

# ACADEMIC MEDICINE

Journal of the Association of American Medical Colleges

Uncomposed, edited manuscript published online ahead of print.

This published ahead-of-print manuscript is not the final version of this article, but it may be cited and shared publicly.

**Author:** Wilkins Consuelo H. MD, MSci; Alberti Philip M. PhD

**Title:** Shifting Academic Health Centers From a Culture of Community Service to Community Engagement and Integration

**DOI:** 10.1097/ACM.0000000000002711

**Academic Medicine**

**DOI: 10.1097/ACM.0000000000002711**

**Shifting Academic Health Centers From a Culture of Community Service to Community Engagement and Integration**

Consuelo H. Wilkins, MD, MSci, and Philip M. Alberti, PhD

**C.H. Wilkins** is vice president for health equity, Vanderbilt University Medical Center, and executive director, Meharry-Vanderbilt Alliance, Nashville, Tennessee; ORCID:

<https://orcid.org/0000-0002-8043-513X>.

**P.M. Alberti** is senior director of health equity research and policy, Association of American Medical Colleges, Washington, DC; ORCID: <https://orcid.org/0000-0002-3381-4882>.

Correspondence should be addressed to Consuelo H. Wilkins, Meharry-Vanderbilt Alliance, 1005 Dr. D.B. Todd Jr. Blvd., BioMedical Building, Nashville, TN 37208; telephone: (615) 963-2820; e-mail: [consuelo.h.wilkins@vumc.org](mailto:consuelo.h.wilkins@vumc.org); Twitter: @DrCHWilkins.

*Acknowledgments:* The authors thank Ms. Rohini Chakravarthy for her critical review of the manuscript.

*Funding/Support:* No research results are reported in this manuscript; however, Dr. Wilkins is the principal investigator of awards from the National Institutes of Health (award numbers U24TR001579 and U54MD010722) and the Patient-Centered Outcomes Research Institute (award number ME 1306-03342).

*Other disclosures:* Dr. Alberti is employed by the Association of American Medical Colleges.

*Ethical approval:* Reported as not applicable.

*Disclaimers:* The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health, the Patient Centered Outcomes Research Institute, or the Association of American Medical Colleges.

*Previous presentations:* Dr. Wilkins presented on this topic during the Association of American Medical Colleges Leadership Forum, Washington, DC, June 12, 2018.

ACCEPTED

## **Abstract**

There is an increasing need for academic health centers (AHCs) to engage communities across their clinical, research, and educational missions. Although AHCs have a long-standing history of community service, a more comprehensive approach to working with communities is required to respond to shifts toward a population health paradigm, funder requirements for community engagement in research, and demands that medical education focus more on social and environmental determinants of health. Community engagement has been employed at many AHCs, though often in limited ways or relying heavily on students and faculty interested in serving communities. This limited involvement has been due, in part, to lack of infrastructure to support engagement, resource constraints, and the lack of a clear value proposition for long-term investments in community partnerships. However, there are compelling reasons for AHCs to take an enterprise-wide approach to working with communities. An enterprise-wide approach to community engagement will require reconsideration of communities, moving from viewing them as people or groups in need of service to seeing them as assets who can help AHCs better understand and address social determinants of health, enhance students' and trainees' ability to provide care, and increase the relevance and potential impact of research discoveries. To accomplish this, AHCs will need to establish the necessary infrastructure to support long-term community partnerships, adapt policies to support and reward engaged scholarship and teaching, and consider new ways of integrating community members in roles as advisors and collaborators across the AHC.

The prestige of academic health centers (AHCs) is due, in part, to their unique role in providing socially valuable goods and services—educating and training the health care workforce, conducting biomedical research, and caring for the most complex and vulnerable populations.<sup>1</sup>

Although this overarching social value drives AHCs' pursuits, most AHCs have traditionally linked the value of their tripartite mission to national and global metrics and vary considerably in terms of the emphasis placed on connections to local communities. However, new demands for value-based care and shifts in focus from individual to population health are changing expectations for demonstrating community benefit. In addition, the intractability of health inequities require AHCs to consider a more strategic approach to linking local partnerships and expertise to national regulations and standards.<sup>2</sup> To achieve this, AHCs should implement coordinated, enterprise-wide strategies to meaningfully engage communities. This will require commitments from institutional leaders, infrastructure to support engagement, and changes in policies to fuel innovative partnerships, facilitate community partner integration, and reward community-engaged scholarship.

