build these different forms of wealth upon which our communities rest and which ones don't? Because building the health and vitality of our communities is not about projects, it's about who's at the decision making table, how decisions get made and how are resources allocated. Healthy communities is about power, not projects, although projects may be the way you get there.

The Healthy Communities movement

There's a very powerful movement underway in the country and you're all part of it, we're all part of it. It goes by the name of healthy communities, healthy cities, sustainable communities, livable communities, that, by the way is what comes from the architects and the urban designers, whole communities, which is what the folks in the interfaith programs actually call much of what their doing, good communities which is what the National Civic League talks about at their alliance for national renewal efforts being, effective communities, compassionate communities. In South Carolina, some of you may know this, the state chamber of commerce

has their lovable communities program. Real brilliant for a chamber of commerce. Fantastic. PATCH, APEX, you're familiar will all these different efforts but they're all working on the same basic thing, which is: How do we mobilize the creativity and resources of our community to create improved health and quality of life?

Now there are a few things that we know and a few things we're learning and I would like to quickly walk through a few lessons. The first of these, which I think we all sort of get intellectually, but it's challenging when it comes to actually what do we do about it, is about a broader definition of health. What actually creates health? What contributes to health? What are the factors that influence health status? That's a question. What influence health? Somebody call something out. The environment, absolutely. What else? Culture, jobs. Balance in our lives. Knowledge, education. I heard the CEO of the World Bank, an extraordinary guy, the other day and you should see their agenda, I mean, they're trying to grow into a relevant institutions in the recent, recent period and somebody asked him a question, If you can do any one thing,, what would you do? And he said, and he was speaking globally, "I would educate another girl." Because what he knows is that the greatest predictor of the health status of any community is the education level of women, just for starters. This is why Monte Roulier and I got so committed to using micro-credit in Tajikistan, small scale investment, to empower women to use the assets they already have to change their communities.

Okay, education. What else? Heredity, right. Fifty percent of what creates health is lifestyle and behavior issues, right? What we do everyday, at home, at work, at play, the choices we make about what goes in our bodies and the sort of behaviors and coaching of what we condone or support that goes on. Fifty percent of it, which means that 50% is not in our institutions-it's in the choices that people make everyday. The first acknowledgement of lack of control. The second is around the socio-economic and political environment. The sort of things people were talking about. It's out in the community. It's those things that actually contribute to health. The next 20% is genetics as was just pointed out and 10% is in the medical care delivery system. Most of what creates health has nothing to do with the medical care delivery system. It's outside the system, and in fact, it's jobs and education and transportation and housing and our faith and all these things that are outside of our "control". I call it the 70% solution-that actually conspires to create health.

Health is not an intervention. Health is a by-product of a community working. That's where health actually comes from. How many of you have seen the work of Herbert Benson and others at the Mind/Body Institute at Harvard talking about the impact of people who have a faith life, who have devotion in their life and its impact on health status and also recovery from surgery and illness? Dean Ornish, that great teacher of exercise and nutrition, I heard him speak the other day about his new book which is called Love and Survival, or something like that. It's great, and he said, yeah, yeah, yeah, exercise and eat well, but what it really comes down to is love and intimacy, and the linkage I'm seeing between morbidity and mortality is around the breakdown of social networks and people not having meaning and love in their life. Ah, wow!

The World Health Organization points out to diseases we ought to be thinking about in the future and at the top of their list as we look to the next century, is they're talking about unipolar depression. This is a disease of meaning in our community and a disease of our culture. James Rouse, the architect and urban designer said a healthy community is a garden to grow people in. So I ask again, the unknowable question for me to you, which is: What does that mean for your institution then, if a healthy community is a garden to grow people in, what does that mean about your programs, your projects?

The meaning of community

Second lesson after a broader definition of health is a broad definition of community. What's our community? Our neighborhood perhaps, our city, our county, our region. It's very interesting in this country, and Pennsylvania points it out very well, as Loren said earlier. This is an extraordinary state. We talk about our nation operating through states with cities and counties as the structure around which we organize most of our activity, and yet we function in a global economy where most of our issues are actually regional and we resolve them at the neighborhood level. There's an

extraordinary disconnect. And that's just the geographic definitions of health, not to mention the other definitions of community, or the way that we relate to each other around faith or culture or profession or interest or passion or however else we might line up. So building healthy communities means cutting across many, many different lines and being able to hold onto ambiguity about what community is. In Colorado we have one community organized across six counties and 90,000 square miles. That's their healthy community effort. One of our good friends and colleagues from Canada said that's not a healthy community. And somebody stood up and said well, we don't think twice about driving an hour and half for a movie and dinner out here. Well, that's their community. In Boston they operate through 18 different neighborhood coalitions, some of them no larger than a handful of blocks. Community looks many different ways and we need to embrace them in the same ways.

The third and perhaps, the most important lesson of all is about shared ownership and I think we have to keep coming back to it. What do healthy communities do to build shared ownership? One of the communities I've had the chance to work in is Lawndale, Illinois. This is a community where 65% of the people live below the poverty line. They went into the two high school's junior and senior classes and identified the girls in the junior and senior classes of these two high schools, and found that one-third of them were already had a child or were currently pregnant, and one-sixth of those babies were being born with a low birth rate. Extraordinary outcomes. The churches, and the neighborhood groups, some of them quite informal, are working with the hospitals and the schools and paired every single girl and boy in those two schools with a mentor. Somebody who'd say, What do you care about? What are you interested in? Oh, you like to draw, do you? What do you know about graphic design or architecture? Or, What's your dream? They basically asked this question: What's more important to you than going home and getting high and screwing around this afternoon? What's bigger? What's bigger inside you? They helped these kids connect with their future. Within two and a half years, as best they know, they cut their teen pregnancy rate to zero. Very little money, very little program, just people connecting to each other. Doing what really only people caring can do. That's ownership. It's

about people engaging in the work that only people really can do, the work of citizens, the work of neighbors, the work of caring people with each other. The community producing the results and being responsible for those results because that's actually what builds power. That's what builds power personally and that's what builds power in communities. And the confidence of communities is no different than the confidence of people. Doing the work that produces the result that helps us feel a sense of ownership and a sense of power. If health is not produced in our health departments or in our non-profit organizations or in our community organizations or in our hospitals, but in fact it's produced out in the community, then that means everybody is responsible for it. That means everybody is actually at the reigns of what creates health, which means something very significant about our own job description. If our job is to improve the health and quality of life of the communities we serve or however you might define that, then it means we have to find the roles and help people connect with the role that only they can play.

I was having a conversation the other day with some public health folks who were trying to sort of rethink the public health system and I said you know what, the public health system is actually just a community system. It's a community system that's the public health system. It's THE community system. And they said, Well then what does that make the public health workforce? and I said everybody's in the public health workforce, since health is created everywhere. Everybody's trying to create partnerships. Monte and I were talking about this at dinner last night. We want to create partnerships between our campuses and educational institutions and the community. But if you go to a chamber of commerce and say, we're trying to create partnerships with the community, or if you go to the United Way, ah, we're working on partnerships with the community, or if you talk to law enforcement official they'll say, we're working on creating partnerships with the community. I often ask the question: Who is this mythical community that everybody's trying to create partnerships with, if it's not actually us? (laughter). And I think it really means something very significant. And I work with hospitals a lot and I think the first thing they're learning is we are also the community and our first job is to just turn ourselves inside out.

