From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century

CCPH Annual Conference Proceedings
April 29 – May 2, 2000 ~ Washington DC

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Suggested Citation

From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century - CCPH 4th Annual Conference Proceedings. San Francisco: Community-Campus Partnerships for Health, 2001.

Acknowledgements

About Community-Campus Partnerships for Health

Community-Campus Partnerships for Health (CCPH) is a non-profit membership organization committed to fostering health promoting partnerships between communities and health professional schools. In addition to our publications, CCPH provides a variety of programs and products to assist you in your community-campus partnership efforts including: customized training and technical assistance, annual service-learning training institutes, an annual national conference, web site, online newsletter and active electronic discussion group for CCPH members. To learn more about CCPH, please visit our web site at: http://futurehealth.ucsf.edu/ccph.html.

CONFERENCE OVERVIEW

Over five hundred participants – including health professions faculty, students, and staff of community-based organizations and government agencies – gathered from April 29 – May 2, 2000 in Arlington, Virginia for Community-Campus Partnership for Health's fourth annual conference. The conference, "From Community-Campus Partnerships to Capitol Hill: A Policy Agenda for Health in the 21st Century" was co-sponsored and supported by the Corporation for National Service, the WK Kellogg Foundation and over 15 national organizations in health and health professions education. With its emphasis on policy, the conference was designed to broaden and deepen participants' understanding of issues that affect community-campus partnerships and the overall health of communities. Enhancing participants' advocacy skills for change within communities, academic institutions, government and the philanthropic sector was an explicit aim of the conference. Ultimately, the conference sought to shape an advocacy and policy agenda for community-campus partnerships. In widely disseminating these proceedings, we hope to bring the voices of those involved in community-campus partnerships at the grass roots level to the attention of national, state, organizational and institutional decision makers.

In her opening keynote presentation, Roz Lasker, director of the Center for the Advancement of Collaborative Strategies in Health, applauded the audience's passion for partnerships but also challenged us all to assess and strengthen the functioning of their partnerships. Drawing on her Center's extensive literature review and study of partnerships across the country, Dr. Lasker highlighted the rationale for community health partnerships and the factors that seem to hinder and facilitate their success.

Nine policy papers, made possible through grants from the Corporation for National Service and the WK Kellogg Foundation, were commissioned for discussion at the conference. Brief descriptions of each paper are included in these proceedings. Prior to the conference, participants were asked to review one of the commissioned papers. During the conference, participants met twice in small group Policy Action Teams corresponding to the theme of the paper they reviewed. Policy Action Team sessions played an important role by providing participants the chance to critically discuss the commissioned papers and develop a set of policy recommendations. These recommendations were an integral part of the CCPH board's September 2000 retreat and January 2001 business meeting, and are included in these conference proceedings.

Given the conference's policy theme and proximity to the nation's capitol, briefing sessions enabled participants to learn about the latest federal policy developments and interact with key decision makers. Briefing sessions covered such timely topics as the Campaign for 100% Access and 0 Disparities, the National Health Service Corps reauthorization and the Healthy People 2010 Objectives for the Nation. Workshops provided a forum for participants to reflect critically on innovative models and stories of health-promoting partnerships and policy change. "Emerging Initiatives" sessions provided opportunities for participants to get involved in new CCPH projects and special interest groups. Site visits gave participants a first-hand look at successful partnerships between community-based agencies and Washington, DC area health professional schools. The conference also highlighted posters and workshops from the Partners in Caring and Community: Service-Learning in Nursing Education program. The PCC program, sponsored by the Helene Fuld Health Trust HSBC, Trustee, is working with teams of nursing faculty, nursing students and community agency partners from across the country as they develop service-learning partnerships in nursing education.

Nicole Lurie, deputy assistant secretary for health at the US Department of Health and Human Services, closed the conference with a rousing call for health professional schools to advance the Healthy People goals for the nation through partnerships with their communities. She suggested the Healthy People goals not only as an action agenda, but as an agenda for teaching health professional students how to promote health, prevent disease and be community leaders. She also highlighted the need to promote healthy living on college campuses, including smoke-free campuses, dealing with binge drinking teaching HIV prevention, and promoting mental health.

