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EXPERIENTIAL TEACHING FOR **PUBLIC HEALTH PRACTICE**

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Experiential Teaching for Public Health Practice

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Experiential Teaching for Public Health Practice: Using Cases in Problem-Based Learning

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FOREWORD

How can we best prepare the public health workforce for today's world?

Diseases and disabilities in the human population today are extraordinarily complex: from chronic diseases such as heart disease, diabetes, and cancer; to infectious diseases such as HIV/AIDS, H1N1 influenza, and Ebola; to illnesses related to occupational and environmental conditions such as asbestosis and lead poisoning. Further, the causes and determinants of these diseases and conditions are frequently multi-factorial and include broad social, economic, and environmental factors such as income, education, and influences associated with where we live, work, learn, and play. Indeed, further progress in promoting the health of all Americans may well depend on an enhanced approach to what constitutes public health practice—one that seeks explicitly to positively affect "upstream" social, economic, and environmental determinants of health.

We know that working on problems whose causes and solutions are unclear requires collaborating with and leading many different groups. This means that the people working in public health from a variety of different professional backgrounds require training that prepares them to deal with this complexity and with the different groups of stakeholders required to collectively address complex public health challenges.

As the Regional Health Administrator for the U.S. Department of Health and Human Services for Region X in the Northwest part of the United States, I have experience in observing and leading teams of public health professionals to work on major public health issues and have had an opportunity to work with a program that is effective in training students to become impressive and confident practitioners. The MPH in Community-Oriented Public Health Practice program at the University of Washington in Seattle has created a rigorous academic environment that allows students to engage closely with health problems in the community and that teaches students to learn by doing.

Students help our region's practitioners solve real problems and develop practice skills that will be used every day to move public health teams to take effective data-driven preventive action.

I urge other schools of public health to consider how they can best incorporate the lessons

from this effective and inspiring program into their own teaching methods. Such efforts will prepare members of our future workforce for the complex challenges that await them.

Patrick O'Carroll
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PREFACE

In 2000, I returned to Seattle from the U.S. Centers for Disease Control and Prevention in Atlanta to work at the University of Washington School of Public Health and Community Medicine. At that time, my UW colleagues made me aware of a remarkable new enterprise: the development of a Master of Public Health program focused on the *practice* of public health. The MPH in Community-Oriented Public Health Practice (COPHP) would be an unorthodox undertaking for two primary reasons. Firstly, the school had a reputation for training future researchers on the fundamentals of research. Secondly, the group of faculty involved in developing the program had decided to base it on the best principles of adult learning theory, and as a result, they were determined to use the problem-based learning (PBL) method as the program's anchor. As a life-long practitioner of public health, I was intrigued and hooked. I was pleased to join with several colleagues in a multi-year exploration of how best to design a program for adult learners so that they could enter the employ of a non-profit or government agency or health care institution and "hit the ground running." Testimonials from employers hiring the graduates of this program as well as from the students themselves have confirmed that, with COPHP, we took the right approach.

This book tells the story of that exploration, our initial program design, and the lessons we learned as faculty and students together re-shaped the program each year to improve the effectiveness of the learning experience. It is directed at all teaching programs that wish to move from conventional methods of teaching and learning, where faculty lectures predominate, to an environment where the faculty craft PBL cases that students use to teach each other; from faculty-governed learning to a shared learning space; and from a knowledge base dominated by theory to one where students discover theory by looking at problems in a practice field. In this book, we provide examples of the PBL cases that faculty have written and used in COPHP courses. A companion project will make the entire set of COPHP PBL cases available for an annual subscription fee (see Appendix L).

The editors and authors of this book understand that it will be the rare program that converts completely from traditional learning methods to PBL. We offer advice and insight into the many aspects of PBL and how, over the years, we have tried to be flexible and pragmatic about its use and interpretation. One of our foremost tenets has been to monitor how both students and faculty have contributed to programmatic quality improvement.

The COPHP program has been fortunate, particularly at its inception, to have the support and vision of leaders in the School of Public Health. COPHP was launched under the direction of Dr. Frederick A. Connell, Associate Dean of the school at the time, who oversaw the first set of PBL cases created from the practice environment and worked through the complexity of

training faculty in a new method of teaching. Dr. Connell had the challenging task of turning a start-up into an accepted institutionalized program. His experience as an epidemic intelligence officer and a pediatrician anchored him in the practice world; his academic credentials as a researcher and ties throughout the school's academic departments helped to assure the program's successful launch. Dr. Connell now has emeritus status.

After the program was stabilized, I took the leadership reins for three years and was followed by Peter House, a senior lecturer in the Department of Health Services and a clinical associate professor in the Department of Family Medicine. Peter successfully met the challenge of moving the program from partial funding by the State of Washington to complete funding from student tuition. The current COPHP Director, Dr. Amy Hagopian, with research interests in global health around health worker migration from low-income to wealthy countries, has helped expand the program's annual cohort to three groups of eight students.

COPHP has been fortunate to have strong faculty leadership for each of the required curricular areas. Several of these faculty members—Aaron Katz, Jack Thompson, Fred Connell, and Stephen Gloyd, with support from then Health Services Chair, Bill Dowling—participated in early conversations about developing a program over post-class libations at a nearby cantina. The conversations over time developed into a formal proposal to the School of Public Health that generated the COPHP program.

Case-writing leads for programmatic content in the PBL cases at the beginning of the program include: Management (Bill Dowling); Population Health (Stephen Bezruchka); Community Development (Jack Thompson and Peter House); Epidemiology and Biostatistics (Fred Connell and Jim Gale); Health Promotion/Health Behavior (Karen Hartfield); Policy and Evaluation (Aaron Katz and Amy Hagopian); and Environmental Health (Bill Daniels). Many current faculty members are chapter authors for this book (Sharon Bogan [former student], Brett Niessen [former student], A. Gita Krishnaswamy [former student], Aaron Katz, Amy Hagopian, Peter House, Karen Hartfield, Jsani Henry [former student], Stephen Bezruchka, Ann Vander Stoep, Michelle Garrison, Tania Busch-Isaksen, Wayne Turnberg, Jude Van Buren, Sarah Ross-Viles [former student], Hendrika Meischke, Chris Hurley, Katie Bell, Ian Painter, Jack Thompson).

To credit all who have contributed to the success of COPHP, I should really name the program's alumni since many of them are substantial contributors to the development and improvement of all aspects of the program. The book chapter on CORE (Anne Althauser, Tara Bostock, Ariel Hart, Jennifer Hagedorn, and Afomeia Tesfai) describes the major contribution that students made to incorporate anti-racism principles into the curriculum.

Thanks to all of the students and faculty who have been a part of COPHP over the years for

their energy, enthusiasm, and devotion to learning. This learning community has shared the insights, the joy, and the continuing relationships resulting from many months of hard work.

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ACKNOWLEDGMENTS

The co-editors would like to thank Alice Porter, manuscript editor, and Sarah Cohen, copy editor, for all their hard work and impressive professional help on this book. Their effort improved the final product immensely.

The enthusiasm and thoughtfulness of COPHP faculty, students, staff, and community partners over the years inspired us to create this resource for other academic public health colleagues.

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Dedication

This e-book is dedicated to faculty and teachers from around the world who are searching for effective and exciting ways to improve student learning.

CHAPTER 1

Introduction and Background

Aaron Katz*, **Jack Thompson** and **Frederick A. Connell**

University of Washington, Seattle, USA

Abstract: Faculty at the University of Washington School of Public Health developed an MPH program that departs significantly from traditional graduate training. They initially sought a pedagogy rooted in adult learning theory and social justice that would prepare courageous problem solvers and excellent critical thinkers. The first step toward this goal was selection of the problem-based learning method to replace the lecture mode. Faculty secured funds to support training in writing PBL cases and facilitating PBL groups, designing a curriculum, and developing administrative processes. They created a two-year curriculum that covers all the core competencies of public health through PBL cases, which are in part shaped by community partners. Fifteen years later, the program that resulted from this effort—the MPH in Community-Oriented Public Health Practice—continues to prepare public health professionals who demonstrate exceptional skills in self-discovery, leadership, teamwork, and collective analysis.

Keywords: Adult learning theory, Community, Curriculum, Critical thinking, Education, MPH, Pedagogy, Practice, Problem-based learning, Public health.

> "The key challenge facing public health education today is reconciliation of the academic environment in which most public health education takes place with the practice environment for which students are destined".
>
> --*Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century* [1].

How can we train excellent public health practitioners?

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Bud Nicola & Amy Hagopian (Eds.)

That was the question that vexed the four founders of COPHP when, 15 years ago, we sat down over bottles of beer. Our public health school at the University of Washington had a strong reputation in public health training and research—it consistently ranked among the top six public health schools in the country. Many of our colleagues were nationally renowned scholars in environmental health, epidemiology, biostatistics, and other fields, and each year the competition to get into our MPH, MS, and PhD programs was intense.

Still, we shared an uneasiness about whether our students, particularly our MPH students, left us well-prepared to work in public health. And our sense of uncertainty was supported by what we heard from the potential employers of our students. These employers—local health departments, health care providers, community organizations, and advocacy groups—sought not just specific research skills or methods expertise but also strong problem-solvers and critical thinkers. They tended to hire students from other disciplines, such as business or health administration, that apparently offered more flexible and applicable skill sets.

So we wondered, what would a curriculum look like that produced creative, courageous problem-solvers who could, according to the WHO definition of public health, help create the "conditions in which people can be healthy?" We were fairly confident that traditional graduate-level courses were unlikely to fit the bill. How does a student learn critical thinking skills by sitting passively in a lecture, watching a continuous stream of bulleted PowerPoint slides? How does a midterm exam or theory-based paper help a student learn the sensitivity and humility needed to work with and in support of communities?

PROBLEM-BASED LEARNING

What we needed was a pedagogy rooted in experiential learning and self-discovery, concepts consistent with adult learning theory [2]. Some of us had used case studies in our courses, placing students in realistic situations and posing questions that pushed them to research contexts, options, and impacts. But each of us has also worked in public health practice, and we knew that real challenges did not come in such neat packages—rarely is anyone around to set the stage or pose

the right questions. Once at work, many of our graduates had to gain the knowledge and confidence to start from zero and still find good solutions and effective strategies.

Another goal we had was for students to gain strong skills in teamwork and collective analysis. Certainly public health professionals must conduct independent research and take individual initiative. But public health is at its core a group effort: professionals working in teams, across disciplines, with comm-unity groups and stakeholder organizations. We wanted to create an educa-tional environment in which our students learned and excelled at leadership skills, meeting facilitation techniques, respectful criticism, and other competencies needed to contribute to and lead high-performing teams.

Many of us in higher education learned how to teach on the job, with little or no formal training, and with only our own teachers as models; this means that lecture is what we're comfortable doing. We have confidence that if we design and deliver a lecture effectively, students will hear and "get" what we consider to be the main lessons, skills, and knowledge. This "I talk, you listen" pedagogy is age-old, but the research on adult education suggests that it rarely results in sustained learning [3]. We began to look for an alternative to the lecture model in which the instructor has total control over the content and flow of a session; we sought instead a method of teaching and learning in which the initiative and control would switch to students.

Through some personal contacts and a bit of literature review, we learned about problem-based learning (PBL), a non-didactic learning method that has been used, notably, in various medical schools. As we learned more about this pedagogy, an opportunity to obtain funding from the university administration arose. Backed by our dean's office, we crafted a successful proposal, which provided support for a year of learning, planning, training, and case-writing.