What is the vision of your community?

What is the vision of your community? What is it? It's not six bullet points that are framed and on the wall, but what is the story of your community's future and how do you tell it together? And if you don't have one, how do you know how to allocate your resources, and how do you know about what measures to hold yourself accountable? Communities that work say, This is the story, and these are the values we stand on.

Fifthly, communities that work know their assets. They say, this is our vision and these are the assets that we have and they try to spend a tremendous amount of time mapping and identifying and building on those assets. I was in Lansing, Michigan a few months ago and there was a woman who ran a hairdresser shop on a fairly busy intersection. She had never been to one of these community meetings before. We had blown up a big neighborhood map on the wall and people were putting post-it notes about the churches and the schools and their households, places in the community, some of them quite informal that were places where community was built. And this woman put up her hairdresser shop and she said, you know, my friend and I who run this shop, we see 20 women a day come through our shop and I finally get it. Not only do we already have these conversations but we could be having the conversation that you're actually having here in this meeting. I'm going to take that back because now I see myself as an asset to this community building effort, that before that I didn't know what you meant. She saw her role in this. She was connected with what the community was going for.

Communities that work measure themselves. They know how they're performing. They have tracking systems. They hold their institutions accountable. In Pasadena they have 70 indicators and their whole, their city departments and their department heads, their departments are actually accountable to performing on the community-wide indicators that track progress toward the vision set by the community. In Seattle they have 40 indicators around which they develop and consider the investment decisions and policy choices they're about to make. How will the policy choice we're about to make move us forward on the indicators that identify what we think is valuable. Hampton

Roads, Virginia have the "Chilno's index". The Chilno's index is the number of pizza deliveries, and number of neighborhoods that the Chilno's pizza drivers will deliver to after dark. (laughter). This is a very gut level indicator that actually touches people to help them be accountable about what they care about.

And finally, systems change. If there is any one thing you could do as a community leader right now it is to stop the fragmentation that is going on in the communities. All these, we are so blessed with many movements and projects and non-profits and collaboratives and all that, that we are sort of a challenge of riches here. But we still do economic development planning over here. The hospitals plan here. The health departments plan here. The schools plan over here. We do transportation planning over here. Housing over here. It's actually a crazy thing to do that. Because most of the issues we address cut across all of those. I had a gentleman who's become a friend of mine, the Mayor of Columbus, Ohio, a city of a million people, a big place. Before his recent reelection, he stood before a group, a big audience like this and he said, I think our city is dysfunctional. And everybody sort of said, Mayor! - his aides were sort of getting nervous in the chairs over there and all that. And he said, I think we're dysfunctional. I go to 20 meetings a week in this community and my staff tells me these are different meetings, but I see the same people talking about the same stuff in 20 different places. (laughter). And they began to lay out all their missions and programs, and that they tried to find the linkages and relationships between them, because they knew that that was their job. That was the leadership job that they had to bring about.

And the final point I want to bring about is that this work takes time. It takes a tremendous amount of time. I have a friend from Saudi Arabia who told me about the, the date, you know the date fruit and I didn't know much about dates, and he said that the date seed takes, from the time that you plant it to the time this tree sort of grows in, he said by the way it looks like a brown twig most of the time, there's no leaves, there's no green, I mean it just looks like a twig most of the time. He said that it take 80 years from the time you plant the seed before it actually bears fruit. Wow! 80 years. The person who plants that date seed will probably never eat the fruit of that tree. Our community

building efforts whatever name, whatever institution they go by are life long journeys. They are not projects for '97, '98, '99, 2000. They are the way we approach our building, the way we approach community building, the way we approach our communities.

We need to turn our institutions inside out

What does it mean? I think first of all it means we need to turn our institutions inside out. One of the boldest things I ever saw was from the Fort Worth United Way. They had all these incredibly well-meaning, talented people who were going to do a training for the neighborhood on how to build community. And they did everything right. They found the minister and they got the Saturday morning in the church basement and they went in, you know, they were going to go in the neighborhood, they had the minister sort of serving to bring everybody together, I mean all this, they were going into the community, they did it all right, and about a week out these fine women of United Way said, wait a sec, wait a sec, I think we may have it backward. They called the minister and said, could you actually ask the people who were going to come to this training to sort of flip the tables on us and would they give us a training on how their neighborhood works, would they tell us how it works in their neighborhood. Which was extraordinary because it uncovered not only for the United Way leaders but for the community themselves what they did know and what assets they did have, and what they had to bring to bear toward the vision that they actually had.

I think one of our great challenges as well, if you want to know whether what you're doing in on track comes from one of my great mentors a fellow named Leland Kaiser. He says that your budget is your ethical document. If you want to know whether what you are investing in is aligned with your values, just look at your financial report. It'll tell you. And I think we could personally just sort of look at our Daytimers for the same basic evidence, because how we spend our time in dollars is perfect in terms of its alignment with what we actually value.

So as we move forward in our efforts, I want to bring something from another friend of mine named Gary Gunderson. He runs the Interfaith Health program at the Carter Center. He's a tremendous fellow and he was talking about coalition building and he said Tyler, you're involved in all these big partnerships and planning and all this stuff, he said, all that stuff's great, but he sort of worked on debunking me, reminding what I don't know. And he said the primary response is not larger and larger coalitions. There's something almost addictive, I would say almost distracting in the process. The problem of a coalition of healthy cities is that there's no logical value of the coalition. There's no way to stop being inclusive, he's saying, and don't stop being inclusive, but there's no way to stop, so you end up constantly feeling like we're not ready for prime time yet. We'll be ready when we get the police in here, we'll be ready when we get the minister in here, we'll be ready when we get the youth in here and this and that and we're just, you know, sort of not, they'll always be some group on the fringes of your coalition that is not under the tent yet and here is his suggestion, which I think is brilliant. He says grab the near edge of some great problem and act at some cost to yourself. I believe both personally, spiritually and also from experience on the ground in communities, that communities actually know what their problems are. Communities know. If you bring a group of community people together they they know what's up. And secondly, most of the time they actually know what they need to do. They know exactly what they need to do. They seem to think they need external help but they actually know, communities know what's up. And I also know this, that somewhere in the country there's a brilliant initiative addressing every issue this nation faces, working, measurable outcomes that are actually trackable. So we know what our problems are and we also know what the solutions are.

We have every resource we need

Thirdly, we also have every resource we need. We have been blessed with everything we need. We are a rich country in every way and our challenge isn't so much how do we get more resources, it's how do we use the resources we have better. How do we align our resource allocation with our vision and values? So if we know what our problems are, we know what solutions are, and we have everything we need, what's the challenge? And I would say the challenge to you as community leaders are, and to particularly to you in institutions of higher learning, et cetera who are on the ground in

community, grounded in community, wedded in community and are creating the context for the thinking of the coming generations, do we have the will to do what we need to do? The personal will, the community will and the political will. Do we have the will to act at some cost to ourselves?

I'm just going to close with this. We already brought up Ben Franklin but I think he's important to bring up again and I brought him also into this room. As he walked out and met with the reporters of the day, at the second congressional congress, they said what is it, what is this country, what are you doing behind those doors? What is this nation you guys are forming? And he said, I give you a republic if you can keep it. Thank you.

