

## TOWN AND GOWN COLLABORATION: A PRACTICAL PERSPECTIVE

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## INTRODUCTION

Federal, state, and local public health entities have a mandate and responsibility to improve the health status of their service populations, not only by facilitating access to health care services, but also by implementing sound public health policies designed to protect the health status of those populations. While many people equate the function of public health entities with medical health care delivery to indigent populations, the many services public health departments provide are predicated on the 10 essential public health services listed in Table 1.

In the US, the federal government plays a significant role as one of the primary funding sources for health initiatives, conducting health surveillance activities, and providing training opportunities for all public health sectors. State efforts are generally coordinated through local county health departments and tend to focus on mandated services which tend to target economically challenged and indigent populations (Marin and Burhansstipanov, 1995; Travers, 1997). However, economic and political considerations as well as legislative mandates have affected county health departments' ability to achieve systematic change among the groups they serve. In fact county health departments rely on their ability to partner with local health partners in order to effectively deliver their programs.

Academic institutions have historically provided educational opportunities for individuals who will soon join the workforce in their respective fields. Institutions of higher learning have also been leaders in fostering scientific inquiry and disseminating results of research endeavors, but many have

Essential Service #1	Monitor health status to identify community health problems
Essential Service #2	Diagnose and investigate health problems and health hazards in the community
Essential Service #3	Inform, educate, and empower people about health issues
Essential Service #4	Mobilize community partnerships to identify and solve health problems
Essential Service #5	Develop policies and plans that support individual and community health efforts
Essential Service #6	Enforce laws and regulations that protect health and ensure safety
Essential Service #7	Link people to needed personal health services and assure the provision of health care when otherwise unavailable
Essential Service #8	Assure a competent public health and personal health care workforce
Essential Service #9	Evaluate effectiveness, accessibility, and quality of personal and population-based health services
Essential Service #10	Research for new insights and innovative solutions to health problems
Source: Council on Linkages, (n.d.)	

suffered from the “ivory tower” syndrome and in many cases failed to coordinate efforts with practitioners who could translate research findings into practice. In many instances academic institutions have developed and implemented interventions designed to enhance the health status of target populations, however, these efforts are not

germane to their function and tend to be sporadic. The lack of coordination among health departments and academia has resulted in gaps in knowledge and service delivery most often affecting those who can least afford to be left behind.

In the last few years increasing numbers of government entities and academic institutions have acknowledged their symbiotic relationship and have sought to build bridges among them. This realization has led to an increase in the number of town and gown partnerships with the goal of pooling resources in efforts to enhance service learning opportunities and engage in applied research (Flick, Reese, Rogers, Fletcher, and Sonn, 1994; Greenberg, Howard, and Desmond, 2003).

## NATIONAL EFFORTS

National initiatives designed to improve the health status and to eliminate health disparities among US population groups can be explored by examining four documents detailing federal efforts in these areas. The report, *Healthy People: the Surgeon General's Report on Health Promotion and Disease Prevention* (1979), was the first comprehensive national epidemiological health assessment and provided the bases for understanding morbidity and mortality among US populations. This document was the basis for a powerful and enduring paradigm shift which focused health care delivery from treating chronic diseases to preventing behaviorally related diseases as the leading causes of death. Not surprisingly, a second document, *Promoting Health/Preventing Disease: Objectives for the Nation* (1980) committed federal efforts to disease prevention and health promotion. This report outlined specific objectives to be attained within the decade following the report's release.

The third report, *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* (1990) provided the basis for innovative initiatives, which sought to address the health concerns of the country by combining treatment and prevention. *Healthy People 2000* provided over 600

specific objectives to be attained by the turn of the century. The progress made toward achieving the health goals indicated in *Healthy People 2000* illustrates the need for inter-disciplinary collaboration (National Center for Health Statistics, 2002).