CHALLENGES

Finding the right pedagogy was the first step, but only the first, and perhaps the easiest. We faced three main challenges to creating the kind of innovative signature program we envisioned:

CHAPTER 2

Competencies

Amy Hagopian*

University of Washington, Seattle, USA

Abstract: All MPH programs in the United States seek accreditation by the Council on Education for Public Health (CEPH). CEPH promotes competency-based education, an institutional process that moves education from an emphasis on what academics believe graduates should know (teacher-focused) to an emphasis on what students should be able to do (student and workplace-focused). These competencies are associated with skills that will be demanded of graduates in their public health workplaces. To assess attainment of competencies, faculty must ask students to produce work products that demonstrate skill mastery. In contrast to typical classrooms, the MPH in Community-Oriented Public Health Practice (COPHP) uses problem-based learning (PBL) cases as the method for achieving competencies and creates real partnerships with government public health agencies and community-based organizations to engage students in producing work these organizations really need. The University of Washington adopted a set of MPH competencies in line with CEPH accreditation requirements, and we have mapped COPHP case learning objectives to these competencies. In this chapter, we discuss the evolution of the competency-based approach in our program, offer examples of problem-based cases from our public policy curriculum, and list the competencies that students will attain by the end of their participation in COPHP.

Keywords: Accreditation, Benjamin Bloom, Case learning, Competencies, Council on Education for Public Health, Paulo Freire, Problem-based learning, Skill mastery, Student-centered learning, Systems thinking.

INTRODUCTION

The Community-Oriented Public Health Program (COPHP) is built on the

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principle that cases and problems naturally produce competencies in adult learners. Our program's founders had in mind a revolutionary approach to public health education—one that placed teachers in the role of "problem-posers" rather than collectors and depositors of information in students' heads. This orientation is based on the work of educational theorists such as Paulo Freire, who advanced and popularized the concept of "problem-posing education" [1], as well as Benjamin Bloom, who categorized and ranked various ways of knowing, valuing, and doing things in an educational context [2]. Bloom and Freire understood that remembering facts and concepts is a fairly low-level cognitive act, one that is easily fulfilled by simply telling students what they need to know. By contrast, to demonstrate competency in a complex field like public health, students must analyze, apply, evaluate, and synthesize information and ideas. In addition, they must apply important public health values, including collective action, to advance social justice and face down power structures that threaten the public's health.

The Council on Education for Public Health (CEPH), the organization that accredits schools of public health in the United States, has promoted competency-based public health education for more than a decade. At the time of COPHP's inception in 2002, CEPH had already begun calling on schools to document the competencies they were attempting to develop in MPH students [3]. Clinical training programs had for some time embraced problem-based learning (PBL); it seemed logical that presenting students with a set of presenting signs and symptoms—a "problem"— stimulated students to synthesize their knowledge in ways they would soon be required to demonstrate in a clinical role [4]. This method also seemed to be a natural fit for the practice-oriented and competency-based approach of COPHP.

WHAT THE WORKPLACE DEMANDS

CEPH describes competencies as "what students need to know and be able to do in varying and complex situations (student and/or workplace focused)" [5]. Competencies encourage institutions to focus on developing the observable skills and knowledge that will be demanded of graduates in their public health workplaces, as defined by employers and professional leaders. After a series of working group discussions and negotiations involving more than 400 individuals,

CEPH in 2006 identified the following competency domains: biostatistics, epidemiology, environmental health, policy and management, and social and behavioral sciences. Crosscutting competencies included communication, diversity, leadership, professionalism, program planning, biology, and systems thinking. As this book was being written, CEPH was completing its overhaul of the public health competency inventory for the next round of accreditation assessments [6, 7].

In addition to defining competency domains and calling on schools to identify and break down large skill sets into discrete competencies, CEPH further challenges schools to design learning experiences and contexts that support students to master competencies as bundled sets. Each competency may have various levels of mastery, from basic understanding to advanced capacity to the ability to lead a project requiring the named skills and knowledge. The guidelines also present a set of verbs to define observable mastery. For example, "understand" is not an allowed verb because a teacher cannot directly observe understanding; "describe" is preferred because it is something a student can *do*. More advanced levels of mastery require verbs such as "synthesize", "design", or "create".

The University of Washington and COPHP were early leaders in competency-based education. The university first established public health competencies in 1999 as part of a self-study in preparation for CEPH accreditation. At around the same time, competencies also drove the creation of COPHP curriculum. Frederick A. Connell, a founding faculty member who was associate dean at the time noted recently, "When we began the COPHP program, we started by articulating 'competencies' for each block —before any cases were written. At the time we may have been the first competency-driven curriculum in the school". [1] Subsequent re-accreditation self-studies occasioned competency revisions across the school. In 2013, using the CEPH competency domains, the School of Public Health and Community Medicine called on its departments (Biostatistics, Epidemiology, Environmental Health, and Health Services) to engage in a process of establishing competencies that could be observed and measured among MPH graduates.

As a UW program, COPHP ensures that our problem-based cases meet the CEPH-identified competencies required of MPH graduates. This is relatively

CHAPTER 3

Pedagogy

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Abstract: The founding faculty of the MPH in Community-Oriented Public Health Practice (COPHP) considered several learning models appropriate for students preparing for careers in public health practice (rather than research). They selected problem-based learning (PBL), which has been successfully applied by other practice-based disciplines and incorporates elements such as strong faculty-student collaboration, group learning, a reiterative research cycle, and case learning based on real-world problems. At its core, PBL is a method in which learning results from the intellectual process involved in understanding and resolving problems. These problems are presented in cases, written by COPHP faculty, that are often based on real public health situations at the state, national, or global level. Most courses also present at least one case that requires students to complete a real-time project at the request of a partner agency such as the local health department. Students explore and discuss the cases in small groups that simulate the structure of actual work environments such as health and human service agencies; and they learn to lead groups and to cope with functional and dysfunctional group dynamics. PBL cases are built on community issues, reinforcing the program's grounding in service learning in the community. The COPHP program also trains students and in use of a course management system through which students post their coursework. Both students and faculty provide continuous feedback on progress in facilitating student learning.

Keywords: Adult learning principles, Case learning, Competencies, Evaluation, Facilitated learning, Group dynamics, Learner-centered education, Learning cycle, Pedagogy, Problem-based learning, Reiterative learning, Research methods, Service learning, Small-group learning, Technology.

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Bud Nicola & Amy Hagopian (Eds.)

INTRODUCTION

During the development of the Community-Oriented Public Health Practice (COPHP) program, the founding faculty discussed and reviewed available pedagogical methods to match program learning needs. They wanted to target COPHP curriculum to a population of students interested in working in public health practice, rather than in research careers. As they reviewed the many teaching methods available, faculty were most interested in methods based on adult learning principles that would require them to assess and respond to the needs, wants, concerns, and current abilities of the target learners. Any educational program should account for the motivation of the learner; reinforce the skills and knowledge being developed; and help students retain key learning and transfer it to new situations [1]. Learning—both in adults and youth— should encourage a sense of self-worth and personal power in learners [2].

Several learning models promote adult learning principles, but serendipity played a role in COPHP's embrace of a model perfectly suited to the approach the founding faculty were seeking: problem-based learning (PBL). One of our new faculty members at the time, Dr. Will Welton, had just arrived from Hahnemann University in Philadelphia and had helped develop a public health master's program there based on PBL.

Furthermore, national organizations such as the Association of Schools and Programs of Public Health had argued for a new commitment to service as part of the educational process. They also supported the use of Boyer's concept of the "scholarship of engagement", in which the practice-based scholar is engaged with practitioners, policy makers, communities, and organizations [3]. As noted in Chapter 1, this idea was wholeheartedly adopted by the founding faculty and reflected in the first year practicum and the second year master's project or capstone. PBL cases are built on community issues. Thus, from its inception, COPHP has been grounded in PBL and service learning in the community.

PBL METHODS AND PRINCIPLES

As implemented in COPHP, PBL involves a small group of students deciding for themselves what they need to study, after discussing some trigger material such as

a written problem or situation taken from the real world [4]. After a period of individual study, the students meet to share, compare, and relate their findings to the original material and to determine whether they have acquired enough knowledge to address the situation or case.

The following definition captures some of the above elements:

> PBL asks students to confront "ill-structured", real-world problems that have no immediate or clear solution. Well-constructed PBL experiences provide a genuine stimulus for learning; are culturally accessible and relevant; allow students to balance cooperative and independent work; require students to self-direct the learning process using a multidisciplinary perspective; and promote metacognitive habits that allow students to self-assess the development and quality of their learning [5].

The PBL method—in which learning results from the intellectual process involved in understanding and resolving problems— has been used successfully for many years in medicine, law and business programs [6, 7]. Its key features are that it is problem based, reiterative, learner centered, small group-oriented, and facilitated.

"Problem-based" refers to the use of simulations of realistic problems or real problems presented by external partners, carefully selected and designed to challenge learners to discover and accomplish the curriculum's major learning objectives. The primary motivation to learn comes from the natural desire to understand and resolve the problem; the problem serves as a vehicle to stimulate and motivate learning. In COPHP, students are also motivated to engage with problems that build their capacity to understand and address the health needs of communities. Learners respond to the problematic situation by defining the problem, identifying areas for further research, synthesizing findings, applying existing knowledge to interpret data, and generating multiple hypotheses. Learners work in a reiterative sequence in which the problem stimulates them to investigate to acquire new information and then return to the problem and incorporate the new knowledge into thinking and decision-making [8].

CHAPTER 4

Administrative Considerations

Peter House*

University of Washington, Seattle, USA

Abstract: The University of Washington's MPH in Community-Oriented Public Health Practice (COPHP) program is fully committed to a problem-based learning pedagogy that is unique among degree programs in our School of Public Health and rare across the country. This intense method of teaching and learning places uncommon demands on teachers and students alike. To teach all aspects of public health practice and to craft a broad curriculum, we draw faculty from other departments in our school and from the practice field as well as from the academy. We select students who bring work experience in public health practice, who share our dedication to social justice, and who are fully prepared to undertake problem-based learning. In this chapter, we discuss the customized set of administrative skills and practices that we have developed to support COPHP and govern admissions, marketing, student support, faculty support and recruiting, instructional technology, educational evaluation, institutional relationships, anti-racism and social justice strategies, and alumni relations. Together, these processes ensure the success of COPHP in producing effective public health practitioners while keeping our fee-based program affordable to students.

Keywords: Admissions, Administration, Advising, Alumni relations, Anti-racism, Case editing, Faculty meetings, Faculty recruiting, Faculty retreats, Faculty support, Institutional relationships, Instructional technology, Internet presence, Marketing, Peer mentors, Peer review, Self-reflection, Seminars, Social justice, Student feedback, Student support.

INTRODUCTION

Our program, the MPH in Community-Oriented Public Health Practice (COPHP),

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is committed to using a problem-based learning (PBL) pedagogy that is unique among degree programs in the University of Washington School of Public Health and Community Medicine and rare among comparable schools across the nation. We teach all aspects of public health practice, so we have an unusually diverse faculty, drawing from other departments in our school and from the practice field as well as the academy. Another factor that sets us apart is that our program is fee-based, which means that we are forced to operate as a business by balancing costs with tuition receipts—all the while working to keep our program affordable to our students. For all these reasons, we have developed and continue to apply a customized set of administrative skills and functions, which we describe in this chapter. These practices govern admissions, marketing, student support, faculty support and recruiting, instructional technology, educational evaluation, budgeting and staffing, strategic planning, institutional relationships, anti-racism and social justice strategies, and alumni relations.