AN ACTION AGENDA FOR COMMUNITY-CAMPUS PARTNERSHIPS

As part of the 1998 CCPH conference agenda, conference participants joined one of eight "Navigating the Future" sessions. These agenda-setting sessions were designed for small groups of conference participants to discuss topic-specific issues including: Principles of Partnership, Cultivating Financial Support for Community-Campus Partnerships, Measuring Outcomes of Community-Campus Partnerships, Public Policy and Advocacy, Institutional Policy Reform, Regional Partnerships, Appalachian Partnerships, and Cultivating and Sustaining Leadership Skills for Community-Campus Partnerships.

The goals of the NTF sessions were to:
- Discuss issues which have an impact on health-promoting community-campus partnerships;
- Develop ideas and recommendations relevant to a given topic;
- Stimulate action on the topic after the conference ends;
- Establish and broaden CCPH peer networks and support; and
- Shape and promote a national agenda for community-campus partnerships and for CCPH

Each group developed recommendations for CCPH and others to consider. A mentoring group on cultural competency also met to develop recommendations for strengthening cultural competency among community-campus

partnerships. Below is a summary of their recommendations. CCPH thanks all who contributed!

PRINCIPLES OF GOOD PRACTICE FOR COMMUNITY-CAMPUS PARTNERSHIPS

Co-facilitators: Cheryl Maurana, Director, Wisconsin Area Health Education Center (AHEC), Director, Center for Healthy Communities, Department of Family and Community Medicine, Medical College of Wisconsin, CCPH Board of Directors; Kara Connors, Associate Director, Community-Campus Partnerships for Health; and Gail Newton, Program Coordinator, Center for Healthy Communities, Department of Family and Community Medicine, Medical College of Wisconsin

CCPH believes that the future of improved community health and higher education rests in part on the development of meaningful partnerships between communities and educational institutions. However, as community-campus partnership efforts emerge throughout the world, community leaders and educators have very little reference to guide, develop and/or evaluate their mutual work and interests. CCPH expects that a defined list of principles governed by a preamble and followed by recommendations for implementation will help all stakeholders to design, implement and evaluate their community-campus partnership efforts. This NTF group refined an initial set of draft principles that were developed during the 1997 national conference into a final draft (below) that was approved by the CCPH board of directors in October 1998. The group also made recommendations for how one would assess the extent to which the principles were applied in practice.

Principles of Good Practice for Community-Campus Partnerships

1. Partners have agreed upon mission, values, goals and measurable outcomes for the partnership.
2. The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.
3. The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.

4. The partnership balances the power among partners and enables resources among partners to be shared.
5. There is clear, open and accessible communication between partners, making it an on-going priority to listen to each need, develop a common language, and validate/clarify the meaning of terms.
6. Roles, norms, and processes for the partnership are established with the input and agreement of all partners.
7. There is feedback to, among and from all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.
8. Partners share the credit for the partnership's accomplishments.
9. Partnerships take time to develop and evolve over time.

Assessing the Principles of Good Practice

Partners have agreed upon mission, values, goals and measurable outcomes for the partnership.
With successes, goals may change and need to be revisited. Partners may have different individual goals, but share the same overall mission for the partnership.
Variables: Changes in behavior among the partners; frequency of revision of goals; congruence between partnership and stated mission, goals and objectives;
Methods: confidential reporting by each partner; open-ended assessment tools

The relationship between partners is characterized by mutual trust, respect, genuineness and commitment.
Variables: Length of relationship, attendance at meetings, extent of follow-through on commitments, information is shared among partners

The partnership builds upon identified strengths and assets, but also addresses areas that need improvement.
Variables: Evolution of partner roles and responsibilities; roles and responsibilities are divided among partners; a map or inventory of partner and partnership strengths, assets and areas of improvement; extent to which strengths and assets are built upon; extent to which areas of improvement are addressed; extent to which strengths, assets and areas of improvement are monitored and revisited; inventory of ways

strengths and assets are being applied to the partnership

There is clear, open and accessible communication between partners, making it an on-going priority to listen to each need, develop a common language, and validate/clarify the meaning of terms.
Variables: phone call are returned; criteria and methods for communication are established; partners are introduced to each other; difficult issues are discussed; silence is acknowledged; realistic deadlines are imposed; a common language is developed; meeting minute are taken and distributed; channels of communication are identified; point person for communications is identified; meetings have agendas; all partners are encouraged to participate.

Roles, norms, and processes for the partnership are established with the input and agreement of all partners.
Variables: an organizational structure for the partnership has been established; job descriptions for partners with responsibilities have been established; extent to which the structure and descriptions are followed

Partnerships take time to develop and evolve over time.
Partnerships evolve at different rates - some more quickly, others slowly. The most successful partnerships usually evolve slowly. Partnerships require patience, and the ability to have a vision and see the potential down the line. Partnerships require a combination of process people and action people. It is important to start small with small successes, measure successes and setbacks.

The partnership balances the power among partners and enables resources among partners to be shared.
Variables: how funds are budgeted and distributed; how partners are informed about grant proposals; what process is in place for proposal development and review

Partners share the credit for the partnership's accomplishments.
Variables: extent to which partners are team-oriented; all partners are identified on publicity and announcements;
Method: review public documents and announcements

WHAT DIFFERENCE ARE WE MAKING? ASSESSING THE VALUE OF COMMUNITY-CAMPUS PARTNERSHIPS

Facilitator: Monte Roulier, Roulier Associates; Senior Technical Advisor, National Civic League; and Chair, CCPH Board of Directors

This group discussed the many possible outcomes of successful community-campus partnerships, focusing on five major stakeholders: the community, academic institutions, participating community organizations, faculty, and students. The group also developed possible approaches to assessing these outcomes at the partnership level.

If community-campus partnerships for health are wildly successful, what are the outcomes for stakeholders and what indicators can be measured among:

- Community & Community Organizations
- University Students
- Academic Institutions
- Faculty

Principles Guiding Assessment Practices

1. Build evaluation in from the beginning (ensure it is ongoing) - *more than a pre- and post-test*
2. Measure the process as well as the product - i*dentify and track process indicators along with outcome indicators*
3. Aim for "realness" and "accountability" - *what is the true outcome? who is the consumer of the evaluation? why is the information real?*
4. Make sure evaluation is relevant and easily understood by the community - *from the "eyes of the consumer", make sure those surveyed see the results*
5. Don't try to measure everything - be *strategic, track additional indicators later, do what you can well*
6. Ensure the community's participation in the evaluation process - i*nvolve community in the design, from the beginning*
7. Give equal consideration to quantitative and qualitative designs

If community-campus partnerships for health are wildly successful, what outcomes will they produce for the <u>community and community organizations</u> ?