### **What Is Community Engagement and Why Does It Matter?**

Broadly defined, community engagement is the application of institutional resources (e.g., knowledge and expertise of faculty and students, technical infrastructure, and physical space) to address and solve challenges facing communities through collaboration with these communities.<sup>3</sup>

Approaches to community engagement are wide-ranging and include community-based service learning, community-engaged research, and community-driven health services delivery.

Community engagement is distinct both from outreach, which is unidirectional, and recruitment into research, in which the ultimate goal of interactions is to enroll individuals in a study. In contrast, community engagement requires bidirectional relationships and interactions that are

built on trust, mutual respect, cultural humility, and mutual benefit.

Although many AHCs have community advisory boards and student-driven community service programs, few AHCs have clearly articulated community engagement missions.<sup>4</sup> A growing number of AHCs have community-engaged research programs,<sup>5</sup> which have recently been elevated due to the Patient Centered Outcomes Research Institute's and National Institutes of Health's Clinical and Translational Science Awards program's requirements for patient and community engagement and the Food and Drug Administration's growing emphasis on the inclusion of patient experience data in clinical trials. Even so, community-engaged research programs unfortunately often take a backseat to clinical and translational research and continue to be siloed within AHCs such that community-engaged research skills are not leveraged for other AHC programs like community benefit planning, community health needs assessments, or service-learning programs.

Skeptics may argue that community engagement is outside of the scope of AHCs, falling more into the public health domain or charity care. Overcoming these barriers requires a cultural shift from health care delivery to a broader perspective on improving health.

### **New Levers for Community Engagement**

Recent shifts in how health care is financed and delivered, additional regulations regarding expectations for hospitals to provide community benefit, and increasing recognition of the need to integrate social determinants of health into medical education and the clinical record call attention to the need for more systematic approaches to community engagement.

Newer financing models like value-based payments (purchasing) reward health systems for high-quality, coordinated care. Successful population health management is likely to be facilitated by incorporating the social risk factors in care planning and coordination. In this approach,

population health management, communities, and local assets play a critical role in helping AHCs understand and intervene on social risk by providing access to healthy foods, reliable transportation, and wellness services. Relatedly, there is a national conversation underway about how to validly and meaningfully adjust for social risk factors in new purchasing models such that safety net hospitals are not unfairly penalized for the health of the community to which patients are discharged while also ensuring true differences in quality are not obscured.<sup>6</sup>

Recent Internal Revenue Service regulations strengthen nonprofit hospitals' obligations to invest in their communities' health as a condition of their tax-exempt status. Every three years hospitals must conduct a community health needs assessment, which engages local communities and public health experts. Through these regulatory efforts, hospitals are now compelled to go beyond downstream spending such as charity care to upstream investments that promote health and improve access to health care. For instance, some hospitals are implementing novel community building activities, including housing and economic development, environmental improvements, and leadership development for community partners. These local investments in community partnerships, community benefit, and health improvement activities can be part of a larger investment effort tied to an AHC's anchor mission that includes efforts to hire, invest, and live locally to boost community wealth, in terms of both the community's coffers and health status.<sup>7</sup>

Across the medical education spectrum, learners are encouraged and expected to engage local communities and patients to better understand the impact of social risk factors on health outcomes, as well as to better understand how to account for patients' social and built environments as care plans are developed. The 2015 revision to the Medical College Admissions Test assesses aspirants on the sociocultural contributors to health. The Liaison Committee on

Medical Education (LCME), the accrediting body for undergraduate medical education, requires medical schools to “... make available sufficient opportunities for medical students to participate in service-learning activities and ... encourage and support medical student participation.”<sup>8</sup>