ADMISSIONS

We know that COPHP is not for all students pursuing MPH degrees. Since our program's inception in 2002, we have been careful to recruit applicants who we think will thrive in our program's pedagogy. For each case we explore in our classes, our faculty direct two three-hour sessions of in-class discussion, and we require our students to do a lot of writing and meet inviolable deadlines. We simply cannot accommodate students who are not comfortable with these demands. At the same time, we undertake the admissions process with respect and humility. We know how important our decisions are to the applicants' lives and how imprecise we humans are in judging each other. Every year we admit students from the lower end of our waiting list who later turn out to be star students and strong public health practitioners.

Our admissions process entails several steps:

- **Interviews**. A second-year student is hired to manage our recruitment efforts. She conducts a telephone interview with every applicant. The interview emphasizes questions about how good a fit the applicant would be with our program. We allow time for the applicant to ask us questions. Most applicants

are then referred to a faculty member for a second interview. Both the student assistant and the faculty member complete a short survey after the interview, and we include these notes in the applicant's files.

- **Observation**. We strongly encourage all applicants to come to Seattle to observe a PBL session. Direct observation is the best way for applicants to get a sense of what they would be getting into with COPHP. The class discussions are always lively, and applicants are nearly always impressed with the enthusiasm and carefully structured, student-led facilitation in the classroom. These visits also provide COPHP with a powerful marketing tool.
- **Written application**. For COPHP, this includes 1) resume, 2) personal statement, 3) required statement regarding diversity, 4) academic transcripts, 5) Graduate Record Examination (GRE) scores, and 5) at least three letters of recommendation. At least three faculty members of our admissions committee read each application.
- **Admissions Committee.** We use a large admissions committee, drafting all faculty and several second-year students and alumni. We review applications in three admissions rounds: early, regular, and "space available".

We know that the reviewers vary in how much emphasis they give to each element of the written application. Some reviewers read the personal statement very carefully while others home in on the letters of recommendation. Several elements, however, are common across most reviewers. Our pedagogy works best when we have students who bring knowledge and experience to the table in their groups, so we look closely at resumes to make sure that we admit applicants with at least two or three years of work experience in public health practice. On the GRE scores, we pay special attention to very high or very low scores. Very high scores (greater than the 85th percentile) correlate with the ability to keep up academically while in school. Very low scores (lower than the 15th percentile) signal applicants who will likely need extra help on academics. For the "great middle" of applicants with neither very high nor very low scores, we pay little attention to performance on the GRE.

MARKETING

Our marketing has two main elements:

CHAPTER 5

Building a Culture

A. Gita Krishnaswamy* and **Amy Hagopian**

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Abstract: Faculty of the Community-Oriented Public Health Practice program (COPHP) continually refine our curriculum to support an anti-racist, inclusive program culture. COPHP faculty draws the most from successful contributions to their own learning, including trial and error, expert and personalized coaching, clear social and cultural expectations, and constructive feedback. COPHP "community of learners" begins to take shape at the first contact prospective students make with the program, as faculty and a graduate student coordinator assess applicants' potential to succeed in COPHP and in using the problem-based learning (PBL) method. Program culture continues to evolve through a busy orientation week designed to prepare new students for the unique demands of PBL and introduce library research methods and the roles of public health workers. Perhaps the most important orientation week activity is "Case 0", a practice PBL case through which students learn about the radical history of public health, adult learning theory, and institutional racism. In analyzing the case, students are exposed to a classroom culture that support formative, reiterative learning as well as self-reflection and equitable team roles and processes. The combination of COPHP's dynamic learning culture, social justice orientation, and student leadership strives to support student activism and community service. In the recent years, COPHP students have helped form two important student-led organizations that address racism, oppression, and reproductive rights. Graduates tend to maintain strong relationships with the program, faculty, and local organizations, further extending COPHP's vital community.

Keywords: Admissions, Anti-racism, Collaboration, Culture, Graduation, Group skills, Multi-cultural, Norms, Orientation, Personal growth, Service, Student-driven.

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INTRODUCTION

COPHP's problem-based learning (PBL) environment supports intellectual growth by providing opportunities for both individual and team-based learning in an intense environment. The group dynamics and cohesiveness of PBL influence both students' learning experience and the outputs of their learning processes. We work to create a strong internal community with shared values and practices—a dynamic, critical learning culture that models and prepares students to participate effectively in public health practice.

The PBL method is particularly significant for cases that involve students in community-based projects with requested deliverables. Our explicit commitment to developing an anti-racist program culture shapes our individual facilitation practices and other program structures. We are striving to evaluate where we sit on a continuum from a mono-cultural, exclusive culture to a multicultural and fully inclusive one. We believe this effort is essential to our roles in educating the future public health workforce. The commitment to social justice drives our emphasis on health inequity and the social determinants of health. We continually refine our curriculum to give students tools of humility, critical analysis, and compassion to ensure that public health is, in fact, the science of social justice Richard Horton in The Lancet, from 2011.

CONTENT IN CONTEXT

During the 2015–16 academic year, several new faculty members joined the COPHP program due to an expansion in class size and some retirements. This unprecedented expansion necessitated the first, formalized orientation to welcome new faculty to the program's core values, collaborative community, and unique learning culture. Orientation participants consisted of faculty new to COPHP, experienced COPHP faculty, and current students.

At the start of the orientation, participants were asked to think about something they had learned to do well and then to write down what helped them learn it well. Some recalled when they learned to bake or swim for the first time; others described the process of learning how to mediate conflict or communicate complex mathematical concepts to a general audience.

When asked to share the factors that helped them learn, participants eagerly created a long list as a group. The list below shows some factors shared by multiple participants:

Having a mentor or role model	Fun and enjoyable
Coaching from experts	Culturally proficient learning
Learning from mistakes	environment
Trial and error	Learning created social connections
Intrinsic motivation	Social or cultural expectation
Practice	Need
Survival	Desire to help others
Constructive feedback	Personalized coaching
Safe space to experience failure	Supplemental resources from experts
Timely and actionable feedback	Heterogeneous team
Positive reinforcement	Collaboration and small group activities
Consequences for not learning	Teaching others
	Necessary to advance a skill

When prompted to think about what *didn't* make the list—in other words, what factors are less conducive or prohibitive to learning—participants were quick to note that textbooks, worksheets, lectures, force, high-stakes assessments, and lack of relevance or purpose did not facilitate their most significant or memorable learning experiences. In addition, the student participants emphasized the ways that racial micro-aggressions, lack of student-endorsed group norms, imbalanced student-student and student-teacher relationships, and a normative academic culture catering to dominant groups disrupt learning for individually affected students and reduce group collegiality.

This opening activity reveals what we instinctively and empirically know about relevance and "learning by doing" and also affirms that *content* cannot be separated from the *environment* in which it is learned. At its most successful, PBL not only exposes students to public health competencies through real world, relevant learning experiences but also necessitates a classroom environment that reflects many of the factors our orientation participants listed.

Apart from the classroom environment, COPHP's overall program culture includes defining characteristics and expectations of its community, including:

- Opportunities for personal growth and accountability to our commitment to

CHAPTER 6

The Handbooks

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Abstract: COPHP uses a series of handbooks to orient students and faculty to the program and to share the program policies and practices. The student handbook for the Community-Oriented Public Health Practice (COPHP) program describes a shared vision of expectations for students, faculty, and alumni. COPHP faculty members drafted the initial version of the handbook, which described the problem-based learning (PBL) process, expectations for student work, and information on capstone and practicum projects. Student coordinators have since developed three handbooks: a general guide for students, a resource about capstones, and an introduction for new faculty. This chapter summarizes the history, development, and purpose of the student handbook and a brief description of the faculty handbook and the capstone handbook. It also describes specific components that are included to facilitate PBL and community-building within the program; because students depend on each other for their learning in PBL, it is important to outline expectations for participation within COPHP community. The student handbook is available online to give prospective students the opportunity to learn what it means to be a part of COPHP community and decide whether the program is right for them. We encourage anyone creating a program similar to COPHP to engage students, faculty, and alumni in the process of creating such a document, which functions as a statement of shared values.

Keywords: Alumni, Community, Components, Coordinators, COPHP, CORE, Culture, Expectations, Faculty, Handbook, Online, Participation, PBL, PCE, Program, Prospective students, Recruitment, Successful, Values, Website.

BACKGROUND

Since the first COPHP cohort enrolled in 2002, it was clear that the program

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Bud Nicola & Amy Hagopian (Eds.)

needed a document to codify expectations for student work and participation. COPHP is built on the idea of community engagement within and outside of the program. The PBL process requires a high level of interpersonal skills, and—in common with real-life work environments—it can produce conflict and difficulty. The student handbook serves first and foremost as a guide to help students navigate the unique aspects of this program including:

- Expectations for student work and the PBL process.
- Guidance for getting the most out of faculty and peer mentorship relationships.
- Support for conflict resolution within the program.
- Standards for student relationships and partnerships with community agencies.

The initial handbook was long and distributed mainly in paper or over email; it covered everything from the PBL process to where students could register for classes and pick up their student ID cards. Over the years, the handbook has evolved into three separate handbooks, each with specific guidance on particular components of the COPHP program. These documents are:

- **Student handbook:** The student handbook has evolved from a catch-all reference for graduate school to a specific document about COPHP and the PBL process. It outlines expectations for student work, participation, mentor relationships, and community engagement. The current version still offers important information about student tuition, financial aid, and registration, but we have removed information about other campus resources to focus the handbook on COPHP experience, with links added as necessary to other university web pages. The student handbook is available publicly on COPHP website for prospective students to peruse as they consider the program.
- **Faculty handbook:**. As the program has grown, so has the number of faculty. COPHP relies heavily on the use of clinical instructors—individuals actively working in the field of public health—and many COPHP faculty members have full-time jobs outside of academia. COPHP faculty handbook helps experienced faculty mentor these incoming and clinical instructors, whose contributions are critical to the success of the program. It covers the basics of PBL facilitation, case writing, grading, the academic calendar, student conflict resolution, and

expectations for student mentorship and academic advising relationships.

- **Capstone handbook:**. COPHP capstone project is a major, year-long (and in some cases longer) undertaking by second-year students. In contrast to a thesis project, required by most schools of public health, COPHP capstone project requires students to work with a community, governmental, or academic agency to respond to a community need with a useful product. The capstone project requires careful planning as well as constant stakeholder engagement. For this reason, we removed capstone information from the general student handbook and created a separate capstone manual for COPHP students.

CREATING AND UPDATING THE HANDBOOK

It would be ideal for a new program to draft initial student and faculty handbooks using the PBL process with the first cohort and founding faculty. Use this opportunity to create a shared vision of student culture, participation, and expectations. Incorporating students and alumni into drafting and revising future versions of the handbook creates a living document that is responsive to the needs of students in the program.

In COPHP, yearly revisions to the handbook are supervised by the student program coordinator, a second-year student in a dedicated part-time graduate student appointee (GSA) position. This position, created during the 2005–06 academic year, provides the dual benefit of administrative support and a scholarship opportunity for the student.