Healthy Communities are safe, clean, promote life-long learning, engage people in meaningful employment, offer access to health care services, have good schools and better individual health. Healthy communities are characterized by:

- Accomplishing more by leveraging resources
- Achieving buy-in and ownership from all stakeholders
- An empowered community that recognizes its strengths and assets
- Appreciating academic institutions as resources
- Continually networking, integrating new partners and building new partnerships
- Creating better and more meaningful connections between students and community
- Decreasing the cost of care
- Developing community skills and competence (i.e. networking, organizing, decision making and acting)
- Enlarging the person power base, such as the number of students rotating, number of volunteers from community, and number of people being served
- Evidence of sustainability, such as increasing money over time, decreasing staff turnover, increasing utilization of services
- Identifying and meeting needs
- Improved individual health status (physical and emotional)
- Improved relationship and trust with the university
- Increased access to expertise and training
- Increased citizen participation and volunteerism
- Increased number of people immunized
- Increasing activity and efficiency
- Increasing interaction with different cultures, socio-economic groups and neighborhoods
- Informing public policy
- More participation in the democratic process
- Reducing the disparity within communities
- Sustainable initiatives
- Well identified and prioritized health care needs and social problems

Indicators for Communities and Community Organizations

- Decreased/Increased incidence of "X": teen pregnancies, drop out rate, incidents of

violence, crime statistics, renters, welfare recipients, homelessness, suicides, infant mortality, use of emergency care, absenteeism in school, environmentally induced diseases etc.
- Person's perceptions of their own health using perceptual instruments (over time)
- Pattern of service utilization
- Number of individuals from different groups participating in community activities, planning and group processes
- Number of community-driven initiatives (based on the community's aspirations and resources)
- Number of partnering projects developed in "X" amount of time
- Skills developed - grant writing, fundraising, working with students
- Increase or decrease in use of identified resources and assets
- New leaders identified--number of new folks participating and playing leadership roles in different community efforts
- Increased or decreased knowledge practices/behaviors to increase individual health
- Number of doctor/emergency visits
- Number of preventive health care visits
- Amount of legislative/policy-driven action resulting from community efforts

If community-campus partnerships for health are wildly successful, what outcomes will they produce for <u>students</u> ?

- Appreciate community strengths and needs
- Become more self-confident/ Feel good about their influence on others
- Better academic performance
- Better and more well-rounded health professionals
- Better citizens and sense of civic responsibilities
- Better communication skills
- Course credit
- Cultural sensitivity working with various groups in community/ Increasing cultural competence
- Greater incentives for working in community
- Increase in future employment opportunities
- Increase recruitment to work in community-based/"under-served/at risk" populations
- Increased critical thinking skills
- Increased leadership capacity
- Increased reflection skills
- Learn community dynamics

- Learn inter-student relationships
- Obtain practical hands-on experience and richer, real world experience
- Understand how to participate in their own government

Indicators for Students

- Class participation
- Continued volunteerism after the course ends
- Number of graduates employed in community-oriented jobs
- Number of students in voluntary programs
- Participation or membership in professional organizations
- Perspectives of community leaders and recipients of service of student attitudes and abilities
- Satisfaction with the overall service-learning experience and acquired skills
- Secondary actions from experience (i.e., writing letters to policy makers)
- Sustainability and continuity of service worked on by students
- The variety of service learning experiences-- look for patterns, gaps and opportunities

If community-campus partnerships for health are wildly successful, what outcomes will they produce for <u>academic institutions</u> ?

- Attract more and better students
- Community and community organizations are viewed as a resource
- Encourage learning community dynamics
- Gain respect and trust from community
- Improved relations with communities
- Increased community support, leading to increase knowledge and education of academic mission
- Increased community-based research opportunities
- Increased sites for student training
- Increased skill in how to work with community
- Increased student sensitivity
- Increased visibility for the university
- More money for university
- More trust of the community
- Provide realistic educational experiences for the students and better education
- Students are getting good jobs
- Sustained involvement with the community

Indicators for Academic Institutions

- Diversity of student training sites
- Duration of community partnerships
- Number of academics on community boards
- Number of community members on university boards
- Number of community placements and partnerships
- Number of grants (external and internal) and dollar amounts of grants
- Number of students (enrolled, graduated, employed)
- Satisfaction of community partners
- Satisfaction of consumers of the services provided by partnerships
- The number of administrators and faculty conversant and supportive of community partnerships

If community-campus partnerships for health are wildly successful, what outcomes will they produce for <u>faculty</u>?

- Better informed teaching
- Changed "reward" structure of university
- Cultural sensitivity and increased awareness of community diversity
- Enhanced credibility of faculty in community
- Faculty credit and recognition for community work
- Greater integration of service learning into curriculum
- Greater opportunities for promotion and tenure
- Greater understanding of how to relate to community
- Improved communication with student and community
- Increased awareness that all education does not need to be clinical
- Increased funding
- Increased job satisfaction
- Increased research opportunities
- More relevant and effective community research
- Personal learning opportunities

Indicators for Faculty

- Actual curriculum changes
- Amount of time in community by faculty
- Amount of time spent in community specific to academic course
- Changes in academic institutional policies (supporting community work)
- Classroom "peer evaluations"
- Content analysis of syllabi

- Faculty support and
- Faculty turnover
- Number of community-based research papers and grants
- Number of faculty involved
- Number of faculty involved in community activities
- Number of faculty rewarded and promoted
- Number of service-learning courses
- Pattern of graduate career choices
- Preceptor feedback
- Quality of reflective documentation
- Student course evaluations

Resources

- Community Indicators Handbook -- contact Redefining Progress (San Francisco)
- Outcome Indicators Handbook -- United Way of America
- Indicators Book -- Department of Housing and Urban Development

CULTIVATING AND SUSTAINING LEADERSHIP SKILLS FOR COMMUNITY-CAMPUS PARTNERSHIPS

Facilitator: Gretchen Kinder, University of Massachusetts Medical Center-Office of Community Programs and CCPH Board of Directors

This NTF group discussed ideas and recommendations concerning the emerging leadership skills for developing community-campus partnership efforts. Given the growing changes in communities, health professions schools, and the health care system, what new skills are needed to effectively respond to these changes? How might these skills be best developed and put into action? How can these leaders help carry the message for the community-campus partnership movement?

Below is a list of leadership skills and qualities identified by conference participants as being essential for facilitating and supporting community-campus partnerships:

- Admitting and learning from mistakes
- Advocating for change
- Balancing and managing visioning and action
- Being an action person
- Being an open-minded learner
- Being empathetic

- Being fair
- Being flexible
- Being open
- Being organized (time management, scheduling and administrative)
- Being patient and recognizing the time involved in developing partnerships
- Being present and future focused (don't be stuck in past and caught up in ideas about the way things should be)
- Being willing to "transform your life"
- Contributing money and other forms of personal wealth/capital
- Demonstrating broad cultural competence (understanding, respecting and seeking out others who are different from yourself)
- Demonstrating commitment
- Facilitating empowerment processes
- Facilitating groups
- Facilitating visioning
- Good communication skills – verbal and listening
- Negotiating

- Persevering
- Risk taking
- Role modeling
- Staying focused and being a task master
- Supporting others

LEADERSHIP CHALLENGES

Conference participants identified three categories of leaders typically involved in community-campus partnerships for health:
- Student
- Community (people without university affiliation, citizens)
- Academic (faculty, staff, administrators)

The group agreed that all categories of leaders should possess, or work towards either possessing or seeking out others with these skills. However, for each category of leader, there are challenges that make the exercise of their leadership difficult.

STUDENTS	COMMUNITY	ACADEMIC
♦Balancing professionalism and collegiality with peers	♦Organizing a much wider constituency to develop teamwork, shared vision and ownership	♦Showing products and concrete outcomes; including outcomes in projects and teaching
♦Being taken seriously by multiple partners	♦Understanding an working with university schedules	♦Facilitating and integrating classroom and community experiences
♦Managing time – scheduling self and activism; set limits	♦Identifying and marshaling the resources to build sustainability	♦Challenging self, students and colleagues to respect and value different kinds of knowledge
♦Integrating classroom and community experiences	♦Balancing liaison role with multiple community roles	♦Navigating the bureaucracy of academic life
	♦Dealing with mistrust and suspicion	♦Dealing with diverse settings

STUDENTS

Priority Challenge:
Appear credible and inspire an apathetic student population in order to create an effective student team.