Through its Clinical Learning Environment Review program, the Accreditation Council for Graduate Medical Education expects residency programs to model how quality improvement methods and processes can be used to identify and minimize health care inequities.<sup>9</sup> The LCME accreditation process also includes a standard related to interprofessional education that requires the core curriculum of a medical education program to “... prepare medical students to function collaboratively on health care teams that include other health professionals. Members of the health care teams from other health professions may be either students or practitioners.”<sup>8</sup> A growing evidence base supports the engagement of community sites as locations for interprofessional learning<sup>10,11</sup> and the involvement of community health workers as a key component of effective interprofessional patient and family care delivery.<sup>12,13</sup>

An AHC can adopt community engagement methods across the spectrum of its research, education, and clinical care missions. Chart 1 presents a selection of community engagement opportunities by mission and how the use of such methods can benefit both AHCs and their communities.

Community engagement methods and practice can be employed by all members of an AHC’s faculty, staff, and administration as well. Imagine if:

- Well in advance of breaking ground on new buildings or capital improvements, AHC administrators spent significant time in local communities to discuss social and environmental issues like the effects on gentrification, jobs, housing, and perhaps the neighborhood environment (traffic, parking, water runoff, blocked views, etc.). Efforts



could be made to hire local contractors, mitigate displacement, and create accessible, community-codesigned spaces for neighborhood use.

- AHC business officers and treasurers invested in local community businesses and housing and partnered with community organizations to deploy other strategies to maximally benefit community wealth as both a health promotion strategy *and* a core component of a long-term financial investment plan for the AHC itself.<sup>14</sup>
- Human resources staff from the AHC aligned and codeveloped employee wellness initiatives with community health and engagement activities to leverage the overlap between staff, patients, and community members.
- Population health management teams at the AHC could adopt the aforementioned clinical-care-related opportunities to their emerging value-based payment models and then evaluate impacts on patients, community health, and metrics such as cost, resource use, and readmissions.

### **What Will It Take to Get There?**

#### **Commitment from AHC leadership**

Because most AHCs have not sufficiently valued community engagement,<sup>4</sup> institutional leaders must openly value and explicitly promote community engagement as an essential aspect of the mission.<sup>3</sup> AHC leadership should drive the narrative beyond seeing community engagement as a social responsibility and emphasize the value of engaging communities in training a culturally sensitive and diverse workforce, conducting the highest-quality research, providing person-centered health care, and recruiting the most sought-after faculty. The president, chief executives, deans, and other senior administrators can be exemplars by allocating resources for community engagement, involving community members or organizations in institutional

strategic planning, and ensuring that community engagement is considered essential in policies at all levels.

### **A centralized infrastructure and enterprise-wide strategies**

A central infrastructure is vital to community partnerships<sup>15</sup> and is a common asset among AHCs highly regarded for productive and innovative community engagement.<sup>4</sup> While these centers, offices, and programs have varied names, budgets, and staffing, they serve a primary role—to provide resources, both tangible and intangible, to enable community engagement. When led and staffed by individuals who can create bridges between the AHC and community, long-term relationships can be built, which will spawn programs in research, education, and care delivery. Yet the importance of centralized infrastructure is often underestimated, in part because successful—yet siloed—community-engaged programs have been developed by faculty and students without such infrastructure. However, when community engagement is dependent on individual faculty- or student-led programs, these programs often dissolve when their leaders depart and the trust that was built with the community is lost. Central structures will help maintain trust, which is foundational for productive partnerships especially among minority and socially disadvantaged communities.