*Healthy People 2010* is the result of collaborative efforts by the Healthy People Consortium which consists of 350 national organizations and 250 state public health, mental health, substance abuse, and environmental agencies. *Healthy People 2010* is divided into 28 focus areas grouped into 10 leading health indicators (see Table 2) which were chosen because they “reflect the major public health concerns in the United States” (USDHHS, 2000) and together they represent significant health issues affecting the US population.

Table 2	
Healthy People 2010 Leading Health Indicators	
1	Physical Activity
2	Overweight and obesity
3	Tobacco Use
4	Substance Abuse
5	Responsible Sexual Behavior
6	Mental Health
7	Injury and Violence
8	Environmental Quality
9	Immunization
10	Access to Health Care

## CAMPUS-COMMUNITY PARTNERSHIPS

As indicated above, public health efforts undertaken by government entities have not always yielded optimal results. Similarly, university efforts, with their emphasis on academic inquiry (basic and applied), have also not yielded expected results (Browstein, 1998; Gilmore and Cambell, 1996). In fact, disparate and sometimes competition for resources have limited cooperation between these entities.

A second factor contributing to the lack of cooperation between public health entities and academic institutions has been the lack of a well-integrated training and practice relationship in

schools of public health. While medical schools have successfully created an integrated academic/research/patient care environment, public health schools, due to their focus on research, have lacked an integrated curriculum based on practice-based training. This practice is changing and currently efforts are underway to increase collaborative opportunities among those institutions.

In 1998 the US Department of Health and Human Services launched its “Initiative to Eliminate Racial and Ethnic Disparities in Health.” This initiative calls for campus-community-public health partnerships. Given this emphasis, it is not surprising, that in 2000, the CDC and the Association of State and Territorial Directors of Health Promotion and Public Health Education produced a report entitled *Building Capacity for Health Promotion Programs in Minority-Serving Institutions*. The purpose of this document was “to spark efforts to foster closer ties and collaboration among colleges and universities, public health communities, and public health organizations and agencies” (Goldman and Schmaltz, 2002, p. 114). One of the enduring results of these efforts is the implementation of paid internship opportunities funded by the Centers of Disease Control and Prevention and administered by the Directors of Health Promotion and Education which are offered to students enrolled in Minority Serving Institutions.

The Centers for Disease Control and Prevention’s REACH demonstration grants are designed to advance community-driven strategies to be implemented in collaboration with public health entities with academic support; the Agency for Healthcare Research and Quality EXCEED grants are designed to promote research on the causes of health disparities, and capacity building; and the Health Resources and Services Administration’s Health Disparities collaborative in cardiovascular health and diabetes require collaboration between public health and academic institutions. The National Heart, Lung, and Blood Institute have also reported success for its “*Salud para su Corazón*” [Health for your Heart] program in partnership with

community agencies with evaluation generally conducted by selected academic institutions.

The federal government is not the only entity actively promoting campus-community-public health partnerships. Private foundations have funded a number of partnerships between health care providers and community organizations with the goal of improved access to health care, increased access to prenatal services, and reduced health care costs (Brownstein, 1998; Bermejo and Bekui 1993; Minkler, 2000; Witmer, 2000) among others.

True partnerships between the public sector and academic institutions involve the coordination and the integration of resources to improve outcomes (Hooper-Briar and Lawson, 1994; Jacobs, 1995; Pappa, Rector, and Stone, 1998; Soothill, Mackay, and Webb, 1995). While much has been written regarding collaborative efforts between academia, the public health sector, and community-based organizations (Bruce, 2000; Butterfoss, Goodman, and Wandersman, 1993; Green, 2001; Maguire-Meservey and Richards, 1996; Schmitz, 2000) few models exist that show successful partnerships between academic and non-academic institutions (Gorosh, Peters, Andresen, Cagan, Iyer, and Lulkin, 2001). Even successful efforts (Eisinger and Senturia, 2001; Phelan et al, 2003; Weech-Maldonado and Merrill, 2004) have not been widely replicated by others in the field.