As the main point of contact for current students, the student program coordinator is in a good position to lead the process of updating the student and capstone handbooks each year based on student and faculty feedback. In the spirit of community engagement, we recommend involving students, staff, faculty, and alumni in the updating process. Particular sections, such as guidance on faculty mentorship roles and expectations, should be revisited each year by faculty and students to determine if roles and expectations should be re-defined.

CHAPTER 7

The Capstone

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Abstract: All MPH programs accredited by the Council on Education for Public Health are required to provide a culminating experience in which students demonstrate their skills and integrate knowledge. In the MPH in Community-Oriented Public Health Practice (COPHP), this experience is the capstone. The idea is to apply theoretical knowledge learned in the classroom to a situation that mimics the demands of professional practice. Faculty coach students through this project, and they assess at its conclusion how well students have mastered the identified body of knowledge and whether they have acquired the competencies required to be public health professionals. For their capstone projects, students establish relationships with clients—typically government public health agencies or community-based organizations—who have real work to do and can support such a learning experience for COPHP students. We have developed an approach to the capstone that allows students a wide range of choices of types of projects while providing a highly structured and motivating environment in which to complete the work. To help our students produce strong culminating projects, we have developed strong expectations and norms. We also apply our own tracking and organizing tools and adhere to our clearly defined philosophy and culture.

Keywords: Accreditation, Capstone, Client, Culminating project, Literature review, Research, Thesis.

INTRODUCTION

The Council on Education for Public Health (CEPH) requires MPH programs to provide a culminating experience that requires each student "to synthesize and

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integrate knowledge acquired in coursework and other learning experiences and to apply theory and principles in a situation that approximates some aspect of professional practice. It must be used as a means by which faculty judges whether the student has mastered the body of knowledge and can demonstrate proficiency in the required competencies".

In COPHP, our culminating experience is called a capstone, and it requires each student to establish a relationship with a client organization that wants work done and is prepared to provide a synthesizing learning experience for the student. These organizations are typically government public health agencies or community-based organizations. We have developed an approach to the capstone that allows students a wide range of choices of types of projects while also providing a highly structured and motivating environment in which to complete the work.

COPHP faculty coach students both individually and collectively through the process of evaluating and selecting their projects. We rather deliberately herd students through the capstone experience by employing several cohort-wide milestone deadlines and tracking tools, and we encourage students to notice each other's progress and struggles along the way. The reward for all this collective attention to the capstone is that almost all students complete a satisfactory project on time.

As our cohorts have grown over the years, we have developed the role of "capstone director". This person establishes mechanisms to track students as they move through the milestones, identifies any individual difficulties, and manages presentations at both mid-point (January) and graduation (June).

CAPSTONE *VERSUS* THESIS

COPHP founding faculty felt strongly that a culminating project for a practice-oriented degree should be, well, practice-oriented. In a practice-oriented program such as ours, it would be inappropriate for students to think up independent research projects to be performed in the privacy of the library or a laboratory. This is why each COPHP student pursues a capstone and not a traditional thesis. A capstone, the way we define it, is conducted with an organization that is eager to

employ the results to improve its operations. Students are expected to define the bounds of the project in negotiations with client organizations, and in each of these arrangements, the student and the client both sign an agreement that spells out deliverables. COPHP faculty are encouraged to coach students in how to interact effectively with the client organization, improve time management and writing skills, and think through large projects with many moving parts.

Another differentiation between a thesis and COPHP capstone is that the supervisory committee for the capstone consists of a single faculty member and the site-based mentor (representative of the client organization). In a traditional MPH thesis, the committee consists of two faculty members.

Despite COPHP approach of collectivizing the experience so that students are shepherded through the capstone in a supportive way, we still have many anxieties to manage. Much can go wrong, with significant implications for the student: the client organization might have fiscal trouble and stop the project; the executive director or another principal could feel threatened by the project (such as when an evaluation reveals cracks in the organization); the mentor assigned to the student could leave the organization or lose interest in the project; human subject approval may be held up long enough to significantly delay data collection; recruiting difficulties for subjects could crop up; and so on. We try to help students understand that these are routine problems in organization-based projects and that they are part of the learning process. This is accomplished by following the timeline outlined below.

THE TIMELINE

On or about December 1 of their first year of COPHP, we introduce the capstone to students in a formal way. In their seminar class, we assemble a panel of alumni who have completed a variety of capstone projects to talk about their experiences. In our most recent session, we showcased an international project, a project in a public health department, a public school-based project, a project with a non-profit organization, and even a project that proved to be somewhat challenging to the student because the client organization was disappointingly disengaged. (Clearly, the best projects are those whose sponsoring organization assigns an

CHAPTER 8

The Practicum

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Abstract: The MPH in Community-Oriented Public Health Practice (COPHP) supports a robust practicum program through a formal partnership with its local health department, Public Health—Seattle & King County, that provides students an opportunity to integrate academic training and practice within a metropolitan health department setting. This arrangement began in 2003, when the University of Washington School of Public Health and Community Medicine and the Public Health agency received a one-year Associated Schools of Public Health "academic health department" grant. Since then, the health department has served as a teaching institution for COPHP students and a venue to train students on-site in real-world public health practice. COPHP student and faculty linkages provide a vehicle to enhance the public health workforce through resource sharing and technical assistance, and have expanded public health department staff opportunities to conduct community-based public health research and projects with UW faculty. Nearly all first year COPHP students are placed in practicum assignments at Public Health that complement their coursework. COPHP pays for a part-time practicum coordinator who is a Public Health employee and a COPHP graduate. The coordinator solicits practicum opportunities from Public Health staff, reviews projects for feasibility and appropriateness of skills, oversees students' self-assessments, and works with site supervisors to initiate the practicums. Students work closely with faculty advisers throughout the process. Practicum projects include community assessment, health education, program planning and evaluation, policy development, and community mobilization. The service learning experience has been beneficial to Public Health, COPHP students, and the greater King County community.

Keywords: Academic health department, Employment, Experience, Faculty adviser, Learning contract, Networking, Partnership, Practicum, Project, Self-assessment, Site supervisor.

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Bud Nicola & Amy Hagopian (Eds.)

INTRODUCTION

A practicum is an essential element of any MPH curriculum and especially of COPHP. Council on Education for Public Health guidelines stipulate that accredited institutions include a practice experience requirement for all students prior to graduation. While classroom education is essential to developing robust skills in core public health areas such as epidemiology and policy development, the practicum experience provides an opportunity to apply classroom learning in real-world settings. When students ask, "Why do I need to study biostatistics if I'm planning to be a health educator?" they usually need not look further than their first-year practicum experience.

In COPHP, problem-based learning is a powerful teaching method designed to prepare students for the work environments they will encounter in governmental and community-based agencies. Given that focus, we wanted to provide a robust practicum program that guaranteed students a comprehensive and well-mentored public health practice experience.

PRACTICUM PARTNERSHIP

Our practicum program is driven by a formal partnership between COPHP and Public Health— Seattle & King County (Public Health), a large metropolitan health department providing the full range of local public health services. Public Health provides prevention-oriented programming and primary care services. The agency partners with community-based organizations to directly provide, as well as advise on, public health initiatives and services. These community connections provide additional networking opportunities for practicum students. Public Health has a strong investment in public health research and a long history of academic-practice collaborations, including a formal "academic health department" program. In 2003, motivated by the Institute of Medicine *Future of Public Health* report urging more academic-practice linkages, Public Health and the University of Washington jointly applied for and received a one-year Academic Health Department grant from the Association of Schools of Public Health (ASPH – now known as the Association of Schools and Programs of Public Health, ASPPH).

Public Health envisioned its health department serving as a teaching institution for public health students, in the same way that the county hospital serves as a teaching hospital for the university's medical school. The partnership would also allow the health department to train students on-site in real world public health practice, enhance the public health workforce through resource sharing and technical assistance, and conduct community-based public health research with UW faculty. The UW shared many of the same partnership goals, and beginning with the ASPH grant, COPHP made a major investment in student training.

Through a unique arrangement with Public Health, nearly all first year COPHP students are placed in practicum assignments at Public Health that complement their coursework; less than 5% of practicum placements are in other community-based organizations. COPHP pays for a part-time practicum coordinator who is a Public Health prevention specialist and a COPHP graduate. Practicum projects include community assessment, health education, program planning and evaluation, policy development, and community mobilization. All students are mentored by master's level staff. The result is a service learning experience that is mutually beneficial to Public Health, COPHP, and the King County community. COPHP students have built a strong reputation with public health staff over the years. They are seen as having a strong work ethic, commitment to social justice, comfort with assignments that entail some ambiguity, and aptitude for working in teams. With these qualities in high demand, there are always more practicum projects available than students.

The practicum program benefits both partners. On the university side, our students are taught to apply what they've learned in the classroom. On Public Health's side, students import new ideas and skills to Public Health. And the program also provides Public Health staff with opportunities to enhance their skills in coaching, mentoring, and supervision. In many instances, the practicum has turned into a capstone, part-time employment, or fulltime employment post-graduation, as Public Health frequently hires COPHP graduates to continue infusing their programs with new ideas and the latest skills in community-based public health.

CHAPTER 9

Skills Seminars

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Abstract: As we developed the curriculum for the MPH in Community-Oriented Public Health Practice (COPHP), it became clear that there were skills and competencies that might best be taught using traditional lecture or interactive faculty presentation and discussion methods rather than problem-based learning (PBL). We see some of these skills as prerequisites to PBL. We try to align these traditional learning sessions, or seminars, with PBL cases and the faculty who facilitate them. Since students, through their periodic input, helped to design the overall COPHP, we have integrated into our program design opportunities for students to take charge of organizing seminars during the second year.

Keywords: Active learning, Competencies, Curriculum, Lecture, Seminar, Skills, Student involvement, Teaching methods.

HISTORY AND BACKGROUND

We designed COPHP around the principle that active learning increases student performance [1]. Nonetheless we recognized that students would benefit early in the program from short presentations or learning labs to impart certain essential skills. We also realized that seminars were an opportunity to showcase local public health role models who were engaged in exemplary work. One such skill is the facility to conduct rapid research using online library resources, understand how to use library databases, and recognize credible sources of information. Over time, this learning took the format of weekly skills seminars in 90-minute sessions.

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Bud Nicola & Amy Hagopian (Eds.)

During the first six years of COPHP, the program director planned all sessions for the first year of the program and involved faculty in planning seminar content for second-year students. More recently students have taken charge of the second-year seminars and have worked with faculty from each block to coordinate with block material, to organize sessions, and to invite speakers on various topics. During a recent year, second year students even took it on themselves to sponsor seminar topics in an impromptu additional forum, with first year students as their primary audience.

The COPHP program directors learned what skills were essential early in the program. These skills include library research, group facilitation, and basic knowledge of the University of Washington's Institutional Review Board and the steps required to obtain approval for a master's thesis or project that involves human subjects. We have found that student ownership of the planning and scheduling of second-year topics has increased interest and participation in these sessions. The student involvement also resulted in active participation by block faculty in attending seminars and coordinating them with PBL cases.