As you read these proceedings, we hope you will reflect on your roles and responsibilities as a change agent within your family, community, organization and profession. We hope you will consider the range of policy issues that affect the ability of communities and higher educational institutions to develop strong and sustainable partnerships that promote health. We invite you to join with CCPH in advocating for policies that will build healthier communities for us all. Our next conference, "HEALTH For All in 2010: Confirming Our Commitment, Taking Action" will take place May 5-8, 2001 in San Antonio, TX. We hope to see you there!

KEYNOTE PRESENTATIONS

ROZ LASKER
Center for the Advancement of Collaborative Strategies in Health, New York Academy of Medicine

What I'd like to do is kick off this tremendous conference by talking about three things. Why your passion and the work that you're doing are so critical to improving health and the functioning of the health system in this country. Why your work is so difficult, why so many partnerships are having problems surviving or thriving, and why so few collaborations have been mainstreamed. And what can be done to make the work you're doing easier.

There are essential reasons for people and organizations to work together around health. It's easiest to think about why this is true by thinking about the health system. Where is the *health* in our health system? For the last fifty years the focus of the health system in the United States hasn't been on health; it's been on the financing and delivery of medical care. Very little attention has been paid to the social, environmental, economic, or behavioral factors that affect health and well being, or to the population-based strategies that are needed to address these factors. And where is the *system* is in our health system? We have lots of component pieces out there, lots of different kinds of health professional organizations and services, but they don't operate together as a system. There's no infrastructure or policy environment to enable them to work together. And so each functions for the most part independently.

Why do we need better connections? Why can't we just go along in this fragmented way? One reason is that we're all trying to address extremely challenging health problems and many of these have prominent socio-economic and environmental components. Another reason is that we're all expected to do more with less and be accountable for results that are beyond our direct control. Because of this lack of connectivity in our health system, it's very difficult for people in organizations who have complementary resources and skills to support each other in achieving these goals. It's also very difficult for the broader community to participate in a meaningful way in health actions and decision making. The power of collaboration to improve health and the functioning of the health system lies in its ability to establish these missing but critical connections. By bringing people with diverse perspectives together, partnerships have the ability to identify new and better ways of thinking about problems. By linking complementary skills and resources, partnerships have the capacity to plan and carry out comprehensive actions that coordinate a variety of reinforcing services, programs, and systems.

I recognize that collaboration is damned tough. Why is it so challenging? It's very difficult for diverse people and organizations to work together.

You need the right group of partners and a process that makes good use of what everyone brings to the table. And if you want to sustain your work you need procedures and structures to support the partnership over time. The ability of partnerships to meet these challenges depends on factors related to partners and their relationships, partnerships as a whole, and the environment in which partnerships function.

Diversity is the most important source of strength for partnerships since it's what provides the complementary perspectives, resources, and skills that make collaboration work. At the same time diversity creates significant challenges. A successful partnership requires the building of mutual trust and respect and a willingness to share power and resources.

The ability of diverse people to work together also depends on attributes of the partnership as a whole. Leadership may be the most important. We need boundary-spanning leaders who understand and appreciate different perspectives and cultures and are comfortable taking risks and sharing ideas, resources, and power. A second factor is the administration and management—the backbone and glue that keep the partnership together. Also important is the governance and organizational structure, to establish the procedures that determine who is involved in partnership decision-making and how it does its work. Partnerships have the capacity to deal with these issues. But some issues are beyond the partnership's control, including how conducive the community is to the partnership's work and public and organizational policy barriers, many of which relate to funding and program requirements.

Is the current interest in collaboration justified even though we know there is a very high attrition rate among partnerships and it's been very difficult to document the effectiveness of partnerships in improving health? I would answer that with an overwhelming yes. And the reason is that I don't think it's possible for any person or organization to achieve health results that we care about working alone. Collaboration has the potential to create a real health system where the word "health" and the word "system" are both meaningful.

So what do we need to do if we're going to realize this potential of collaboration? What can make your

job easier? First, develop a way to assess how well partnerships function. Second, create tools to help partnerships broaden community participation in their work. Third, establish coalitions to develop and advocate for options addressing policy barriers. Fourth, develop better methodologies to assess the impact of partnership actions on the health of the community and the functioning of the health system. Fifth, pay more attention to leadership development and capacity building at the community level. And sixth, create the support networks that help us do our work much better.