Effective partnerships generate numerous benefits to both groups. For universities, a partnership can facilitate the enrichment of academic programs by providing real life learning opportunities, while public health departments and communities can benefit by gaining access to information sources and technologies that might otherwise not be available to them (Freeman, 2003).

The literature has identified a number of factors, which have prevented the implementation of true campus-community-public health collaborative efforts. Perceived differences in agendas (education and research vis-à-vis service delivery), time

commitments, budgetary factors, and the “Ivory Tower Syndrome” have affected campus-community-public health partnerships. Fortunately, barriers are disappearing and a number of programs are now being implemented (Green and Mercer, 2001; Krieger, Allen, Cheadle, Ciske, Schier, Senturia, and Sullivan, 2002; Roussos and Fawcett, 2000). This is due in part to the realization that interdisciplinary collaboration between campus, community, and public health agencies is paramount to successful and effective health promotion and prevention programs (Bermejo and Beku, 1993; Butterfoss, Goodman, and Wandersman, 1983; Gillies, 1998; Health Care Forum, 2000; MacQueen et al, 2001; Pinzon-Perez & Gonzalez, 2007; Rains and Ray, 1995).

## THE CENTRAL CALIFORNIA REGION

The Central San Joaquin Valley in California represents a microcosm of the cultural diversity present in California. In addition to being one of the largest and mostly rural areas in the nation, the region is also one of the most culturally diverse in the nation, is home to a large number of first generation immigrants, hosts more than 70 ethnicities, and speaks over 100 languages.

As might be expected this highly diverse population presents some unique health characteristics and challenges to public health officials who seek to reduce barriers to access to care, eliminate health disparities and provide culturally competent services. Shortages in health workers, particularly public health nurses and other specialists, continues to plague the region. The dearth of services, the need for unique approaches to address the needs of the region, and the leadership exhibited by interested parties, has lead to one effort to a support of ongoing regional public health planning and response in a coordinated effort. The white paper describes the development of the Central California Public Health Partnership shares lesson learned from its first few years.

## THE CENTRAL CALIFORNIA PUBLIC HEALTH PARTNERHSIP

The Central California Public Health Partnership (CCPHP) represents a regional approach dedicated to reducing health disparities in the Central California area. The Mission Statement of the CCPHP indicates that it seeks to “...provide a neutral forum for, and facilitate collaborative efforts by its members, in the exchange of information, professional training, identification of local resources, regional planning, and related activities to address the needs of the communities served and the local healthcare staffs which serve them.” As such, the CCPHP seeks to take timely and coordinated action on issues affecting the region while taking advantage not only of economies of scale, but, in addition, mobilization of community based resources on a regional basis.

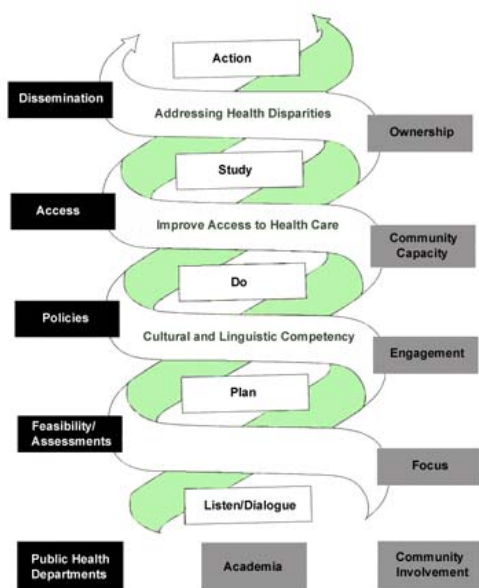
The CCPHP is a formal collaborative effort established between California State University Fresno and the Fresno County Community Health Department, the Kern County Department of Public Health, the Kings County Department of Public Health, the Madera County Public Health Department, the Merced County Public Health Department, and the Tulare County Health and Human Services Agency. Together these entities represent the six counties in the Central Valley with a total population of 2.3 million people. Since its inception the CCPHP has expanded its membership to include the counties of San Joaquin and Stanislaus.