Causes:
- Lack of communication with sites and faculty.
- Lack of creativity within the project.
- Lack of faculty interest.
- Lack of ownership.
- No feedback from community and faculty.
- Perceived lack of time.
- Project is difficult to sell to others.
- Student status makes it difficult to be taken seriously.

Recommendations for CCPH:
- Develop and disseminate a dynamic tool/product to help students understand community-campus partnership processes, including roles of different players, principles of partnerships, public relations, other models at work.
- Award and recognize successful service learning projects.
- Develop and disseminate a teacher tool for feedback and evaluation.
- Sponsor conference workshops oriented towards helping students to understand their individual values and apply them to their project.
- Sponsor a student / faculty forum.
- Include at least one student-oriented session each day of the national conference.

COMMUNITY

Priority Challenge:
Organizing a much wider constituency to develop teamwork, shared vision and ownership while
understanding the barriers to communication.

Causes:
- Fear of loss of control / competition
- Fragmentation of community demographics
- Lack of collaboration / communication
- Lack of personnel / resources
- Lack of trust, understanding

Recommendations for CCPH:
- Establish a network, mentoring or buddy system with representatives from a broader

perspective of health to give support and advice to CCPH community partners
- Include a community skills track at the national conference.
- Include more community members in the planning of the conference.
- Involve community in writing CCPH materials - move language away from academia
- Provide community scholarships for conference participation.

CAMPUS-BASED FACULTY AND ADMINISTRATORS

Priority Challenge:
Navigating the bureaucracy of academia in order to integrate community-based experiences into the curriculum.

Causes:
- Accreditation standards
- Faculty overload
- Have to have academic support before other concerns are addressed
- Lack of evaluation of service-learning to date (can't prove worth to administration)
- Lack of resources to support service-learning
- No perceived reward
- Resistance from students (time and value)
- Restating/redefining unit relationship with the community
- Top-down approach to governing
- Unfamiliar teaching strategy
- Up against historical, traditional way of education (i.e., service-learning can be viewed as a "feminine" "feel - good", "fluffy" way of teaching)

Causes that are Within the Control of Academics:
- Begin to substitute service-learning for other course components
- Bring community members in to talk with students and faculty
- Design good service-learning programs to break down resistance of students
- Invite students who had good service-learning experiences to speak to resistant students
- Publicize and celebrate service-learning experiences
- Show outcomes are good to gain support for program

Recommendations for CCPH:
- Create a support group for faculty
- Share research on service-learning to support its value
- Provide technical assistance o help set up evaluation of projects
- Sponsor a "train the trainer" program in service-learning faculty development
- Start a mentoring program to link experienced service-learning faculty with those who have less experience
- More "documentation" of programs and outcomes at the CCPH conference
- Reduce cost, don't provide lunch; make lunch a time to explore
- Set up interest groups or caucuses based on faculty issues
- Include a faculty/staff development track in the conference
- Begin working with accrediting organizations to make service-learning a required part of curriculum
- Develop incentives for exemplary service-learning programs
- Develop service-learning marketing strategies or some sort of public relations toolkit to implement on member campuses.

Priority Recommendations for CCPH

1. Develop a network or buddy mentor system based on geography, skills and interests
2. Provide conference bonuses or other incentives / recognition for recruiting new members
3. Provide technical assistance for promoting CCPH within community - campus partnerships (i.e., public relations kit)
4. Offer resources for connecting researchers and for disseminating research
5. Develop leadership skills through the conference
   -one workshop per day geared specifically towards leadership skills of community, students and academics (e.g. community, student and academic track similar to Navigating the Future)
   -more downtime; initiate interest group caucuses for connecting during downtime
   -formal recognition at conference for leaders within CCPH and the healthy communities movement

Parking Lot Issues
Things we thought were important but did not have time to discuss fully:

- Volunteerism versus community-campus partnerships
- Leadership skills to be taught vs. being based on one's individual personality and motivation
- How to be lead people out of their comfort zone into ones perceived to be "unsafe"
- What mentoring means and how to foster it

CULTIVATING FINANCIAL SUPPORT FOR COMMUNITY-CAMPUS PARTNERSHIPS

Facilitator: Hugh Bailey, America Works Partnership and Member, CCPH Board of Directors

This group identified sources of funding for community-campus partnerships, discussed fundraising strategies, identified the skills needed to successfully raise funds, and made recommendations to increase funder interest in community-campus partnerships.

Successes
- Apply for funds as a partnership
- Build on personal relationships
- Collaborative governance
- Communicate success
- Create mutual benefit to both parties
- Hospital links students to community sites
- Interdisciplinary models
- Start small in a pilot site
- Technical assistance and feedback from outside structure
- Use volunteers

Challenges
- Academic institutions often wait to the last minute to ask for letters of support
- Funders increasingly expect matching funds or in-kind contributions
- How to get on funders' agendas
- Identifying good funding source
- Inability to identify sources that fund infrastructure for these partnerships, unrestricted funds, staff time
- Lack of advocates for "our story"
- Little recognition of partnerships as legitimate and capable of securing funding and maintaining program
- Local foundations often emphasize direct service provision but not the infrastructure needed
- Non traditional grantwriters are in short supply

- Shared leadership is difficult – issues over ego, money, and power
- Students lack training to write grants
- The unwillingness of the community to take a leadership role in developing community-campus partnerships
- Time of tenure track faculty to do development research is rarely funded
- Trust takes time to develop

Ideas

Marketing
- Communicate successes
- Demonstrate validity of the project
- Involve enthusiastic volunteers and students as advocates for the program
- Produce written reports

Strategic planning
- Begin before the program even starts
- Consider the market and environment in which you are working
- Develop a long range funding plan
- Examine the program focus
- Match funders with specific objectives

How to approach funders
- Start with previous established relationships
- Respond to request for proposals (RFPs)
- Discuss clearly with funding officers what the funders are looking for
- Seek out why funder did not provide funding
  - Were objectives not clear?
  - Was there a change in the funder's funding direction?
  - Was there a change in the funder's priorities

Institutionalization issues within higher education
- Tell public relations officer about the program, and communicate throughout the program duration not just at the end
- Work with other disciplines

Institutionalization issues within community organizations
- Have the board of the organization buy into the project
- Provide public relationship media coverage
- Share responsibilities of the project with partners
- Teach organization how to write grants

Recommendations / Next Steps

- Bring funders to next conference (new conversion funding)
- Define the infrastructure needed for community-campus partnerships, such as staffing, time
- Educate community and institutions on value of working together
- Encourage institutions to place value on partnerships but also demonstrate through action "more than just lip service"
- Focus on changing the reward system for faculty

Possible Funding Sources

- Carolyn Foundation – Minnesota & Connecticut (focus on children)
- Ford Foundation
- Pew Charitable Trust
- Pharmaceutical companies (Pfizer, Burroughs Welcome)
- Professional associations (American Academy of Pediatrics)
- Robert Wood Johnson Foundation
- WK Kellogg Foundation

INSTITUTIONAL POLICY REFORM

Facilitators: Tom Irons, Associate Vice Chancellor for Health Sciences, East Carolina University School of Medicine and Member, CCPH Board of Directors; and Skip Cummings, East Carolina University School of Medicine

This NTF group discussed policy issues at the higher education and community organization levels that serve to impede or advance the development and sustainability of community-campus partnerships. The group also discussed the skills needed to effectively advocate for policy change.