FIRST-YEAR TOPICS

Students have helped identify topics that are better learned *via* structured skills seminar or bringing in community experts to discuss their experiences than through the free-form research cycle that is PBL. In particular, seminars address aspects of these topics where a seminar will provide an overall framework, teach a specific skill, or share perspectives from experts and community members. For the first year, topics are selected to address the following overall learning objectives:

1. Describe large public health problems facing populations:
    - Global burden of disease
    - Institutional racism
    - Challenges faced by immigrants
2. Incorporate important public health methods into your case work, including:
    - Conducting community-based participatory research
    - Reading journal articles and conducting literature reviews

- Conducting stakeholder analysis

3. Apply skills required for successful problem-based learning, including
   - Facilitating small groups
   - Writing well
   - Conceptualizing and planning for the capstone project
4. Embrace the role of political activism in public health

Examples of Seminar Sessions in the First Year

Methods #1: Small Group Facilitation

This session addresses issues such as the indicators and factors contributing to successful meetings, ways to become a better facilitator, how students can best prepare for roles as facilitator or group participant, and ways to provide feedback to group facilitators to improve their skills.

Capstone Master's Projects

In this session, a panel of recent graduates discusses how to choose a capstone project.

Working in Communities

This session supports conversations about the effect of working in communities and the role of students and faculty in cultivating and sustaining community relationships.

SECOND-YEAR TOPICS

The following are the overall learning objectives for second year seminars:

1. Describe the role of public health activists in advancing progressive public health policy:
   - Running for office
   - Running a policy institute
   - Professional association involvement
   - Farmworker housing advocacy: NW Justice Project

CHAPTER 10

COPHP Curricular Content Areas

The following subchapters represent the main teaching blocks of the COPHP program. Each subchapter will include:

- The role of this topic in public health practice and in an MPH curriculum
- Learning objectives for this topic
- Application of experiential and problem-based learning to the topic
- Case examples and the process of choosing cases
- Working with communities
- Challenges of teaching this topic

CHAPTER 10-1

Population Health

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Abstract: A population's health status and factors determining it are vital to producing health of the citizens therein. The evidence is overwhelming that people in the United States have worse health outcomes than those in other rich nations. Yet this fact is little appreciated in the United States. U.S. public health practice remains rooted in the 20th century with efforts to change personal behaviors, access health care, and ensure satisfactory sanitation outcomes. Professional public health education remains similarly stuck in the last century's paradigms. The population health block of the MPH in Community-Oriented Public Health Practice attempts to orient students to 21st century public health with a focus on creating appropriate structures in societies to make a population healthy. Such an approach is inherently political, which is a challenge in the United States because we tend to view health through an apolitical lens. This chapter explains the population health approach, which requires students to look at other countries to learn about health production. The goal: for people in the United States to not be dead first but to live longer healthier lives.

Keywords: Barker hypothesis, Early life, First thousand days, Health, Inequality, Inequities, Life expectancy, Medical harm, Morbidity, Mortality, Population health, Socioeconomic gradient, U.S. mortality.

LEARNING OBJECTIVES FOR THE POPULATION HEALTH BLOCK

As in the other blocks of the COPHP program, we build our coursework on learning objectives. By the end of the population health block, students should be able to do the following:

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1. Rapidly synthesize public health literature and facilitate problem-based learning groups.
2. Describe concepts of health as applied to human populations.
3. Analyze the status of health in the United States and health inequities within the United States and between the United States and other nations.
4. Analyze the trends in relative health status for the United States in recent times.
5. Critically discuss the impact of current medical and public health interventions on health outcomes for populations.
6. Recognize the contribution of medical care to morbidity and mortality.
7. Consider the key role of societal hierarchy in determining health.
8. Prioritize health production efforts over the human life span, and consider when hierarchy may have its maximal impact.
9. Relate early life to adult health.

CASE EXAMPLES

When we launched the COPHP program in 2002, we decided to begin with population health. Our first challenge was to situate health status in the United States in the context of other nations. This context is relevant in the current selection of cases we use for the population block, summaries of which are as follows:

Americans: Dead First

The initial case in the population health block exposes students to the fact that U.S. mortality outcomes are shockingly poor. We die younger than people in the other rich nations. The mechanism we use to make this point is that of a speechwriter for the president who wants to tell the people this bad news. The case brings students to the Institute of Medicine's report on “U.S. Health in International Perspective: Shorter Lives, Poorer Health”, a reputable source that is backed up by many others. Students outline the speech and it is then recorded as they present it. The case requires students to come up with conceptualizations of health for a society. People in the United States seem to prioritize living a longer life rather than a shorter one. U.S. health care spending—an estimated $3 trillion in 2014, or fully a sixth of the U.S. economy—amounts to close to half of the world's total health care expenditures. In this case, we expose students to our high

level of spending as well as the paradox that it does not buy us health (life expectancy). The rest of the block continues to explore these points.

The 49th Parallel: A Health Divide

The University of Washington is located close to the U.S.-Canada border, so it is natural to compare the health of people in Canada with those in the United States. This comparison reveals vast health inequities—namely, poorer health outcomes for those in United States. A similar contrast is revealed when we compare the status of residents of Washington State with those of our provincial neighbor to the immediate north, British Columbia. The case situates an MPH graduate working in the Washington State Department of Health who is asked to make health comparisons with Canada. Students are tasked with playing a board game on the social determinants of health developed by a Canadian medical student and a public health student. They are also required to organize a community event and hold a screening of one of two documentaries: *These are Unnatural Causes: Is Inequality Making Us Sick,* or *The Raising of America: Early Childhood and the Future of our Nation.* New documentaries are forthcoming.

More Health Care = More Health

In the United States, medical care is considered to be the key factor in producing health, and the terms "health" and "health care" are widely considered to be synonymous. This case continues the story of the Department of Health student employee, who must come up with a media campaign to inform the public about the limitations of health care in producing health. In the process, the student is exposed to the concept that medical care, that is, the provision of medical services to sick people, is always a leading cause of death (medical harm). As with all cases in the population health block, we hope to challenge students' core beliefs. The students have to consider the profit motive in delivering medical care in the United States, an exercise that also explores the possibility that not-for-profit institutions may achieve lower associated mortality than do for-profit institutions in the health care system. The students grapple with ways to inform the public about these matters. During this block, students come to appreciate the limitations of medical care in producing health, a concept that is rarely addressed in MPH

CHAPTER 10-2

Community Development

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Abstract: Community development is a key concern of public health and a central focus of the MPH in Community-Oriented Public Health Practice (COPHP) curriculum. Our community development blocks, which occur in both the first and second year of COPHP, introduce students to the challenges of working with communities on issues related to health. These blocks are intense for faculty and students alike because they must cover in a short period a broad range of material that spans sociology, organizational theory, epidemiology, and psychology. They also require students to make quick connections between a growing body of research literature and real word community challenges; entail organizing and conducting fieldwork with community partners; and expose students to provocative ideas and norms. The COPHP program has achieved considerable success with its community development blocks in meeting learning objectives that address issues such as defining and applying a true concept of community in a variety of settings; recognizing communities' assets and problems; describing approaches to getting things done at the community level and assembling a team to do them; and completing strong written assignments on tight deadlines. Through the community development blocks and student projects, the COPHP program has built enduring connections with community partners and has helped address local challenges ranging from securing housing and health services for homeless youth to accommodating the needs of recent immigrants in disaster preparedness.

Keywords: Cognitive distortions, Communications skills, Community, Community assets, Community based participatory research, Community development, Community organizing, Community partners, Practical applications of theory, Project planning, Public health practice, Student presentations.

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Bud Nicola & Amy Hagopian (Eds.)

INTRODUCTION

As public health professionals come to recognize the underlying and fundamental determinants of health, we become more interested in the power of social capital and community factors in promoting health. Until fairly recently, the profession's focus has been on the proximate causes of morbidity and mortality (heart disease, cancer, stroke, *etc.*) rather than the fundamental issues that lead to those manifestations of poor health. These underlying factors include racism, poverty, isolation, alienation, powerlessness, and other problems that are better addressed by social activism than by medical intervention. Public health activists have long recognized the power that lies within communities to advance public health and well-being, and there is a growing body of literature and experience from which to draw for this course.

A major challenge associated with offering a course addressing community development is the range of material that must be covered. Community development is an interest of sociologists, organization theorists, political scientists, epidemiologists, and psychologists, to name a few disciplines contributing to our knowledge of working with communities. Another challenge is resolving what, exactly, to call this concept. “Community” must be one of the most worn-out words in the social services field. Many government agencies and voluntary organizations use the word in their names or mission statements. But if you ask folks what the term means, they will have a hard time agreeing on a definition. Similarly, some believe the phrase “community development” is paternalistic, thus leading us to some of the political issues in the field. An overriding goal of this block is for our students to understand the concept of community.

We know from our work developing the COPHP program that there are few courses on community development for health, *per se*, on the University of Washington campus or elsewhere in the country. We also know that the concepts concerning communities commonly arise as we teach other subjects essential to public health practice.

OUR APPROACH: LEARNING THROUGH APPLICATION

The key to our teaching approach in this block is practical application. We

emphasize skill development over the attainment of knowledge. Just as we expect students to explore community development theory, we also search for opportunities for practical applications of the theories. We believe that community development skills are achieved through application, and we believe that the applications must be real; students must undertake actual useful work to give context to the theory. Without context, community development theory can appear to be turgid and pedantic, especially for those students who have never worked in communities. The COPHP program offers two courses in community development, and the timing is key.

First-Year Course

First-year students start our program with a block on population health and the social determinants of health. There is a lot to learn in this block, and much can be learned in the library. We encourage our students to read academic studies as well as the popular press, government documents, and white papers. The population health view is from "10,000 feet" and is strong on theory. For the community development block, however, we intentionally bring the students back down to earth to work on problems at the community level. We want them on the ground in communities talking to people from all parts of the community and not just sitting in front of their computer screens to complete learning assignments.

We find community partners that have real work they would like to have done, and students get assignment memos from agencies with specific work requests. This step assures that agencies' expectations are clear and it puts gentle, but real, pressure on students to get something done in a short time frame. That pressure, we know from the literature on adult learning [1], instills in students a compelling need to develop and *retain* knowledge and skills.

Day One of cases in this block supports a theoretical exploration of a community-based problem to prepare students for their assignments. In Day Two, a community-based agency makes specific work requests, including a letter with the assignment. From this point, students fill in remaining knowledge gaps and make a plan to get the work done. Typically the students have about 10 calendar days to 1) do their fieldwork, 2) write a report, and 3) make a presentation.

CHAPTER 10-3

Quantitative Research Methods

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Abstract: When public health graduate students enroll in their first epidemiology and biostatistics courses, they vary widely in their knowledge of and comfort with quantitative research methods. This chapter highlights the challenges and rewards of presenting quantitative concepts to students using a problem-based learning (PBL) approach. We suggest adaptations to usual PBL practice to optimize learning for a diverse group of learners. We introduce instructors to a variety of teaching tools for conveying quantitative methods course learning objectives. We provide synopses of six PBL cases and suggest ways to develop cases that incorporate "shoe leather epidemiology" and meet community data analytic needs. Finally, we contrast learning through lecture with learning through experience, arguing that with PBL, students gain knowledge about quantitative research methods that is more than skin deep, and as such, has longer and deeper staying power when graduates embark on their careers as public health practitioners.

Keywords: Biostatistics, Case writing, Community-based teaching, Didactic *versus* experiential instruction, Epidemiology, Learning environment, Learning objectives, Math anxiety, Preparing public health practitioners, Problem-based learning, Public health learners, Public health pedagogy, Public health practice, Quantitative methods, Teaching.