With funding from The California Endowment and the Stewart Foundation, the Central California Public Health Partnership initiated during its few years of existence a number of activities designed to address health issues affecting the Central California population. Those efforts have been directly related to three of the 28 *Healthy People 2010* Focus areas (access to quality health care services, educational and community-based programs, and public health infrastructure).

The foundation for the CCPHP’s collaborative efforts has been a commitment to eradicating health disparities and the notion that political borders must be broached for the purpose of achieving public health success. Further, an integral part of this regional process, and the acknowledgement of all the partners, is to include the broadest possible base of stakeholders not only as providers of input, but also as sources of coordinated action.

Concurrent with its internal development, the CCPHP has commissioned two needs assessments to serve as the framework of its efforts. The first needs assessment was designed to identify the salient health needs of the Central California area. Data from this assessment was, as will be discussed below, utilized as the basis for two extraordinarily well attended multicultural public health conferences.

The second needs assessment was designed to provide the basis for strategic planning. The need to enhance regional approaches was among the key findings of this needs assessment. As a result, the Central California Public Health Partnership has developed a working model (Figure 1) for addressing the regional health needs of the Central San Joaquin Valley.



One of the first regional activities sponsored by the CCPHP was the development of the Central California Public Health Training Academy. This entity was formed to serve the continuing education needs of the county health departments and to provide technical assistance to community based organizations. Funding from each of the partnering counties led to the development of curricula in the areas of public health, biostatistics, and cultural competence. Currently, the Public Health Training Academy offers 14 distinct courses targeting professional and entry-level staff. While not all counties have used the services, the entity exists to serve their needs. Additional information about the Public Health Training Academy may be found at <http://www.csufresno.edu/publichealth>.

In January of 2002 the CCPHP sponsored the first Multi-Cultural Public Health Conference in the City of Visalia, California. The purpose of this conference was to explore issues related to improving multicultural community health care in the Central Valley. Conference sessions addressed culturally-sensitive health care delivery methods with an emphasis in cultural competent education and health care worker skill enhancement. Over 400 people participated in the one-day event exceeding the most optimistic projections. One of the sessions at this event resulted in the advancement of the development of the Central Valley Health Policy Institute (CVHPI). For more information about the CVHPI visit its website at [www.cvhpi.org](http://www.cvhpi.org).

A second public health conference was held in 2003, this event attracted over 600 professionals and community members. Conference participants had an opportunity to hear leading experts in health issues affecting the central valley as well as develop skills related to cultural competence and service delivery.

The CCPHTA also identified the need to address the increasing rates of overweight and obesity in the region. Funding from The California Endowment and most recently the Robert Wood Johnson Foundation has resulted in the development of a



regional obesity prevention program which is started to gather national and international attention. For more information about these activities visit [www.csufresno.edu/ccchhs/institutes\\_programs/ccrop/index.shtml](http://www.csufresno.edu/ccchhs/institutes_programs/ccrop/index.shtml).

Internal capacity building has been an on-going effort of the CCPHP. Partners have attended annual retreats which have also been used for strategic planning. During regular meetings participants discuss current issues and explore venues for future collaboration.

## DISCUSSION

The establishment and success of the Central California Public Health Partnership is the result of serious commitment to addressing health care issues in the Central Valley from a regional perspective. The success to this date has required a great deal of political commitment by 1) necessitating the development of a structure; 2) requiring the allocation of resources (both internal and external); 3) by requiring flexibility on the part of all involved; and 4) by developing the interest in the value of regional assessment and action beyond political and role determined boundaries. One of the factors facilitating the successful implementation of this campus-community partnership has been the willingness of public health departments to reach to the “ivory tower” and the university’s commitment to training public health practitioners while developing curricula designed to enhance the existing public health workforce.