NICOLE LURIE
U.S. Department of Health and Human Services

When I came to the Department of Health and Human Services about a year-and-a-half ago, we were in the process of putting together a set of goals for the country that also would be our priorities for the office. Our overall priorities are closely related to two important initiatives that we have going on, Healthy People 2010 and the Eliminating Disparities Initiative. The priorities are: creating a balanced community health system; eliminating disparities; and promoting global health.

A balanced community health system is built upon a bedrock of universal access to care, offers every child a healthy start in life, encourages and supports people to adopt healthy lifestyles, and makes mental health a priority. The health of individuals and the health of communities are inextricably linked. As we talk about issues like healthy lifestyles, we must recognize that the choices that people are able to make as individuals are very much conditioned and supported by the kinds of community environments—both physical and social—in which they live.

We also seek to eliminate health disparities that are associated with race, ethnicity, socio-economic status, urban versus rural residence, and sexual orientation. In regard, in particular, to health goals related to race and ethnicity, as a country we had different goals for different groups of people up until Healthy People 2010, and some were not as ambitious as others. This time it's a single goal for everybody, and that has really galvanized groups in the country in some very important ways.

Our global health priority recognizes that the health of this nation and the health of the entire world are inextricably linked and we're all interdependent upon one another.

Healthy People is a really thick document with about 467 objectives. Because it is so large, we decided to focus on ten leading health indicators, related to community and lifestyle issues, systems, and environment: physical activity; obesity; tobacco use; substance abuse; responsible sexual behavior; mental health; injury and violence; immunizations; environmental quality; and health care access. We try to get them in front of the American public on a regular basis, with the intent to use them very much the way we use the leading economic indicators.

We have a variety of strategies to address these problems. We're beginning to organize a series of forums to develop national plans for the leading health indicators. One of our biggest challenges is to develop a data infrastructure that lets us track where we're going, and to get data and information down to a state level and ultimately down to a community level. There's important data that comes from states and states have a fair amount of flexibility in choosing the type of data that they collect—we need to work with each state to shape the kinds of questions and optional modules that will help inform your communities.

Probably my other comments will be a little bit like preaching to the choir, but let me talk to you about my notions about what you ought to be doing. The first is to make these not only health professions issues and activities, but also campus- and community-wide issues. We have a huge amount to learn and departments like economics, anthropology, and sociology can contribute to this. As a working example, we've had a tremendous experience this year working with several universities' anthropology and ethnography departments as we've put together community HIV crisis response teams. The tools of ethnography have pointed us in some important directions.

With regards to health professions education in particular, I'm a big advocate of using Healthy People not only as an action agenda, but also as a teaching agenda. The objectives, leading health indicators, and health disparities issues provide important opportunities for education and service-learning.

A next piece of this clearly is seeking to increase diversity in the work force, and I don't just mean in medical or dental school, but across the board. We also need to start promoting healthy living on college campuses, which includes having smoke-free campuses, dealing with binge drinking and other issues, teaching HIV prevention, and promoting mental health.

I hope that universities will become increasingly open to requests from communities to partner with them around Healthy People goals. We all know that

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this is easier said than done. We also have to be careful to build these partnerships to be sustainable

I'd like to challenge you to help develop academic, promotion, and tenure standards for participation in community partnerships and service-learning.

Think about policy level activities not only on a federal level, but also on state and local levels. Invite your state legislatures and your local city council people to come join you in some of your activities to see the value added. Introduce them to communities over time. And we need to support students and faculty in tangible ways for doing this kind of work. and community partnerships. Start to develop some cross-walking and educational models to help build support for you and the notion universities, communities, cities, and states ought to be involved in these activities.

I look forward to continued partnerships and engaging with all of you as we move forward in this decade and beyond to achieve our goals.

COMMISSIONED PAPERS

Nine policy papers were commissioned for discussion at the conference. Brief descriptions of each paper are provided below. The complete text of each paper is available on the Community-Campus Partnerships for Health web site at http://futurehealth.ucsf.edu/ccph/guide.html#CommissionPaper. Edited and peer-reviewed versions of the papers will be published in a special issue of the journal Education for Health in summer 2001 (please check the journal's web site for details at www.the-network.org/efh. The papers and journal issue were made possible through the generous support of the Corporation for National Service and the W.K. Kellogg Foundation.