These central structures should be the front door to community-engaged programs for faculty, staff, and students, as well as for the community. The key functions of the structure vary based on the needs and priorities of the AHC and community and will likely include creating and coordinating strategic partnerships, building capacity to collaborate, streamlining processes needed for engagement, setting standards and expectations for engaged programs, and acting as a clearinghouse for information and resources. Above all, a centralized infrastructure can serve as “connective tissue” across the institution, ensuring program and evaluation alignment, minimal

redundancy of efforts, and the inclusion of crucial stakeholders both internal and external to the AHC. Leadership of these structures should be influential among internal and external stakeholders and have the vision to help align community engagement with new and existing programs across the enterprise. The Association of American Medical Colleges, with funding from the Agency for Healthcare Research and Quality and the Centers for Disease Control and Prevention, is currently developing tools and resources focused on building a systems approach to community health and health equity that AHCs can use to facilitate this kind of coordination and connection.<sup>16</sup>

### **Faculty leaders in community engagement**

The success of community-engaged programs in AHCs is highly dependent on faculty; yet, there are substantial barriers and few incentives for community-engaged faculty. Though it is distinct from service learning and community service, community-engaged scholarship is often undervalued, thus faculty may perceive community-engaged scholarship as risky or work that must be done in addition to other forms of scholarship. To recruit and retain productive and innovative community-engaged faculty, community-engaged scholarship must be broadly recognized and rewarded. Promotion and tenure committees must include faculty experienced in community-engaged scholarship to judge the merits of the scholarship's rigor and quality.

### **Long-term commitments**

Because community engagement requires relationships with communities and organizations that have different priorities and assets than AHCs, it takes time to build partnerships and cultivate trust. There is often a critical window of partnership building during which common goals are agreed on and expectations are set. This is vital to the stability and sustainability of partnerships. The pace of initial partnership building can be slow, especially in communities where there is a

history of being undervalued or disrespected by academia. Thus, AHCs must be committed to developing long-term relationships.

To be successful, AHCs will need to shift the institutional culture that has historically limited community engagement.<sup>17</sup> This requires addressing the formal policies that fail to recognize the unique needs of community-academic partnerships and scholarship, as well as the informal policies that undervalue community assets such as requirements for serving on advisory boards and for how information is disseminated to the community. Given the broad need for culture change, AHC leadership must demonstrate unequivocal support for the advancement and institutionalization of community engagement.<sup>3</sup> AHCs' fiscal, contracting, grants management, and human resources systems will need to adapt policies and procedures to better accommodate the needs of community partners with varying structures. Broadly, faculty, staff, students, and trainees must recognize community engagement as an integral part of the AHC mission, and specifically, committees responsible for developing and implementing policies must modify them to integrate the community.

The need for cultural change is not only at the individual AHC level, but also nationally. Although there are AHCs with exemplary—if still largely siloed—community engagement programs across the country, there are few AHCs that have implemented sustainable structural and policy-level changes to enable community engagement. A substantial barrier to community engagement is the traditional way that knowledge is accepted as legitimate in the academy—that is, it must be disciplinary, expert-led, hierarchical, and university-based.<sup>18</sup> National organizations that set standards for health professions' education and research training must adapt policies and standards to fully embrace the knowledge and evidence generated through community engagement, which is often transdisciplinary, heterogeneous, hybrid, demand-driven, and

entrepreneurial. Additionally, research funders should adapt funding announcements to specifically include opportunities for community engagement, allow expenditures that are aligned with community partners' needs and expertise, and disburse payments directly to community partners to help minimize the power differential that is exacerbated when awarded funds are housed within the academic institution. Finally, there is a need to expand the evidence base of and develop a common language and core metrics for community engagement across AHCs. These efforts require national leaders capable of galvanizing change and building consensus among stakeholders from different sectors and backgrounds, as well as organizations committed to advancing community engagement nationally across AHCs.

## **Conclusion**

If successful, community engagement in AHCs will lead to community integration throughout all aspects of the enterprise. This approach holds the promise of being transformational, resulting in a health care workforce better prepared to care for all populations, novel research discoveries that can be more easily translated and implemented, and ultimately, fulfilling the goal of healthier communities.