One of the first successes of the CCPHP was bridging the gap between theory and practice. Since its foundation, CCPHP partners have developed a deeper understanding of their roles and functions, thereby decreasing the skepticism that is often found between academicians and practitioners. County health departments have become more involved in academic issues and faculty and staff are more aware of health issue and the services as well as the real-time issues affecting the county health departments. The continuing capacity building by the partners has

resulted in requests for neighboring counties to join the CCPHP.

It has been said that the real challenge in a collaborative effort between academia and communities is not in forming a partnership, but rather in maintaining it. The CCPHP draws from large and small counties in the Central California region as well as the largest public University. The diversity in philosophies and resources has resulted in power issues, communication issues, and questions about whose agenda is being pursued. Structural differences in the governance of the CCPHP members have presented opportunities for clarifying roles and responsibilities for each of the partners. Similarly, issues of shared governance have been addressed during the development phase of this emerging organization. One tool employed to achieve this goal has been the annual review of the organization’s by-laws. The CCPHP has benefited and grown by applying the principles suggested by the Community-Campus Partnership for Health which include mutual trust, open communication, and patience.

In the area of resource development, the creation of a new entity has required an investment of time and resources by all involved. Each of the partners has invested many hours and staff resources to insure the survival of the organization. The partners have contributed to the cost of developing training curricula and the university has developed training opportunities and delivered them at-cost. Similarly, each of the partners has agreed to share decision-making and expand their vision and mission to include a regional approach. This last issue deserves some further consideration.

While the university has as its mission to serve a broad regional basis, that is not the case of local health departments. Members of the CCPHP have collaborated and shared resources due to their realization that effective public health programs must be collaborative in nature to address health issues which do not respect political boundaries.

CCPHPP members also realize that by sharing resources they can have a greater impact on public health issues than if they attempted to address them alone.

Finally, external funding has been obtained to finance some of the CCPHP efforts. These resources have been used to cover expenses associated with those events and none of the participants have increased their operating budgets as a result of those events.

Finally, lessons have also been learned in the area dealing with a desire to have a regional approach to issues. Program development and implementation has been affected by a number of issues including distance. The geographic area covered by the CCPHP expands over 24,000 square miles making it impossible for members to hold frequent face-to-face meetings. Currently, the CCPHP meets approximately every two months with about 85% of the members attending on a regular basis. Not surprising the counties farthest away are less likely to attend all meetings. In an effort to decrease distance as a barrier for participation, meetings are rotated among all member counties. The CCPHP also utilizes electronic media to increase communication among the partners.

## CONCLUSIONS

As indicate before, individual efforts by government entities, academia, and community groups to individually address health disparities among population groups have yielded mixed results. Success has been influenced by changing demographics, the need for culturally and linguistic competency, growing expenditures at a time of decreasing budgets, improved technology and the technological divide, workforce shortages, and misdistribution of resources.

To-date the CCPHP has sought to promote programs which will achieve regional results based on Healthy People 2010 principles. Results from the implemented programs indicate that despite growing pains, there has been an increase in shared

perspectives between academia, community, and public health departments. Similarly, there has been a development of common interests as well as joint action in regional activities in addition to an enhancement of communication across cultural groups. These early results encourage CCPHP members to forge ahead and work through some of the issues described above.

As regional coordination and planning mechanisms are gaining acceptance on issues involving economic development, transportation, land use and air quality in the Central Valley, there is an impetus also for collaboration on regional community health planning to meet the needs of the rapidly growing and culturally diverse population. The Central California Public Health Partnership represents efforts by public health officials to work with academic institutions in their efforts to address the needs of their service populations. The CCPHP was started as a means of fulfilling six counties' goals of protecting and enhancing the health status of the population they serve, implementing measures designed to prevent disease, and coordinating with local and national public health entities in the collection, dissemination, and application of surveillance data. This campus-community-public health partnership is reviewing its objectives to better achieve those goals. CCPHP members realize, support, and promote the strengthening of campus-community partnerships to increase program implementation, foster organizational development, and influence systematic societal change.

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