Integrating Student Learning Objectives with Community Service Objectives through Service-Learning in Health Professions Schools Curricula
Authored by Kate Cauley

This paper emphasizes the role of service-learning as a tool to aid health professions schools respond to significant trends such as the shift in health care services delivery toward more community-based settings. After a brief overview of the philosophy of service-learning, the author introduces a Service-Learning Protocol intended to guide faculty members in making the shift towards community-based education. Guidelines include establishing ongoing relationships between faculty and service sites; developing an orientation component which focuses on the community being served; and developing a reflection component which allows students to synthesize the service and learning aspects of their training. Strategies for implementing service-learning are discussed, such as providing continuing education credit and faculty mini-grants.

Working With Our Communities: Moving from Service to Scholarship in the Health Professions
Co-authored by Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson

This paper addresses a major concern raised by faculty involved in community-campus partnerships: the lack of institutional rewards and recognition for their community-based scholarship. After a brief review of the historical perspective on scholarship, this paper presents a model of community scholarship based on 3 components: learning that combines curricula with community needs; community-oriented research; and engagement in community-campus partnerships to improve health. Recommendations are made for how academic institutions can assess the quality and impact of faculty who are engaged in community-based teaching, research and service. Examples of national and institutional efforts to recognize and reward community-based scholars are presented as models.

Promoting Collaborations that Improve Health
Authored by Roz Lasker

This paper explores the concept of collaboration, particularly in relation to community partnerships. Recognizing that the promotion of health and health care cannot effectively be accomplished by one person or group, collaboration is recognized as a powerful method of connecting people and groups to improve health. An extensive literature review reveals significant factors that can influence the success rate of collaborations such as trust, power differentials, governance, and public and organizational policies. Recommendations are made for managing these factors. An appendix of resources is also included.

Public Policies to Promote Community-Based and Interdisciplinary Health Professions Education
Co-authored by Janet Coffman and Tim Henderson

There is currently a shortage of health professionals who have both the necessary clinical training and

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competencies to work effectively in non-hospital environments. This paper begins with the premise that community-based and interdisciplinary learning play a significant role in addressing this concern. The federal government and the state each plays a role in providing financial support to the "public need" of health professions education, yet fiscal constraints are a major barrier to the expansion of community-based and interdisciplinary health professions education. Although there have been recent improvements at the federal level, with the Graduate Medical Education consortia demonstration project, and statewide, with the use of state general fund appropriations, this paper provides recommendations on how to further expand public support for community-based and interdisciplinary health professions education. An appendix includes contact information for the U.S. Bureau of Health Professions and state Medicaid agencies.

Building Partnerships: Stronger Communities and Stronger Universities
Authored by Loomis Mayfield

The *engaged university* is one that supports research and teaching to address community needs; functions on an interdisciplinary level; and promotes community-university partnerships. This paper examines the historical roots of the *engaged university* concept, and discusses two models that support this concept: community-based research and service-learning. Recommendations are made for sustaining and institutionalizing the tenets of engagement and changing rewards systems to promote faculty involvement in the community. An appendix includes information on government resources, private foundations, academic and planning organizations, university/community partnerships, service-learning, and selected higher education mission statements.

Community-Based Participatory Research: Engaging Communities as Partners in Health Research
Co-authored by Barbara Israel, Amy J. Schulz, Edith A. Parker, Adam B. Becker

This paper explores the principles of and rationale for community-based participatory research (CBPR), citing its collaborative nature between community members and researchers in all aspects of the research process. After reviewing the challenges and barriers to utilizing CBPR, the authors present policy recommendations designed to further its use, particularly encouraging the commitment to communities as equal partners. An appendix includes

resources for community-based participatory research.

Racial and Ethnic Disparities in Health Status: Framing an Agenda for Public Health and Community Mobilization
Authored by Gerard Fergerson

After reviewing the historical context of gathering information on race and ethnic disparities in health, this paper provides an agenda to address and change these health disparities through strategies involving social, cultural, and economic factors. Pointing to areas of improvement, this paper looks to improved social justice eradicating discriminatory policies, encouraged health professions development and training with support to work in underserved areas, improved insurance coverage and policies, policy leadership development among health care providers so they can act as advocates, and advanced interdisciplinary research which is inclusive of all factors which affect disparities in health.