## References

1. Blumenthal D, Campbell EG, Weissman JS. The social missions of academic health centers. *N Engl J Med*. 1997;337:1550-1553.
2. Alberti PM, Bonham AC, Kirch DG. Making equity a value in value-based health care. *Acad Med*. 2013;88:1619-1623.
3. Gelmon SB, Seifer SD, Kauper-Brown J, Mikkelsen M. Building Capacity for Community Engagement: Institutional Self-Assessment. Seattle, WA: Community Campus Partnerships for Health; 2005.  
<https://ccph.memberclicks.net/assets/Documents/FocusAreas/self-assessment.pdf>. Accessed February 1, 2019.
4. Goldstein AO, Bearman RS. Community engagement in US and Canadian medical schools. *Adv Med Educ Pract*. 2011;2:43-49.
5. Selker HP, Wilkins CH. From community engagement, to community-engaged research, to broadly engaged team science. *J Clin Transl Sci*. 2017;1:5-6.
6. National Quality Forum. A Roadmap for Promoting Health Equity and Eliminating Disparities: The Four I's for Health Equity. Washington, DC: National Quality Forum; 2017.
7. Ubhayakar S, Capeless M, Owens R, Snorrason K, Zuckerman D. Anchor Mission Playbook. Chicago, IL and Washington, DC: Rush University Medical Center and The Democracy Collaborative; 2017. <https://www.rush.edu/sites/default/files/rush-anchor-mission-playbook-091117.pdf>. Accessed February 1, 2019.

8. Liaison Committee on Medical Education. Functions and structure of a medical school: Standards for accreditation of medical education programs leading to the MD degree. Washington, DC: Liaison Committee on Medical Education; 2013.
9. Weiss KB, Bagian JP, Wagner R. CLER pathways to excellence: Expectations for an optimal clinical learning environment (executive summary). *J Grad Med Educ*. 2014;6:610-611.
10. Stubbs C, Schorn MN, Leavell JP, et al. Implementing and evaluating a community-based, inter-institutional, interprofessional education pilot programme. *J Interprof Care*. 2017;31:652-655.
11. Ryan M, Vanderbilt AA, Mayer SD, Gregory A. Interprofessional education as a method to address health needs in a Hispanic community setting: A pilot study. *J Interprof Care*. 2015;29:515-517.
12. Centers for Disease Control and Prevention. Integrating Community Health Workers on Clinical Care Teams and in the Community. Atlanta, GA: Centers for Disease Control and Prevention; 2018.
13. Scott K, Beckham SW, Gross M, et al. What do we know about community-based health worker programs? A systematic review of existing reviews on community health workers. *Hum Resour Health*. 2018;16:39.
14. Norris T, Howard T. Can hospitals heal America's communities. Washington, DC: The Democracy Collaborative; 2015. <https://democracycollaborative.org/content/can-hospitals-heal-americas-communities-0>. Accessed February 1, 2019.
15. Driscoll A. Analysis of the Carnegie classification of community engagement: Patterns and impact on institutions. *New Directions Institut Res*. 2014;2014:3-15.

16. Association of American Medical Colleges. Building a Systems Approach to Community Health and Health Equity: Welcome and Program and Workshop.  
<http://www.aamc.org/healthequitysystems>. Accessed February 1, 2019.
17. Michener L, Cook J, Ahmed SM, Yonas MA, Coyne-Beasley T, Aguilar-Gaxiola S. Aligning the goals of community-engaged research: Why and how academic health centers can successfully engage with communities to improve health. *Acad Med*. 2012;87:285-291.
18. Sandmann LR, Saltmarsh J, O'Meara K. An integrated model for advancing the scholarship of engagement: Creating academic homes for the engaged scholar. *J High Educ Outreach Engag*. 2008;12:47-64.

**Cited in Chart 1 only**

19. Joosten YA, Israel TL, Williams NA, et al. Community Engagement Studios: A structured approach to obtaining meaningful input from stakeholders to inform research. *Acad Med*. 2015;90:1646-1650.
20. Kost RG, Leinberger-Jabari A, Evering TH, et al. Helping basic scientists engage with community partners to enrich and accelerate translational research. *Acad Med*. 2017;92:374-379.
21. Guthrie S, Krapels J, Lichten CA, Wooding S. 100 metrics to assess and communicate the value of biomedical research: An ideas book. *RAND Health Quarterly*. 2017;6:14.



