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Integrating Healthy Communities Concepts into Health Professions Training

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SYNOPSIS

To meet the demands of the evolving health care system, health professionals need skills that will allow them to anticipate and respond to the broader social determinants of health. To ensure that these skills are learned during their professional education and training, health professions institutions must look beyond the medical model of caring for communities. Models in Seattle and Roanoke demonstrate the curricular changes necessary to ensure that students in the health professions are adequately prepared to contribute to building Healthy Communities in the 21st century. In addition to these models, a number of resources are available to help promote the needed institutional changes.

INTRODUCTION

Futurists tell us that we need to anticipate the future or we will forever be developing solutions to yesterday's problems. Similarly, according to a recent Pew Health Professions Commission report, "most of the nation's educational programs remain oriented to prepare individuals for yesterday's health care system."[1] We are not doing an adequate job of anticipating the future and aligning curricula with the needs and demands of the health care system as we expect it to evolve. To correct this shortcoming, the Commission reviewed the list of competencies for health care professionals' education and training that it had proposed in 1991 and updated it to reflect the characteristics and needs of the health care system of the early 21st century.[1] Several of these competencies speak directly to the skills and awareness health care professionals need if they are going to contribute to building Healthy Communities:

- Incorporating the multiple determinants of health into clinical care.
- Improving access to health care for those with unmet health needs.
- Partnering with communities in health care decisions.
- Rigorously practicing preventive care.
- Integrating population-based care and services into practice.
- Working in interdisciplinary teams.
- Ensuring that care balances individual, professional, system, and societal needs.
- Being advocates for public policy that promotes and protects the health of the public.

These competencies are heavily focused on building health professionals' skills in community health improvement activities so that they can both anticipate and respond to the broader social determinants of health.

In order for health professionals, particularly clinicians, to contribute to the work of Healthy Communities, they must understand the profound difference between what is commonly referred to as "community health" and what is meant by the term "healthy communities." Many health professionals cite their engagement in community-based practice, work for the underserved, and public health and prevention activities as evidence of their contribution to a Healthy Communities process. Many of these professionals are working from a "community health" paradigm, which reflects their understanding that health is the product of a changing mix of factors that interact over time. While this marks a major change from the predominant reductionistic clinical orientation of a few decades ago—and reflects an understanding of the "new morbidities" such as teen pregnancies that are behaviorally driven and largely socially determined—it does not necessarily reflect a Healthy Communities orientation.

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As articulated by the World Health Organization for its Healthy Cities initiatives and shaped by cities and towns in this country and worldwide, the concept of Healthy Communities is grounded in social epidemiology, with community empowerment and grassroots activism at its core. In contrast to the professional, mostly hierarchical, and top-down "community health" model, it emphasizes a multi-sectoral approach to identifying and changing the social and environmental factors that have a negative impact on a community's health and well-being. Changing the power structure of a community to ensure greater egalitarianism may be both a process and an outcome of a Healthy Communities initiative. This is a markedly different set of processes and outcomes from those referred to by clinicians when they use the term *community health*.

TWO MODELS

Here are two examples of training programs that are intentionally integrating Healthy Communities concepts and competencies into their courses and other educational activities.

Longitudinal residency curriculum. On July 1, 1999, the Carilion-Roanoke Family Practice Residency in Roanoke, Virginia., launched a longitudinal community medicine curriculum based on the grounding principles of Healthy Communities. The new curriculum is based on the philosophy that health embodies the well-being of the patient, the family, and the community and that collaboration among the appropriate stakeholders is key to improving health. The program focuses on the skills needed to be effective collaborators and promotes civic responsibility among the family practice residents who elect to participate in the program.

The program emphasizes experience as a key to learning. For example, residents are required to apply for Medicaid and Temporary Aid to Needy Families in order to learn about how social services are organized and to understand the experiences of clinic patients. In addition, they are required to engage in dialogue with the local community in order to learn about community strengths, concerns, and priorities. Based on the interest of students and the community, residents engage in existing community programs as both workers and learners.