Social Change through Student Leadership and Activism
Co-authored by David Grande and Sindhu Srinivas

Citing the emerging need for leaders in the health professions, this paper explores the potential of health professions students as leaders, and advocates for individual, institutional, and organizational support of student leadership and activism. After reviewing key components needed in the health professions curriculum to foster leadership and activism skills – such as strategic planning and public speaking, the authors provide examples of successful models of student leadership development. An appendix includes websites and publications about leadership.

Advocating for Community-Campus Partnerships for Health
Authored by Charles Huntington

This paper provides a clear, easy-to-understand description of the political processes involved in advocating for health promoting community-campus partnerships. Beginning with a review of how a bill becomes a law, the author examines different advocacy strategies, including visiting legislators, authoring position papers, communicating with the media, and raising funds. Particular attention is paid to advocacy strategies that can be used by associations like Community-Campus Partnerships for Health. Recommendations are provided as an agenda for action.

CONFERENCE POLICY RECOMMENDATIONS

Prior to the conference, participants were asked to review one of the commissioned papers described above. During the conference, participants met twice in small group Policy Action Teams corresponding to the theme of the paper they reviewed. Led by experienced facilitators, the first meeting focused on the policy issues and options presented in the paper as a starting point for discussion. During the second meeting, participants reflected on their experiences during the conference and formulated key findings and recommendations. Below is a summary of these policy recommendations. Highlights were presented by CCPH board chair Gretchen Kinder during the closing conference session. Achieving these policy recommendations will require the efforts of many individuals and organizations. Over the next 6-12 months, the Community-Campus Partnerships for Health board of directors will shape the ideas and recommendations from the conference into a set of policy priorities for CCPH. We encourage your comments the policy recommendations below. Please send these to CCPH's executive director, Sarena D. Seifer, at sarena@u.washington.edu or by phone at 206-616-4305.

General Policy Recommendations

Advocate for policies at the federal, state, local and institutional levels in support of community-campus partnerships (i.e., service-learning, community-based participatory research)

Advocate that federal, state and local funding be used to support community-campus partnerships and to promote community-based and interdisciplinary health professions education

Recommendations for Academic Institutional Policy

Adopt mission statement that explicitly supports community engagement and its connection to teaching, research and service

Adopt promotion and tenure criteria and processes that recognize and reward faculty for community scholarship expand their assessment of reputable journals in which community scholarship can be credibly published. Ensure that faculty members receive credit for the role they play in grants submitted by community-based organizations, and their involvement in training and technical assistance to community partners.

Adopt job performance criteria and processes that recognize and reward staff for community partnerships

Treat community participants as equal partners, with access and input on important issues like the budget.

Offer incentives for community participation, such as stipends, travel money, adjunct faculty status. Include service-learning as a core component of health professions education

Significantly involve students in decision-making Student-driven projects should be supported by their institutions in a way that fosters student leadership. Support includes but is not limited to:
- Funding a service-learning coordinator
- Utilizing senior level students as mentors and teachers
- Faculty development programs
- Leadership development for students through formal program
- Ensuring the appropriateness of student projects with the community

Establish policies regarding the capacity of community-based organizations to have fiduciary responsibility for grant or university's fiduciary responsibility to community partners.

Establish policies regarding allocation of indirect funds to the community or the partnership.

Adopt principles of partnership and principles of community-based participatory research

Affirm and support faculty involved in SL, especially as programs are just getting started, through such mechanisms as continuing education credit for faculty development seminars and faculty mini-grants

Recommendations for Community Agency Policy

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

Identify collaboration as a clear part of job descriptions

Recommendations for Funder Policy

Use grant making criteria to make the community an equal partner in partnerships (i.e., insist on community participation in the budget process, direct funds to community organizations)
Fund the dissemination of models that are developed through their funding (i.e., the dissemination grants that CNS recently offered for funded service-learning projects)

Provide sufficient resources for an evaluation component right from the start of the project (process and outcome evaluation).

Make greater use of one-year planning grants that focus on creating the relationships and infrastructure necessary for developing and maintaining long-term community-campus partnerships, especially as part of a longer term funding initiative with up to 5 years of additional funding.

Provide long-range funding for community-based participatory research projects that focus on physical, mental and social well-being, as well as on enhancing understanding of and addressing the biomedical, social, economic, cultural, behavioral, historical and political determinants of health and disease. At least 10-year efforts are needed in order to effect changes in these broad scale determinants of health.