## Chart 1

### How Specific Community Engagement Opportunities Can Benefit AHCs and Communities

Mission	Community engagement opportunity	Benefit to community	Benefit to AHC
Research	Scientists, regardless of discipline, develop research questions in collaboration with community. <sup>19,20</sup>	Aligns research resources with local needs; increases connection to STEM mentors and training; develops community capacity to use research, seek grants, and increase CBOs' sustainability; and ensures data can be used to support local advocacy efforts.	Increases relevance of research and likelihood that findings will be broadly implemented; increases recruitment and retention in clinical studies; enhances scientists' competitiveness by strengthening external validity; increases internal validity by adding community perspective to construct definitions and measurement tools or strategies; produces stories useful for marketing and advocacy; and develops trainees' skills in communication, collaboration, and engagement.
	Researchers work with community members to improve the relevance and conduct of studies, as well as the dissemination of findings and discoveries.		
	Research centers invite community members to serve on search committees and interview faculty applicants, and incorporate those perspectives into hiring decisions.	All of the above, plus provides community the opportunity to exercise agency and influence decisions and increases opportunities for mutually beneficial projects.	
Medical education	Medical educators integrate the community and CHNA when developing interprofessional learning opportunities. Community-based learning is evaluated in terms of outputs and outcomes relevant for learners, community members, and the AHC itself. <sup>21</sup>	Ensures learner service aligns with community needs in respectful and valued ways; evaluation allows improvement to CBO's program and exposure to evaluation science, which is important for the partner agency's own improvement efforts; and learners' passion and commitment present a different side of the AHC.	Develops interprofessional competencies; develops trainees' communication, collaboration, and engagement skills; achieves LCME standards; exposes learners directly to local sociocultural contributors to health; and produces stories useful for marketing and advocacy purposes.
	Learners across health professions and the medical education spectrum directly contribute to local CHNA processes as data collectors, analysts, or by presenting results to community groups.	Increases exposure and connection to learners, increases awareness of local health improvement activities, and presents more opportunities to codesign CHNA-related health interventions.	Provides additional labor for teaching hospitals' community-related administrative functions; provides research practicums focused on survey design, focus group development and execution, data analysis, data reporting, program development, etc.; offers educators new opportunities to teach

			about social determinants of health, population health, public health, etc.; and, provided GME involvement, contributes to the clinical learning environment's instruction on health and health care disparities.
	Residency directors routinely model the stratification of their patient data by sociodemographic characteristics to identify health care inequities. Residents partner with community members, patients, and faculty to develop interventions.	Results in improvements to clinical work flows more likely to benefit patients' and community members' health outcomes.	Contributes to the clinical learning environment's instruction on health and health care disparities; targeted disparity-focused QI efforts can have impact on overall measured quality; when implemented in an ACO or similar setting, can result in increased shared savings; advances scholarly output; and increases trainees' patient and community engagement skills.
Clinical care	<p>Clinical teams use data across multiple levels—clinical, sociodemographic, and neighborhood—to tailor care plans in ways that are responsive to the health and the environmental or social profiles of their patients.</p> <p>Clinicians and care teams, through their EHRs, have robust linkages to hospitals' community health improvement efforts and make appropriate and timely referrals to community assets that can provide social support and resources for patients and their families.</p>	Improves health outcomes, enhances knowledge of and access to community assets, and increases demand or support for local CBOs' programs.	Improves quality of care, particularly on measures related to readmissions, cost, and resource use; enhances physician and provider wellness through increased ability to manage patients' social factors; increases efficiency and impact of hospital community health or prevention efforts by enhancing alignment or reducing redundancy with local initiatives; and advances scholarly output.

Care team members spend time at community-based referral partners meeting staff, engaging patients, and learning about local social service processes to improve their community knowledge and profile and to increase their ability to make appropriate, knowledgeable referrals.

---

Abbreviations: AHC indicates academic health center; STEM, science, technology, engineering, and mathematics; CBO, community-based organization; CHNA, community health needs assessments; LCME, Liaison Committee on Medical Education; GME, graduate medical education; QI, quality improvement; ACO, accountable care organization; EHR, electronic health record.