INTRODUCTION

Epidemiology and biostatistics form the backbone for public health research and practice. Epidemiologists and biostatisticians develop, hone, and apply quantitative research methods to count, describe, and ascribe risk to potential

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Bud Nicola & Amy Hagopian (Eds.)

causes of health conditions and evaluate health interventions, programs, and policies [1, 2]. Communities rely on epidemiologists and biostatisticians to characterize the prominent health problems affecting their populations, to provide and interpret the evidence for making decisions about which health programs to implement, to track temporal trends in diseases and exposures, and to serve as public health detectives when diseases of mysterious origin appear. This chapter is about how we use problem-based learning (PBL) pedagogy to prepare public health practitioners to appreciate and use quantitative research methods to improve health in populations.

TEACHING QUANTITATIVE RESEARCH METHODS *VIA* PBL

Previous chapters introduced PBL as a method of teaching in public health courses. Teaching quantitative research methods *via* PBL is both highly challenging and rewarding and differs from teaching population health, community development, or other COPHP courses in two important ways:

- **In epidemiology and biostatistics, there are right and wrong answers**. While perspectives on the political forces that shape population health are to some extent based on opinion, questions about the strength of association between a risk factor and a health outcome, the sensitivity of a screening test, or the crude *versus* age-adjusted mortality rate are answered *via* computations and formulas. Thus in addressing quantitative methods, PBL discussions focus less on debating global issues and more on struggling to grasp quantitative concepts: underlying variable coding and regression equations, the meaning of statistically significant effect modification, or the implications of a low positive predictive value.

In addition, course concepts are taught in sequence. Students must grasp the initial building blocks—differences between proportions, rates, and ratios—before they can move forward to understanding prevalence, incidence, odds ratios, and relative risks. Instructors must follow a logical, linear progression to introduce these quantitative research concepts. Once the learning momentum accelerates, if students fall behind, it is difficult for them to catch up.

- **There is wide variation among students in experience, skills, aptitude, and confidence about quantitative methods.** Many able students emerge from their

primary, secondary, and post-secondary education with an unhealthy anxiety about performing poorly in math. Student anxiety is a major impediment to successful attainment of learning objectives in a PBL context. To optimize learning, the instructor must listen to and appreciate the variation among students in comfort, learning styles, and skills. Rather than expecting one size to fit all, the instructor charts and supports multiple pathways to mastery.

PBL TEACHING STRATEGIES FOR QUANTITATIVE METHODS

To address the unique features and specific challenges of teaching "public health math", we offer students a variety of learning modalities. Over the 10-week Quantitative Methods (or Quant) course, groups of eight students meet together to read, digest, and discuss six PBL cases during two 3-hour sessions per week. During these sessions, the students work together, with minimal instructor intervention, to make sense of the case and identify the questions the case is raising. By the end of the class session, they have compiled a list of "need to know" items that they divide into eight pieces, one for each student. Each student conducts research, composes a three-page "posting" to teach classmates the concepts, and submits the posting prior to the next class. All members of the group are expected to read classmates' postings and prepare for discussion in the next classroom session. The instructor reads student posts and comments on epidemiology/biostatistics points that were well-made as well as those that were poorly articulated or incorrect. The following day, in a pre-class coaching session, the instructor reviews these points with a student facilitator who will lead the class discussion.

During several of the PBL sessions, students gather in a computer lab to learn to use statistical software and accumulate skills in statistical analysis. We offer weekly 1.5-hour seminars in a semi-didactic format during which a skilled math communicator uses PowerPoint slides to convey quantitative concepts and demonstrate their application through examples. We augment didactics with problem sets that students complete in small groups. Assigned readings—usually deemed impediments to discovery learning in other PBL courses—help to even the playing field among students with different learning styles and abilities and to establish a common vocabulary and library of examples. A reference shelf in the

CHAPTER 10-4

Environmental Health

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Abstract: The Environmental Health block of the MPH in Community-Oriented Public Health Practice is designed to help students understand the environmental public health system and how it investigates and reduces community risks from agents that cause disease, injury, and death. The case studies primarily address the recognition of various hazards in the environmental and occupational setting; the theoretical construct for understanding the properties of these hazards; the exploration of the factors that can generate or diminish exposure and reduce disease incidence and severity, especially in vulnerable populations; and the importance of risk communication in addressing environmental issues. The cases ensure that students learn about local, state, and national laws and regulations promulgated to reduce exposure and disease from environmental factors and also how to mine these standards for gaps and incongruent policies. They focus on determining causal factors and mitigation approaches as they explore the politics and pressures of the environmental health challenge. We press students to search for inequities in exposure and disease risk such as evidence of institutional racism in high risk communities. This core prepares public health practitioners to work on community environmental health risks to reach fair resolutions and reduce adverse health outcomes.

Keywords: Built environments, Causality, Climate change, Environmental contamination, Environmental epidemiology, Environmental health, Environmental racism, Executive briefing, Exposure pathway, Exposure potential, Hazard analysis, Health disparities, Institutional racism, Protection standards, Regulations, Risk benefit analysis, Risk mitigation, Town hall meeting, Toxicology, Vulnerable populations.

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Bud Nicola & Amy Hagopian (Eds.)

LEARNING OBJECTIVES

We expect students to understand the core concepts of environmental health (EH) in the current paradigm of public health practice, and the learning objectives for this block reflect this expectation. They are:

1. **Increase awareness of the environment's role in healthy communities**. Students learn to define the concept of environmental health and apply that concept to a variety of community settings and topical situations. Digging deeper, they learn to recognize principal health risks from chemical, microbial, and physical hazards encountered through environmental pathways and to attach significance and context to problems within communities. Given that change is constant, it is important that students can identify and describe potential effects of demographic change, economic development, built environments, environmental pollution, and climate and ecosystem change on health.
2. **Understand the environmental public health system at the local, state, and national level as it works to reduce exposures to agents in the community's environment**. The environmental health field is largely based on laws and regulations that are implemented and enforced by federal, state, or local public health agencies. Our cases are designed to explore the complex interactions between federal, state, and local policies and the agencies charged with their implementation.
3. **Increase understanding through quantitative and qualitative characterization of complex, multi-faceted environmental public health problems.** Students define and characterize exposures to physical, infectious, or toxic agents from major environmental and occupational health problems that are associated with morbidity and mortality in both industrialized and developing countries.
4. **Recognize how vulnerable populations can be at greater risk for a variety of environmental health-influenced health outcomes.** Students learn to think critically about what population characteristics are associated with greater risk for disease and injury associated with environmental contamination, both generally and within the specific context of each case study. They practice important concepts of environmental justice and community engagement while

proposing sustainable solutions to environmental health problems.

5. **Envision the component steps and overall process of conducting a health hazard assessment.** Consistent with our problem-based learning approach, we design environmental health case studies to present some of the many environmental hazards that can confront a community. Students work through their learning objectives to understand the concepts of hazard analysis and exposure of an agent, including a risk analysis of the agent based on its toxicity and dose, the frequency and duration of exposure, and the exposure pathway. They also probe the particular characteristics and vulnerabilities of the exposed community and the environmental context surrounding the case—which can enhance or decrease exposure potential of this community to the agent under study. The disciplines of toxicology, epidemiology, and laboratory science are explored in the learning objectives as methods to evaluate the risk of exposure and disease so students more fully understand the risk paradigm of an environmental health threat.
6. **Understand the various approaches to preventing, controlling, and mitigating environmental health risks to a community.** COPHP students conduct research to find approaches to controlling or mitigating hazards as they also seek to determine the root causes for the community's exposure to the agent of concern. Through the review of the literature, interviews with involved entities, and discussions with real communities about their challenges in similar scenarios, students learn about environmental health risks and develop strategies to decrease the harm of these risks to communities.
7. **Understand and develop skills to effectively educate the public, policy makers, elected officials, and other stakeholders about environmental public health risks and health risk assessments.** This communication includes disease and injury causation to ensure that decisions are sound, are risk-based, and result in appropriate public health actions. We expose students to different communication modalities to communicate health risks and proposed solutions.

CASE EXAMPLES

We select cases for the environmental health core with the goal of providing a learning platform of relevant current events that illustrates the complexity of a

CHAPTER 10-5

Health Behavior and Health Promotion

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Abstract: Students in the MPH in Community-Oriented Public Health Practice (COPHP) frequently progress to careers that require strong skills in health behavior and health promotion. Learning objectives for COPHP's Health Behavior and Health Promotion block cover skills in program planning and assessment, theories of behavior change, and application of an equity lens in health promotion. Cases in this block explore content through specific health topics. As in other COPHP blocks, students teach themselves and each other as they review cases, write and discuss learning objectives, post research findings, and conduct practical assignments. Faculty who facilitate this block rewrite cases annually to ensure they include at least one timely topic that the students will be eager to explore, and real world practitioners lead seminars that complement the cases. Challenges of the Health Behavior and Health Promotion block include teaching complex theory and extensive skills in a short time, keeping the health topics compelling to students, and making sure students maintain an appropriate balance between exploring interesting health topics and understanding the fundamentals of health promotion.

Keywords: Assessment, Communication, Cultural competency, Ethics, Health behavior, Health promotion, Literacy, Objectives, Planning models, Prevention, Primary prevention, Program design, Program planning, Protective factors, Risk, Secondary prevention, Tertiary prevention.

INTRODUCTION

COPHP students take the Health Behavior and Health Promotion block at the end of their first year in the program. At this point, they have been immersed in

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population health, community development, quantitative methods, and environmental health, and they are ready to synthesize skills from those topics and design health promotion programs. Students are typically very excited for this block; many declare in their admission materials that they picture their futures working with communities to implement successful health programs. Many COPHP graduates do indeed find health program management jobs in community organizations or governmental agencies.

The coursework in the Health Behavior and Health Promotion block covers program planning models, assessment techniques, theories of behavior change, equity in program planning, health communication, and an introduction to program evaluation. Students approach these fundamentals through the COPHP program's social justice lens, which encourages them to analyze the faults as well as the merits of health interventions and exposes them to the ambiguities and challenges of developing health programs as community outsiders.

APPROACH

As with other COPHP blocks, we teach Health Behavior and Health Promotion with a set of cases built around a health topic (obesity, communicable disease, tobacco) that also include teaching notes with prompts and questions to ensure students cover important learning objectives. We use classroom time to collectively generate learning objectives, and then students have two or three days to research an objective using primary and secondary sources and write up a post for their peers. We then analyze the posts in class. Faculty participate very little in the discussions but provide extensive feedback on postings, especially focusing on how well students synthesize information from their research and are able to communicate their ideas to their peers. Most of the cases culminate in a practical project that the students do alone, in small groups, or as a class. Examples of projects are designing and presenting a health communications campaign, developing a sample health intervention that focuses on an assigned level of the social-ecological model, and creating a mock town meeting to discuss a disease outbreak.

WORKING WITH COMMUNITIES

This block uses weekly seminars to introduce students to local examples of health promotion efforts similar to those in the cases. The seminars provide an opportunity for students to conduct a dialogue with experienced professionals about health topics and the skills involved in health promotion. Seminar speakers have included health outreach workers who engage with men who have sex with men, a health communications account manager from a national firm, and a panel of professionals developing obesity programs for families, employees, and large geographic populations. We encourage students to develop questions in advance for the speakers, and a faculty moderator assures that the questions are equally distributed across the small group cohorts—this assures that all groups receive information relevant to their specific interests or concerns.