Barriers to Institutional Policy Change

Indirect Costs
- Indirect costs can pit the university vs. the community. Universities often have very high indirect costs, and it is unclear where these funds go.
- There is a lack of incentives for universities to change their policies regarding indirect costs.

- History of (poor) university involvement without following through
- Personnel dependent

Faculty promotion and tenure policies
- Community work is perceived as a barrier to promotion and tenure
- Student community involvement is often extracurricular with no direct rewards from the school

Accreditation Policy
- Accreditation policies are often cited as a barrier to curricular change, but often these are perceptions that are not based in knowledge and facts about the policy. In other words, academic administrators and faculty can cite these policies to maintain the status quo.
- Accreditation policymakers can lack knowledge about the role and value of service-learning in health professions education.

Curricular policies
- Calendars, time, space, and people are often already committed well in advance.
- Different funding cycles
- Differing expectations (community vs. university)
- Differing time frames (community vs. university)

Facilitators of nstitutional Policy Change

- Community agency staff and board leadership
- Crisis, such as a legislative directive
- Curriculum reform effort
- Funding (reallocation of) resources
- Incentives - mutual benefits and opportunities
- Individual commitment
- Leadership
- Rewards for students, faculty, community
- Structured mechanism for communication
- Structures and policy support
- Student involvement
- Sustaining force

Strategies to Help Promote these Facilitative Factors or Overcome Barriers

- Barriers are personnel dependent and have in common a significant lack of knowledge about community problems. Major

facilitating factors are leadership and rewards (students, faculty, and community).
- Building on pride in success seems especially important for academic administrators. Major need therefore is publication. One good strategy for some has been to bring in credible national leaders with whom we work and have those leaders publicly praise our programs.
- Identifying key supporters at the highest level is most important point.
- In cases where local political leaders have the ability to positively or negatively influence growth and development of an institution, these leaders can be very effective in changing institutional policy. They must, however, be very well educated about the nature of partnership, service-learning, etc.
- Informal leaders (not deans but key committed and respected faculty) should be identified and carefully nurtured.
- Leadership development for students and faculty is also very important. Formal training programs involving successful leaders from institution and community can be very helpful.
- Most leaders will be verbally supportive, but may go no further in terms of commitment. Education and constant reinforcement are the key.
- One key issue seems to be establishment of set of core values on which all can agree, and constant reinforcement of those core values. A good example of a core value which it is hard to deny is that whatever we do, education or service, our goal must be to improve the health status of people.
- Students when properly educated and vested in service-learning can do some powerful pushing and shoving. Strong student leaders need to be nurtured and mentored very carefully.
- Supporters must be educated about service-learning concepts and given a sense that there is real academic validity to what is being done.

Skills For Developing and Implementing these Strategies

- The group should first see and review notes, then return comments about them and recommend skills development strategies.
- Most important skill is leadership, next is communication.

- Sharing of stories of successful programs is very important for skill building.
- All those working in this area should have a good enough knowledge of service-learning concepts to present these educationally to various groups.
- Community leaders are very important partners in any skill- building training. Otherwise, their perspective may be missed and policy change less likely.
- Simple final words: We should all be working to insist that institutional missions be redrawn to address their service obligations, and we need as many leaders as possible to begin really pushing this agenda. The community should appear in the mission statement of all academic institutions. CCPH might want to draft and circulate a "boiler plate" mission statement.

PUBLIC POLICY, ADVOCACY AND COMMUNITY-CAMPUS PARTNERSHIPS

Facilitator: Liz Maker, Community Academic Coordinator, University of California, Berkeley School of Public Health, Community Health Academy

This NTF group discussed public policy issues at the national, state and local levels that serve to impede or advance the development and sustainability of partnerships. The group made recommendations for policy change and strategies for implementation. The group also discussed the skills needed to effectively advocate for policy change.

Policy issues that are relevant to community-campus partnerships
- Access to health care.
- Categorical funding and the need to support broader health programs.
- Curricular policy - promoting that community learning is critical in health professions education, and that students must develop community competency.
- Health care as a right, not a privilege.
- Lack of diversity in the health professions. The need to increase access to health careers to people of color and women.
- Opportunities to create or respond to local policies which enhance community health.
- Resource allocation for health care.
- The Balanced Budget Act's effect on rural communities, especially in relation to home health care.

- The need to educate people to increase their knowledge about how to influence public policy.
- The need to harness community power to change health policy.
- The need to link needs and assets, and create common ground between business and health care providers.
- Welfare reform.

Roles for CCPH members in policy development and advocacy
- Consensus builder, conflict resolver and mediator.
- Creator of opportunities for things to happen.
- Expert
- Linker between grassroots groups.
- Listener to community concerns and ideas.
- Proactive or reactive?
- Radical or "within the system"?

Skills CCPH members will need to become successful policy advocates
- How to educate/empower/mobilize lay people. How to stimulate grassroots involvement.
- How to motivate students, faculty and health professionals to advocate for policy.
- How to use stories as a way to motivate people to support policy.
- Knowing when to apply pressure on policy-makers, and when to provide support (or when to get behind legislation).

Policy recommendations for CCPH
- Advocate at the state level to ensure community representation on managed care organization boards.
- At the next CCPH annual meeting, provide training for members on the skills needed to advocate for policy on the national, state and local levels.
- Communicate with managed care organizations on the vital importance of including community perspectives to establish policy.
- Create CCPH chapters at the regional, state or local levels to network and share information on common policy issues.
- Define organizational roles and establish partnerships with like-minded organizations. Clarify similarities and differences. Identify potential areas of conflict and collaboration. (An example of a like-minded organization is the National AHEC Organization).

- Establish communication links between and within CCPH members and grassroots organizations through CCPH newsletter; fax, internet web sites and list servs
- Hire a public policy person at CCPH to gather policy information and disseminate information to CCPH members.
- Mobilize CCPH members to support increased access to health professions training by families impacted by welfare reform.
- Model community-campus partnerships by expanding membership and participation by community representatives. Suggested strategies: offering scholarships to community-based organizations to attend the annual CCPH conference, offering reduced membership fees to community groups, provide certificates of attendance to community members to help them to document their efforts with CCPH.

EXPLORING THE FUTURE COMMUNITY-CAMPUS PARTNERSHIPS IN THE APPALACHIAN REGION

Facilitators: Hilda Heady, Executive Director, West Virginia Rural Health Education Partnerships; Associate Vice President for Rural Health, West Virginia University; and Member, CCPH Board of Directors; and Bruce Behringer, Executive Director, Office of Community and Rural Health, East Tennessee State University

This NTF group discussed and drafted statements regarding the future of existing and developing community campus partnerships by highlighting the regional capacities in the Appalachian states represented by the participants and those of which participants may have knowledge.

The group addressed the following questions: Are there unique Appalachian issues when developing and implementing community-campus partnerships? What is the status of these partnerships in each state? The group also addressed whether such unique issues are related to the geographic region, to social, economic, and/or cultural factors, and identify the similarities and differences in the region concerning rural and urban partnerships. What are the facilitators and challenges to implementing these partnerships in the Appalachian Region?