Recognize that the burden for change can not be limited to residents of marginalized communities (community level interventions) but that these initiatives need to include specific links to broader policy change efforts.

Support initial and continued funding for the infrastructure necessary for developing and maintaining community-campus partnerships. These funds should not be project-specific or project-related.

Fund community-based organizations directly as well as universities. Require, as appropriate, that community-based partners be the direct recipient and fiduciary of community-campus partnerships grants.

Fund comprehensive approaches that extend beyond categorical perspectives and traditional research designs (i.e., recognize diverse methodologies and the validity of multiple approaches to research)

Provide technical assistance and pre-application consultation for organizations that have little experience completing application forms

Incorporate principles of community-campus partnerships in grant request for proposals

Review criteria for judging applications and the persons involved in the review process need to be consistent with the principles themselves (i.e., including academicians with expertise in community-based participatory research and community members who have been involved in CBPR endeavors.)

Provide an equal number of planning grants and subsequent intervention funding (often incongruent)

Recommendations for federal Bureau of Health Professions Policy

Increase funding for Area Health Education Centers and other Bureau of Health Professions grant programs that support community-based and interdisciplinary education and for programs aimed at increasing the number of health professionals from disadvantaged backgrounds

Ensure that methodologies used to award discipline-specific Title VII and Title VIII grants provide incentives for health professions schools to provide training in community-based sites

Provide health professions schools with greater flexibility in implementing community-based and interdisciplinary educational initiatives supported by BHPR grants, as well as initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds

Expand eligibility for BHPR grants, especially for allied health disciplines and community-based organizations

Decrease grant periods to permit funding for a greater number of new initiatives

Fund leadership development programs based in educational institutions and non-governmental organizations. A demonstration project in a subset of schools would offer an opportunity to evaluate specific curricula developed in diverse settings.

Consider giving block grants to replace or supplement categorical funding.

Recommendations for federal
Bureau of Primary Health Care Policy

Encourage community health centers, migrant health centers and other Bureau of Primary Health Care grantees to participate in health professions education

Educate grantees about revenue streams for community-based health professions education
Continue efforts to enhance partnerships between the National Health Service Corps and health professional schools

Consider options for improving coordination of educational activities and care delivery at National Health Service Corps sites

Consider giving block grants to replace or supplement categorical funding.

Recommendations for federal Health Resources and Services Administration Policy

Fund partnerships through the new Office of Community Access Programs that support health professions education as well as delivery of health care services to underserved populations.

Recommendations for federal Health Care Financing Administration Policy

Expand the range of community-based sites that are eligible for direct medical education reimbursement (where costs of community-based training are not covered by teaching hospitals)

Develop a methodology for reimbursement of community-based sites for indirect medical education. Once a methodology is developed, amend the Medicare statute to permit reimbursement of community-based sites that incur training costs for both direct and indirect medical education.

Require or encourage states to: link Medicaid Graduate Medical Education payments to performance, specifying that a significant portion of medical school and residency training occur in out-of-hospital settings known to be in short supply of health professionals or are related to achieving better service for Medicaid recipients and other underserved or uninsured populations.

Expand eligibility for and distribution of Medicaid Graduate Medical Education payments to certain out-of-hospital providers of graduate medical, nursing and allied health education qualified to directly receive these payments.

Recommendations for federal
National Institute of Health

Create National Institute of Community Health

Recommendations for State Policy

Target or weight appropriations to state initiatives aimed at increasing the number of health professionals from disadvantaged backgrounds (i.e., Governors' schools/other K-12 enrichment programs.)
Target or weight appropriations to undergraduate and graduate training programs that stress community-based and multidisciplinary education

Develop incentives to expand community-based and interdisciplinary training by using general fund appropriations to institute a requirement (i.e., a third year family practice clerkship for medical students) that stresses significant experience in out-of-hospital community settings.

Mandate rural and urban underserved service-learning learning experiences in state health professional schools

Use general fund appropriations to increase per-capita spending for training in primary care and public health

Use general fund appropriations to locate more primary care residency and graduate nursing training in community-based underserved areas

Institute an inner city or rural rotation option that stresses significant experience in out-of-hospital community settings for all graduate health professions students

ACKNOWLEDGEMENTS

We thank the following individuals and organizations for their support of CCPH and the conference:

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