A family practice physician and a nurse practitioner at the residency program spearheaded the development of the curriculum over a two-year period. This involved a significant amount of work in sharing the Healthy Communities philosophy in both the institution and the community. Shifting the institutional definition of health to one that incorporates Healthy Communities concepts, in contrast to simply thinking of health as the absence of disease, made up a large portion of the internal education work. In addition, the residency program needed to be oriented to the resources and interests of the community as a means of setting the groundwork for meaningful community engagement. The program did a significant amount of work with the community to build trust and undo misconceptions about the residency program and its family practice center, which had supplanted a proposed community health center.

While the success of the program has yet to be measured, the number of physicians who initiate or work with community partnerships will be tracked as an indicator of success. Methods of measuring the application of collaborative skills in clinical care and decision-making have not been worked out yet. In addition to teaching clinical and Healthy Communities skills to residents, it is anticipated that the work with the community will set the stage for future collaboration to improve the overall health of the community and its people in all dimensions, not simply medical or public health.

Interdisciplinary graduate course. "Community Development for Health" is an interdisciplinary graduate course taught by Public Health faculty members at the University of Washington in Seattle. The course uses a combination of didactic and experiential learning to meet the following goals:

- Understand the concept of community and the field of community development.
- Meet successful community developers in the health field.
- Define community and recognize its structure in a broad range of settings and situations.
- Learn about, develop, and demonstrate skills in community development for health.
- Develop cultural competence and recognize the importance of culture in working with communities.
- Embrace and value community activism—as students, working professionals, and members of neighborhoods and society.

Graduate students in public affairs, nursing, health services/health administration, and public health participated in the course during the winter 1999–2000 quarter. Students chose a study community, and each week they prepared a practical tool for use in a real or theoretical Healthy Communities project. Assignments included drafting a press release, writing a meeting agenda, designing a community survey instrument and plan of administration, developing an intervention campaign, writing a door-to-door or telephone solicitation script, constructing a map of the community's power structure, writing a project budget, and developing an intervention evaluation plan. Weekly class sessions featured community experts who discussed topics ranging from power and leadership to administration and finance to community organizing. The course has been awarded permanent status, largely due to positive student feedback and course evaluations.

This course is the first of its kind at the University of Washington in Seattle. While university faculty and staff members provided strong support for the idea of such a class, practical support has been more difficult to obtain. The interdisciplinary nature of the course made it difficult to find a niche within the institution. Recruitment of students for the course was difficult at first because it was initiated as an elective health seminar, not as a permanent course or part of a degree sequence. Enrollment appears to have been largely due to student word of mouth rather than faculty or advisor recommendations. Recently, the course has been awarded permanent status, largely due to positive student feedback and course evaluations.

FOCUS ON THE HEALTH PROFESSIONS

The health of communities is not just the responsibility of medical and public health professionals. Indeed, the role of economists, environmental scientists, architects, urban planners, social workers, community organizers, educators, religious leaders, engineers, artists, and political scientists are all integral to creating and sustaining healthy communities. However, the health professions deserve special attention for several reasons. The first of these reasons is the misperception on the part of clinicians and policy makers that creating healthier communities is solely the responsibility of medical and public health professionals. Second, some medical and public health professionals already think they are "doing it" when working from a community health orientation, yet they are missing the profound importance of grassroots work and community empowerment. Without training and experience in the Healthy Communities approach, they run the risk of becoming frustrated with their under-

standing of the process. They may give up and return to the relative security of their clinical environment. Third, if we think that simply training more clinicians to meet patients' needs will improve health status, we are committing ourselves to a perpetual game of catch-up, running and still losing ground. Given the aging of the population, advances in treating diseases, and patients' expectations for successful treatment, we must orient the system to wellness, health, and prevention, with our communities functioning as reinforcers and enhancers. Fourth, the "new morbidities," behaviorally and socially driven, require clinicians to use an inductionist, multisectoral approach. The medical consequences of these conditions are exceptionally expensive, and the medical sector has a role to play in reducing their incidence. Finally, education in Healthy Communities competencies returns medicine to its origins as a mission-driven profession, countering the current forces pushing it to become just another "commodity."

INTEGRATING HEALTHY COMMUNITIES INTO HEALTH PROFESSIONS TRAINING

The cases reported above illustrate ways in which Healthy Communities concepts and processes can be intentionally integrated into health professions training programs. The following are steps to consider in developing a new education or training program.