The group identified the strengths and capacities in the region that facilitate partnerships and the challenges these partnerships face. Finally, the group identified the benefits and goals of continued networking activities.

Are there unique Appalachian issues when developing and implementing community-campus partnerships? What is the status of these partnerships in each state?

The group addressed whether such unique issues are related to the geographic region, to social, economic, and/or cultural factors, and identify the similarities and differences in the region concerning rural and urban partnerships.

- Isolation is a shared feature in the Appalachian region. This is characterized by the following: A great deal of time spent traveling, lack of public transportation, and isolation of professionals from each other. However, in some situations, in terms of preferred lifestyle by those with a pioneering or missionary spirit, this can have positive aspects for some professionals.
- Communication problems exist between providers and patients, and in the perceptions, stereotypes, and expectations of both providers and patients or community members.
- Values that are unique to the residents.
- The need for consistency and sustained approaches to partnerships.
- Resources are limited or lacking and there is a difference in the perception of resources and their availability for various needs. There are environmental and cultural impact on resources.
- Sometimes the community voice is hard to find, especially in very low income areas.
- Lack of vision and insight shows up in knowledge of and use of the political structure, in short term solutions, in the minds of the money and power brokers and in the minds of community residents. Some have a fatalistic view of their communities.
- Time: the Appalachian culture is very old and we need to remember that long term problems take long term commitments.
- Myths and their perpetuation are barriers to partnerships. The common myths have at their base the perception that we have to be either winners or losers leaving no room for creativity, insight, and solutions that may have yet to be discovered. The group

agreed that many values and beliefs are based in the history and results of the extractive economy of the Appalachian region.

What are the facilitators and challenges to implementing these partnerships in the Appalachian Region?

The group identified the strengths and capacities in the region that facilitate partnerships and the challenges these partnerships face. In looking at the rationale for partnerships there are many strengths and assets within the Appalachian culture to foster partnerships:

- A strong sense of community and some isolation creates dependency on each other so that collaboration becomes a natural response to problem solving
- Independence and resourcefulness.
- Collaboration among community based agencies
- Strong value base that includes faith, family ties, and ties to home no matter where an Appalachian lives.

Do we, as partnerships in this region, have interests or needs to network or relate within the region?

The participants identified the benefits and goals of such networking activities and decided if such networking is to be pursued and through what vehicles.

Recommendations for building trust and respect in partnerships
- Give something away
- Move beyond what is in it for me
- Show a genuine interest
- Show up - your presence shows respect
- Try to include all partners
- Unmask the masquerades

Observations and Recommendations about the Future of Appalachian Community-Campus Partnerships

- CCPH has potential to assist campuses and communities to improve health
- Create a "network" or informal linkage among the programs within the Appalachian region. Include all of Appalachia not just rural settings

- Create an electronic discussion group, or listserv, for Appalachian programs
- Exchange ideas and support one another
- Examine models of community-campus partnerships
- Support student exchange programs
- Appalachian community-campus writing group
- Share our stories
- Develop educational and service standards
- Sponsor a regional summer service-learning institute
- Present information about community-campus partnerships during regional conferences
- Take advantage of new technologies for communication and learning.
- Involve students more in our programs
- Propose an Appalachian meeting during the next CCPH national conference
- We need to think more about the role and impact of managed care
- A strong CCPH involvement and showing at the 1999 Louisville National AHEC meeting should be made and that "we" (the Appalachian group) should submit a proposal for this conference and bring back new learning to the region.

EXPLORING THE FUTURE OF COMMUNITY-CAMPUS PARTNERSHIPS IN PITTSBURGH AND WESTERN PENNSYLVANIA

Facilitators: Becky Zukowski, Executive Director, Southwest Pennsylvania Area Health Education Center ; and Sarena *Seifer, Executive Director, Community-Campus Partnerships for Health*

This NTF group discussed ideas and made recommendations for strengthening community-campus partnerships in Pittsburgh and Western Pennsylvania. The group addressed these and other questions: What are the facilitators and challenges to implementing community-campus partnerships in Pittsburgh and Western Pennsylvania? The group will identify the strengths and capacities that facilitate partnerships and the challenges these partnerships face. What resources are available to strengthen existing and foster new community-campus partnerships in Pittsburgh and Western Pennsylvania? The group identified the resources available at the national, regional and local levels. What needs to be done to strengthen existing and foster new community-campus partnerships in Pittsburgh

and Western Pennsylvania? Finally, the group identified the needs and opportunities, and possible vehicles, partners and funding sources for initiatives designed to strengthen existing or foster new partnerships.

What are the assets and resources in Pittsburgh and Southwestern Pennsylvania that facilitate community/campus partnership?

The group revealed that the Pittsburgh community has a great many assets and resources which lend themselves to the development of partnerships. The Pittsburgh area has within a very small geographic area, many colleges and universities. This lends itself to a great many academic endeavors which involve the community. Additionally, the student mix at the schools is very diverse culturally and economically. Students appear to bring interest, energy and enthusiasm when interacting with the community. There is a history of real relationship-building between the schools and the communities. This history has resulted in a general attitude of cooperation seemingly not found in other parts of the country. The group also believed that the economic/social issues of urban Pittsburgh present great opportunities for partnership. There is great potential for community collaboration around common issues, services and economic development. Finally, the healthcare re-structuring and reform has presented many opportunities for creativity and innovation in an effort to provide access to care.

What are the challenges to initiating or sustaining partnerships within the Pittsburgh community?

The group believes that it is extremely hard for "outsiders" to break into the Pittsburgh community. The reputations built over the years (both positive and negative) will impact the response of the community to any proposed partnership. The geography of the region often poses difficulties for programs attempting to impact both urban and rural communities since they are often quite diverse and require different intervention. City and county governments are often quite charged with political issues and overtones which may impact partnerships or prevent partnerships from developing. The group brought to the table some long standing issues surrounding community exploitation by

schools and groups conducting research. Additionally, there are many groups working in similar areas and communities are often confused and/or unaware of initiatives underway.

What are the driving forces for students who are asked to be involved in community campus partnerships?

Hands on experience is very positive and provides opportunity to test new skills and receive academic credit at the same time. The community offers future employment connections. Training in community sites is often interdisciplinary and reflects the "real world". The community is the future of their practice, for the most part, and learning how to work with the community while attending school is essential. It also provides opportunity for the student to "give back" to community and to possibly see results from their efforts. Often these experiences provide the only opportunity to work with a diverse culture. Students often bring idealism, energy and motivation to the setting.

What are the restraining forces for students who are asked to be involved in community campus partnerships?

The group revealed that often students are not given "academic credit" for their efforts or experiences as a part of the community campus partnership. Although the group felt that the motivation should be something more than this, it was conceded by the group that students are often quite busy between academics and the necessity of working in order to be afforded the opportunity to attend college. A partnership experience without academic credit often becomes an impossibility for many. Students discussed the fact that many times the objectives of the experience are not made clear to them. They often struggle with issues related to transportation, safety and increased costs related to travel. Further complicating these issues is the lack of understanding regarding why they need the experience or what this experience will help to prepare them for in the future. Making a connection between the experience and future would be quite valuable and often is not made clear by faculty. Site mentors or community based faculty are not always made aware of the students role in the community setting.