LEARNING OBJECTIVES AND CASE EXAMPLES

The Health Behavior and Health Promotion block covers a broad area to equip students for public health careers. As the list below reveals, most of the objectives include understanding a key concept and being able to apply it. The application occurs in the practical assignments and posts. The learning objectives are:

- Develop a comprehensive understanding of a health problem and risk and protective factors associated with it; identify predisposing, enabling, and reinforcing factors that foster or hinder health and well-being for a health issue.
- Describe the distinction between primary and secondary prevention.
- Explain how to use rapid assessment techniques to involve target populations and the community in problem identification and solutions.
- Identify Precede/Proceed model phases; use planning models to assess factors that affect the health of designated groups.
- Define cultural competence frameworks and explain how they relate to health promotion/disease prevention practice.
- Recognize historical underpinnings of relationships between diverse communities (*e.g.*, African-American, gay) and the public health system.
- Understand the interaction of environmental variables and health behaviors.
- Understand principles and issues involved in ethical and sensitive conduct of

CHAPTER 10-6

Evaluation

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Abstract: COPHP Evaluation block occurs over a four week period during the second year of the program. It builds on a case that focuses on designing an evaluation for an outside client. The evaluation requirements are detailed early on in the case, and the class subsequently meets with the client to clarify questions about the evaluation and understand constraints on the process. Students then design the evaluation, write a report on the evaluation plan, and present the plan to the client at the end of the course. The case covers evaluation theory in the first two days, and the course focuses on applying to the design process both evaluation theory and quantitative design skills covered previously in the quantitative methods block (epidemiology and biostatistics). The block emphasizes the important skills of interacting with clients and eliciting and clarifying evaluation requirements.

Keywords: Barriers, Data, Evaluation, Evaluation design, Evaluation theory, Evaluator, Logical framework, Policy, Program theory, Variables.

INTRODUCTION

The evaluation block takes place at the start of the winter quarter in the second year of the program. As the block lasts for just four weeks, the class designs, rather than conducts, an evaluation. The focus on the design process has the advantage of emphasizing the process of developing an evaluation question through interactions with an outside client. Students lead this process, producing a detailed evaluation plan for the client and presenting the results to the client on the last day of the block. We cover evaluation theory through a combination of the

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learning objectives for the second day of the case and class seminars.

CASE DEVELOPMENT

COPHP finds clients for its evaluation block either directly through faculty contacts or through requests sent by email to program faculty and graduates. Cases are not recycled; each year, every class features its own case, although occasionally classes that occur simultaneously will uses cases that share the same client. After a client has agreed to participate, faculty draft the case based on interactions with the client, typically in person or by phone. Following are some recent clients and cases:

Real Change Organization

Evaluation of services offered to the vendors of *Real Change*, a weekly street newspaper sold by homeless and other very low income individuals in Seattle.

The Seattle Office of City Auditor and The Seattle Office of Civil Rights

One project involving evaluation of the effects of the new Seattle paid sick and safe leave ordinance on employment of low-wage vulnerable populations. A second project involving evaluation of the effects of the Seattle paid sick and safe leave ordinance on minority and immigrant employers who own small businesses (*e.g.* nail salons, restaurants, *etc.*).

Assessment, Policy Development, and Evaluation Unit (**APDE**), Public Health —Seattle & King County

Evaluation of the SeaTac and Tukwila Food Innovation Network

Neighbor Care and King County School Health, Public Health—Seattle & King County

Evaluation of knowledge and uptake of long-acting contraceptives in Seattle high school-based clinics.

Health Equity Circle and IAF Northwest

Evaluation of clinic based organizing.

CLASS PROCESS

The cases are relatively short; day 1 is written to elicit learning objectives that target knowledge the students will need about the client and about the subject matter domain. During the first week a seminar is also typically given by a guest presenter with experience designing and conducing public health evaluations (for example, as an evaluation consultant). This seminar covers the process of developing evaluation questions, developing a theory of change, and using logic models.

Day 2 targets evaluation theory and is generally similar year to year. We hint that students may generate suitable learning objectives for this day by summarizing individual chapters of an evaluation textbook (for example, Grembowski's *The Practice of Health Program Evaluation*). Some topics (such as reliability and validity) are already familiar to the class from the quantitative block. Day 2 learning objectives also focus on evaluation theory for vulnerable or difficult-to-reach populations.

Day 3 ideally occurs immediately after a "meet the client" seminar, and it starts the process of designing the evaluation. We usually provide the evaluation question, but students often refine it further in consultation with the client. As part of the assignment, we provide a table outlining different aspects of an evaluation plan that should be included in the report; this serves as a grading rubric for the final project. Students typically assign roles during Day 3, and a specific student (often the student who takes on the role of project manager) has responsibility for coordinating all client interactions, as additional questions for the client are usually generated throughout the design process.

Students often begin by developing a theory of change and/or logic model, followed by selection of specific methods to answer different aspects of the evaluation question. We encourage students to create skeleton tables so they become familiar with clearly defining their data needs and thinking in terms of

CHAPTER 10-7

Policy

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Abstract: The policy block is a cornerstone of COPHP experience. For 10 weeks at the beginning of the second year of the program, students engage in public discussions across all spectrums of the social determinants of health and such non-traditional public health topics as free trade and nuclear waste disposal. During this block, students work through real-life scenarios and participate in actual policy development. They benefit from the close relationships the program maintains with non-profit organizations, and the work they have conducted under their auspices during the policy block has been well-received and influential. In the course of community-based projects, students work in concert with local stakeholders and public policy makers. By the end of the block, students have learned the basic concepts, analytical tools, and skills for policy analysis, development, and advocacy, and some have also developed the inclination to pursue public health policy careers.

Keywords: Advocacy, Analytic tools, Conflict, Context, Cultural framework, Delivery, Financing, Health policy, Policy, Policy analysis, Political framework, Public policy, Stakeholder, Values.

INTRODUCTION

At the beginning of students' second year, an entire academic quarter (10 weeks) is dedicated to the study of health policy. Health policy refers to public decisions that guide organizational and individual behaviors affecting health and financing, delivery, and use of health services. Students learn the basic concepts, analytical

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tools, and skills for policy analysis, development, and advocacy. By understanding the complex array of factors that affect public policy, and therefore how organizational and individual behaviors are influenced in regards to health, students are able to work within the cultural and political frameworks that influence and change the nation's health system.

Without adequate exposure and study of this topic, students would leave the program with a significant gap in their ability to be effective public health practitioners. Public policy in particular touches aspects of every life in the United States and is a major determinant of health outcomes. Even if students chose not to pursue a career in policy, this block prepares them to know how to get a health promotion campaign funded, assess critically whether initiatives or levies will benefit their community, or how to design a study that will both get the necessary answers and be useful in addressing conflicts among key stakeholders.

LEARNING OBJECTIVES

The learning objectives identified in the policy syllabus are:

1. Identify and understand the historical, social, cultural, economic, and political context of a public policy issue.
2. Identify and analyze the stakeholders and their interests in relationship to specific policy issues.
3. Identify and apply the policy tools and analyze options for using them to address a specific public policy issue.
4. Understand and analyze the roles of science and values in choosing a course of public policy action.
5. Identify appropriate measures of success or failure of a public policy action.
6. Present concise analyses of public policy issues both orally and in writing.

MAKING POLICY

The COPHP program is rooted in experiential and problem-based learning and this continues in the policy block. No case of the policy block occurs in isolation, as each block is rooted in real-life scenarios and requires students to reach out to public health professionals around the world. The block also takes the students on

an all-day field trip to visit the Hanford nuclear site in southeastern Washington State, followed by activities to develop and execute a lesson plan for local high school students that addresses the site's long history producing plutonium for the nation's defense program and the cleanup of the nuclear waste it generated.

Additionally, the policy block draws on the real-world needs of partner organizations to develop policy stances. Faculty have relationships with a number of policy-related organizations and agencies, and they have engaged students in working on cases with these partners. For example, as a service to the Seattle-based Economic Opportunity Institute, COPHP students conducted some of the early research on stakeholder views of city-mandated sick leave policies, contributing to the 2012 ordinance adopted by the Seattle City Council. One of our alumni works for the Washington State Board of Health developing health impact assessments (HIAs) for legislators seeking estimates of the health effects of proposed legislation; we now have a case where students help develop procedures for those HIAs and actually conduct them. For the county health department, students have researched best practices in policy to reduce the consumption of sugar-loaded beverages, how the federal Patient Protection and Affordable Care Act (ACA) could be leveraged to improve the health of jail-involved individuals, and how the ACA would affect insurance coverage in King County, especially as related to small businesses.

Since 2010, the American Public Health Association has adopted eight policies authored by COPHP students. They are:

- Prioritizing Cleanup of the Hanford Nuclear Reservation to Protect the Public's Health Policy #20105
- Improving Housing for Farmworkers in the United States Is a Public Health Imperative #20107
- Improving Access to Higher Education Opportunities and Legal Immigration Status for Undocumented Immigrant Youths and Young Adults #20117
- Improving Housing for Farmworkers in the United States Is a Public Health Imperative #20118
- Anticipating and Addressing Sources of Pollution to Preserve Coastal Watersheds, Coastal Waters, and Human Health #20126

CHAPTER 10-8

Management and Leadership

Chris Hurley[*], **Katie Bell** and **Bud Nicola**[*]

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Abstract: The Management and Leadership block in the COPHP program focuses on providing students with the skills and knowledge needed to direct and coordinate the efforts of individuals and organizations. Managers and leaders accomplish their work through and with others and must understand, motivate, and manage individuals, groups, and teams. Managers also establish directions, plan and organize the work to be done, identify and resolve problems, budget and manage the organization's resources, evaluate and improve performance, drive change, and establish and manage external relationships. In this block, we use cases set in a variety of different community health settings to explore the full range of management and leadership skills. Mini-cases illustrate management principles. Students visit several community organizations to observe management at work.

Keywords: Communication, Conflict management, Financial management, Interpersonal competence, Leadership, Leading change, Management, Organizational equity, Personal awareness, Strategic planning, Team dynamics.

MANAGEMENT AND LEADERSHIP ROLES IN PUBLIC HEALTH PRACTICE

COPHP graduates will practice their population health skills in organizations with other people. Without regard to a student's precise career trajectory, the COPHP program encourages all students to acknowledge and embrace their responsibilities as both formal and informal leaders in improving population health. Skills taught in the Management and Leadership block will help students work effec-

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Bud Nicola & Amy Hagopian (Eds.)

tively in groups and teams, in large and small organizations, with for-profit and non-profit and governmental organizations, and across organizations in collaborative teams.