Integrate the program into the academic mainstream: One indicator of success is the integration of the new curriculum, course, or training initiative into the academic mainstream of the sponsoring institution. For the University of Washington, this meant working toward getting permanent course status in the School of Public Health for the "Community Development for Health" course. Education about Healthy Communities concepts and processes must be introduced through institutional mechanisms that support curricular innovation. The experience of the Carilion-Roanoke Family Practice Residency shows that this process can take a long time, particularly in institutions steeped in the medical model. At the University of Washington, an incremental approach was used; the course was first introduced as an interdisciplinary seminar. The strength of the course, as demonstrated through student and community feedback, served as the means by which permanent course status was gained. Faculty development—through the sharing of information at faculty meetings and workshops and the recruitment of respected faculty members as champions of a proposed change—should not be overlooked as a strategy for institutionalizing Healthy Communities concepts into the curriculum.

Include community members: Active involvement of the community is a key tenet of a Healthy Communities process. Therefore, representatives of the community must be included in planning, teaching and evaluating curricular experiences that incorporate Healthy Communities concepts. This can be achieved by involving them as members of the planning or curriculum review committees, course instructors, and guest speakers; placing students in community sites or with community preceptors for service-learning activities[2]; and developing principle-centered partnerships with community organizations and Healthy Communities initiatives.[3]

Develop learning goals that reflect Healthy Communities concepts: The University of Washington in Seattle provides one model for integrating Healthy Communities concepts into a public health curriculum. The Pew Commission for the Health Professions identifies a number of ways to integrate their proposed competencies into academic learning goals and course development.[1] Some of their suggestions are:

- Include the sciences of psychology, sociology, public health, and health policy and economics in the curriculum.
- Include learning experiences in the curriculum related to environmental hazards, community social problems, and geopolitical threats.
- Provide longitudinal learning experiences that require students to apply interdisciplinary concepts in care provided to a defined population in the community.
- Provide learning experiences that help health students understand the link between basic health services and health outcomes and the social and economic burden of illness.
- Incorporate planned interdisciplinary experiences into the curriculum.
- Arrange learning experiences that require students to become actively involved in public and private policy advocacy.[1]

Don't reinvent the wheel: A growing number of organizations and health professions schools can provide resources and models for integrating Healthy Communities concepts into health professions training. Among them are:

- Community-Campus Partnerships for Health (**www.futurehealth.ucsf.edu/ccph.html**). CCPH

was founded in 1996 as a national nonprofit organization designed to foster partnerships between communities and educational institutions to improve health professions education, civic responsibility, and the overall health of communities. CCPH offers publications on community-campus partnerships as well as training and technical assistance. In addition, through its membership, CCPH provides access to an extensive network of individuals and institutions working to promote health professions reform at the local, state, and national levels.

- Health Professions Schools in Service to the Nation (**www.futurehealth.ucsf.edu/hpsisn.html**). Seventeen health professions schools, ranging from medicine to pharmacy to public health, participated in this three-year demonstration project, which was an effort to integrate community service across the curriculum and culture of their institutions. Two publications, a final report and a workbook of evaluation methods and tools, are important resources for curriculum development and sustainability. Two additional publications, a syllabus guide and a compilation of case studies from participating schools, will be available soon.

- Coalition for Healthier Cities and Communities (**www.healthycommunities.org**). This coalition is a loose network of organizations and Healthy Communities initiatives committed to information and resource exchange. Through its website, the coalition is serving as a link to community resources and to information on successful models. The coalition is currently organizing a nationwide dialogue to learn what community residents believe supports the health of their communities and what additional resources or processes might promote improvement.

- Center for the Advancement of Community-Based Public Health (**www.cbph.org**). The Center is a national nonprofit membership organization dedicated to promoting community health and well-being by fostering collaborative partnerships among health practitioners, academic institutions, and local community groups. The Center provides training and technical assistance, leadership development, and policy advocacy.

- The Community Tool Box (**ctb.lsi.ukans.edu/ctb**). The Community Tool Box is a Web-based guide to tools, resources, and information necessary for promoting community health and development. The Tool Box provides information on topics such as running a meeting or developing indicators of community health.

Integration of Healthy Communities concepts into health professions education is an important factor in ensuring that the delivery of health care keeps pace with changes in the economic and social environment. This will require institutions to look beyond the medical model and expand their vision to see the development and delivery of health services as one component of a healthy community. A growing number of resources and models are available to help individuals and institutions promote the organizational change necessary to make this shift.

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