What are the driving forces for faculty and / or academic institution who are asked to be involved in community campus partnerships?

The academic mission of many of the schools includes an emphasis on community. Sustainable partnership fulfill the mission while serving the community. Leadership at the academic institutions have made a personal commitment to facilitate community development. Faculty practice has become an issue in many settings and community campus partnerships provide the opportunity for this to become a reality. Local and national funding opportunities are many times available and are directly connected to collaborative models involving the community. Academic institutions often feel obligations for community/civic involvement. There is also some political pressure generated from a variety of sources to respond to community challenges. The respect of the community is felt to be a high priority by academic institutions. Visibility of the academic institution in the community is felt to be important for student recruitment.

What are the restraining forces for faculty and / or academic institution who are asked to be involved in community campus partnerships?

Often there is a lack of structure or system in place to support community involvement. Faculty may have to "break through" traditional structures to facilitate community involvement. Many demands are placed on faculty regarding research and publication. Involvement in community is not a requirement for tenure and promotion and therefore many times falls lower on the priority list due to time limitations. Many faculty themselves feel insecure in a community environment and therefore have difficulty getting out of their comfort zone. If more faculty were educated on how to begin they may be more open to facilitating partnerships. Faculty development would be an asset with regards to community involvement.

What are the driving forces for communities who are asked to be involved in community campus partnership?

The community provides a wealth of resources for students. The learning environment helps them to translate the ideal into the real. Students bring energy and enthusiasm and often help to motivate staff as well as remind them of the basic goals of their professions. Skills are often learned in the community site that can be translated to other environments. The community can facilitate problem solving in the real world. Overall, the community has a lot to offer students and there is a genuine commitment of the community site to the students who are involved. Additionally, the community site often benefits by having students give a "fresh look" at issues and concerns within the agency.

What are the restraining forces for communities who are asked to be involved in community campus partnerships?

Communities are often not prepared to serve in the role of mentor or faculty member. Frequently students are sent to the site and no communication has been received by the site regarding objectives or course requirements. This results in the community agency often over or under utilizing the students. In some instances, the community has felt exploited by the partnership when no sustainable product is left following completion of a project or student rotation. There is often a loss of productivity when students are rotating to a community agency or doing a community service project.

What action plan can be developed to improve or maintain existing partnerships?

The group proposed the following in response to the brainstorming regarding community campus partnerships:

- Develop a Community Campus Forum. This group would consist of local community agencies and academic faculty. Meetings would occur quarterly and would have structured agendas. The goals of the Forum would be structured at the first meeting. The time line suggested for development of the Forum: Fall 1998.

- Continue to develop leadership within academic institutions related to community involvement and successful service learning experiences. Successes should be published in local newspapers as well as academic journals.

- Communicate to decision-makers within academic institutions regarding the challenges and barriers to community campus partnerships.

Overall the group felt that the Pittsburgh area provides a wealth of opportunity for community-campus partnerships. Continued involvement, focus on making best practices better, and knowledge that the benefits for both students and communities are great will make community campus partnerships viable in Pittsburgh.

CULTURAL COMPETENCY IN HEALTH PROFESSIONS EDUCATION

Mentor: Vickie Ybarra, Yakima Valley Farmworkers Clinic and Member, CCPH Board of Directors

This mentoring session engaged participants in a discussion of cultural competency in health professions education. Vickie Ybarra works for Yakima Valley Farm Workers Clinic, a large community/migrant health center in central Washington State, where she has been Director of Community Health Services for eight years. She has her undergraduate degree in nursing and in 1996 completed her Masters in Public Health at the University of Washington. Most of her work involves development, oversight and evaluation of support programs for Spanish-speaking pregnant women and families with young children. She is also active in her community with health care workforce development, particularly working to increase the number of local Hispanics entering nursing.

Questions raised by participants

- How do we get administrative or leadership-level competency in cross cultural education in health professions education?
- What are specific methods for teaching cultural competency?
- How do we break down barriers for students who may be have barriers to learning cultural competence?
- What are methods to measure effectiveness of a program to teach cultural competence?
- How do we include neighborhood environment in cultural competence training?
- How do we do the above in a relevant manner, without tokenism?

- How do we address language/literacy barriers in cultural competency training?

Training of Health Professional Students

- There needs to be deliberate institutionalization of specific curriculum. The curriculum should be based on respectful relationships between health care provider and patient/client, with opportunity for community input into curriculum.
- There needs to be a self-examination component as the starting point for any training in cultural competency.
- Not everyone can teach cultural competency, particularly considering the skills necessary to process students going through effective self-examination. Faculty need to those interpersonal process skills.
- Cultural competency training is NOT teaching laundry lists.
- Cultural competency training should not be limited to classroom experience; it needs to include the community through an experiential learning component.
- There are a number of ways for the community to participate in development of cultural competency training, such as a case study, community preceptors as adjunct faculty.
- Students and patients also need to be involved in the curriculum.
- Professors and faculty need to be sensitized
- Potential resources include the Multicultural Institute in Washington DC, the Cross-Cultural Health Care Program in Seattle, and the American Medical Student Association's modules on cultural competence.

Commitment to Prepare Health Professionals of Color and/or From Community

- Need to develop a "pipeline" approach that includes early support of science and math, mentoring and shadowing experiences, and summer programs directed at youth.
- There has been limited success with youth-directed programs - often lose them over the summer, high attrition because of issues in the urban neighborhoods, and even those who succeed may not be choosing health professions.
- Use of Lay Health Educator model to train people from the community who are interested in health professions; involve

faith-based communities and recruit potential students from these communities.

- Looking at college/university entrance requirements - are they accessible to minority and bilingual students?
- Consider looking to the health care agencies in the communities, they may often have developed some kind of intermediate health care worker to serve either as an assistant or interpreter or aide-type who may be a potential pool of adults interested in health professions education.

ABOUT THE HEALTH PROFESSIONS SCHOOLS IN SERVICE TO THE NATION PROGRAM
The Health Professions Schools in Service to the Nation Program (HPSISN) is a national initiative designed to strengthen partnerships between health professions schools and their communities. A program of the Pew Health Professions Commission and the National Fund for Medical Education, HPSISN receives support from The Pew Charitable Trusts, the Corporation for National Service, and the Health Resources and Services Administration. In April 1995, the HPSISN program awarded three-year service-learning grants to 20 health professional schools across the country. The grantees are a diverse group of schools of medicine, dentistry, nursing, pharmacy and public health whose community partners include public schools, community health centers, community development corporations and social service agencies.

ABOUT COMMUNITY-CAMPUS PARTNERSHIPS FOR HEALTH
Community-Campus Partnerships for Health (CCPH) is a nonprofit organization that fosters health-promoting partnerships between communities and educational institutions. Based at the Center for the Health Professions at the University of California-San Francisco, we seek to work collaboratively across sectors of higher education, communities and disciplines to achieve successful community-campus partnerships. We identify students, institutional leaders and community leaders as equal constituencies, and we serve as a welcoming bridge between the many government and foundation-sponsored initiatives in community-oriented health professions education. As a "home" to the community-campus partnership movement, we work with our board, members and staff to advance our mission:

> **"to foster partnerships between communities and educational institutions that build on each other's strengths and develop their roles as change agents for improving health professions education, civic responsibility, and the overall health of communities."**

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