LEARNING OBJECTIVES

The Management and Leadership block aims to help students explore the evidence and experience base underlying and informing management best practices. Students gain insight in assessing their own proclivities, strengths, and weaknesses relevant to management and leadership. They strengthen their competencies and skills to carry out core management and leadership functions and responsibilities, including the following fundamental learning objectives:

1. Manage with and through people, groups, and teams.
   - Describe the basic roles and responsibilities of managers and leaders. Understand the major theories of management and leadership. Describe approaches for energizing commitment and involvement by an organization's people in addressing challenges, achieving goals, and improving performance.
   - Describe approaches for recruiting, retaining, and developing human resources.
   - Assess personal strengths, weakness, and preferences and explore the implications of personal style and behaviors on abilities to work effectively with others.
2. Establish organizational direction, goals, and operational plans.
   - Describe the elements and methods for formulating organizational strategies, plans, and programs. Explore the limits of long term planning and the importance of contingent approaches in response to change.
   - Develop and communicate an organization's mission, vision, and values to motivate the organization's people and guide unit-level planning.
   - Explain the importance of aligning organizational goals, culture, structure, reporting relationships, budgets, and reward systems.
3. Guide and manage conflict productively.
   - Manage effective group decision-making, collaborative problem-solving, conflict resolution, team-building, and teamwork.

- Identify organizational problems that impede an organization's ability to carry out its functions; analyze problems; and identify potential solutions.

4. Budget and manage resources.
   - Explain methods for budgeting financial and human resources in support of goals, programs, and projects, and explain techniques for managing within a budget.
   - Describe sources of external funding and processes for seeking grants and other external resources.
5. Lead and manage change.
   - Explain approaches for bringing about change in organizations, including empowerment, training, removing obstacles, dealing with resistance, and rewarding successes.
   - Describe the elements and process of formulating a plan for introducing significant change in an organization.
6. Understand the dynamics of groups and effectively lead and manage teams.
   - Describe approaches for developing effective working relationships between an organization, its community, and other external stakeholders important to its mission.
   - Describe approaches for advocacy, collaboration, and social marketing to gain support for an organization's mission and programs.
7. Evaluate and improve organizational performance.
   - Describe performance measures and monitoring methods and the use of data and best practices to improve performance.
   - Define the core tools for analyzing and improving workflows and processes.
   - Explore the roles and responsibilities of managers and front line staff in improving safety, service, and financial performance.
8. Assess and improve the organization's performance as a just and equitable contributor to improving community health.
   - Describe tools to assess and enhance an organization's competence and effectiveness to engage and serve the diverse constituencies that make up its workforce and community.
   - Explain best practices for creating an equitable inclusive workplace.

CHAPTER 10-9

The Committee on Oppression, Racism, & Education (CORE)

Ariel Hart[*], Jennifer Hagedorn, Anne Althauser, Tara Bostock, Afomeia Tesfai, CORE Founders and **Amy Hagopian[*]**

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Abstract: The Committee on Oppression, Racism, and Education (CORE) is a group of Community-Oriented Public Health Practice (COPHP) students working to integrate anti-racist principles into the program. CORE provides a common language and framework to discuss racism in COPHP. It has a twofold overall purpose: to tackle manifestations of racism playing out in the classroom environment and in the COPHP program structures, and to ensure all students graduating from the COPHP program are prepared to address issues of racial equity as public health practitioners. By confronting the underlying drivers of health disparities that plague people of color, CORE has become a force for institutional change not just in COPHP but also in the School of Public Health, elsewhere in the University of Washington, and in the community.

Keywords: Anti-racism, Anti-racist education, Anti-racist principles, Anti-racist public health program, Classroom culture, Community engagement, Community organizing, Health equity, Institutional change, Institutional organizing, Institutional racism, Internalized racial inferiority, Internalized racial oppression, Internalized racial superiority, Micro-aggressions, Racism, Student-driven change, Systems of oppression, Undoing institutional racism, White privilege.

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Bud Nicola & Amy Hagopian (Eds.)

BACKGROUND

Problem-based learning, the teaching and learning method used in COPHP, gives students an opportunity to create the learning environment they want. But even within COPHP classrooms, students of color were experiencing the same, and sometimes more severe, micro-aggressions and marginalization than they had in past work and educational settings.

Before CORE, students lacked a common language or framework to discuss racism in COPHP, and it became clear that the program needed additional resources and dedicated time for anti-racist education. Several cases offered opportunities for students to discuss racism and its effects on health, but the conversations lacked depth and highlighted students' hesitancy to focus on racism. The program offered one two-hour seminar during fall quarter to explore the ways racism affects public health. But as future public health professionals, students felt it would be negligence to graduate with an MPH and not have a more comprehensive understanding and vocabulary about racism than could be offered in a couple of seminars.

CREATING CORE

In fall 2013, a few students came together to discuss the manifestations of racism in the classroom and within the structures of the COPHP program. They decided the program needed external support to become anti-racist. Students initially formed CORE to bring anti-racism organizers to COPHP, but the group quickly expanded its goals to become a force for institutional change within COPHP, the School of Public Health, other schools within the University of Washington, and the community.

CORE's goals are:

1. To support the COPHP program to deepen its commitment to using an anti-racism lens in all aspects of the program.
2. To work with other student groups, organizations, and departments across health sciences programs and the university as a whole to dismantle social, political, and economic oppression to create a sense of restored community and

mutual caring.

3. To build and maintain relationships with community organizations to establish accountability to racially oppressed communities in the Seattle-King County region.

FOCUS ON RACISM

In the United States, the racial categorization of human beings has enabled certain groups of people to have disproportionate access to educational, economic, social, and health opportunities. This specious categorization has played a pivotal role in creating the economic inequality and the poor health outcomes that we see in our country today. Our current societal institutions and systems frequently screen out people of color in a systematic manner from obtaining wealth, prosperity, and general success. Therefore, CORE members felt it was vital to critically analyze their own institution, the COPHP program within the University of Washington School of Public Health, to move toward a fully inclusive environment.

Other oppressions (sexism, heterosexism, classism, *etc.*) are also linked to health outcomes. But without an intentional focus on eliminating racist policies and protocols (both formal and informal), efforts to confront these other "-isms" will undoubtedly perpetuate racial disparities. Confronting the underlying drivers of health disparities that plague people of color requires that students build the skills necessary to identify barriers to health equity and challenge the systems and institutions that privilege white people to the detriment of people of color.

Guiding Principles

CORE adopted the anti-racist organizing principles of the People's Institute for Survival and Beyond as a framework to guide efforts internally and externally. Before fully embracing and using the principles, CORE brought anti-racist organizers to campus for a deep dive into racism in the United States and an examination of how internalized racial oppression and superiority were playing out in the classroom. CORE called for an anti-racist analysis to be integrated into the curriculum and competencies for all future cohorts as well. Partnering with the People's Institute provided students with a common analysis of racism as well as a deep understanding of oppression and organizing strategies to bring social

CHAPTER 11

Final Thoughts about the Future of COPHP and Conclusions

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Abstract: Public higher education in the United States is in great flux. A number of factors adversely affecting the effectiveness of higher education in the U.S., such as the erosion of public financial support, have undermined the COPHP program. Recruiting and retaining an ideal mix of motivated students and faculty are ongoing program tasks. In spite of these challenges, COPHP is an effective program for producing successful, motivated, and highly sought-after graduates in public health.

Keywords: Culture, Higher education, Faculty, Funding, MPH, Program size, Students.

REFLECTIONS

Now that our the COPHP program is a little more than a dozen years old, we have enough experience to reflect on how we might have designed some things differently. We also have some musings about our future.

We have highlighted all the ways in which our program succeeds and thrives in the previous chapters of this book. In this chapter we will reveal some of our continuing concerns and some of the downsides of this pedagogical model.

First, we exist in the context of public higher education in America, which is seriously in disarray. "Contingent" faculty are now the norm in U.S. higher education, with tenured or tenure track faculty at most institutions in the minority,

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and at our university this reality is even more exaggerated. The University of Washington (UW) as a whole moved from a position of 70% regular tenure track faculty before the 2008 economic collapse to 30% now. Public health master's programs at our university, and across the U.S., commonly supplement regular faculty ranks with part-time faculty whose regular employment is elsewhere; this can bring in niche areas of expertise. COPHP does this to an extreme. Further, those who do have more regular faculty appointments at the university are obligated to bring in the bulk of their salaries through grant funding, as state appropriations are far too small to support a full-sized school of public health. This context creates a situation where our highly student-focused program relies on faculty willingness to volunteer time to assess twice-weekly postings (usually in the evenings, when class is the next morning), as well as to contribute to the life of the program through monthly faculty meetings, admissions committee, student orientation, first-year student advising (which includes practicum supervision), annual faculty retreat, capstone presentation day, graduation celebrations, and our many social events throughout the year. It is not clear that this arrangement is sustainable, especially as grant opportunities dwindle for our regular faculty and appropriations for our faculty with public health day jobs decline in tandem.

Our program is one of many programs in the UW School of Public Health, which admits nearly 200 MPH students each year (along with other master's degrees, such as health administration). Other MPHs include programs in social and behavioral sciences, maternal and child health, environmental health, epidemiology, global health, international health metrics and evaluation, genetics, nutrition, an executive MPH using distance learning, and even an occasional biostatistics MPH. We swim in that rich stew and benefit from much cross-fertilization and the elective courses generated by a school of this size. Some of our faculty teach in other programs as well. Our program is well known in the school, and other faculty have occasionally approached us about how to introduce some problem-based learning into their courses. Nonetheless, because our PBL classes are entirely self-contained, each of our students is surrounded by only 23 other students (in groups of 8) for all their core course time—about seven hours per week. This kind of insularity and intensity has contributed to a mixed reputation in the school. Our students are known for being intensely driven, hard-

working, and vigilantly focused on social justice concerns. They are popular with faculty offering electives in that our students are attentive and prepared, they contribute to class discussions, and they skillfully take on leadership roles in small group projects and discussions. They can also be overly focused on the process aspects of their classroom dynamics and when a problem arises can spend quite a bit of time and energy on what to an outsider can look like self-absorbed activity. It has also happened that a group of students will decide a faculty member is not sufficiently attentive to classroom dynamics and deferential to student-driven norms and expectations, which can be painful and discouraging for that faculty member. The student intensity has definite advantages for a strong, well-regarded faculty member, but can lead to burnout and loss of some faculty members where there is a teaching style and cultural mismatch with the program.

One of the goals we set for ourselves was to make available our model to international universities. One of the clear advantages of U.S. higher education is that it nourishes creativity, curiosity, questioning and well, just sassiness. In many places, especially in low and lower-middle income countries, higher education is still stuck in more traditional models of lecturing and memorization for exams. Ideally, our program could attract international students who could then return to their home countries to teach in their universities using this approach. The fiscal reality, however, is that because COPHP is so expensive, and has so little public funding support, we cannot make it available to international students at a price they can afford.

This price issue has other negative consequences. Our high tuition and lack of publicly funded scholarship opportunities limits our ability to attract first generation and other low-income students. We have considered ways to "scale" the program to make it more affordable; all scenarios include increasing the class size or leaving students to manage PBL class sessions without faculty presence. This year, we are experimenting with a 30-student public health skills class for MPH students in other programs where students will select projects from among several offerings proposed by community-based partner organizations.

We believe we have reached a maximum program size at 24 students per year. This puts some practical limits on any academic or social event involving all

Appendix A-List of Online Resources

1. **COPHP website**
   http://www.mphpublichealthpractice.uw.edu/
2. **Capstone titles, sorted by general topic areas, or in a matrix by international, quantitative, schools-based, environment, vulnerable populations, population health, health departments**
   http://www.mphpublichealthpractice.uw.edu/overview/capstone/
3. **Faculty handbook**
   http://www.mphpublichealthpractice.uw.edu/pdfs/faculty-handbook.pdf
4. **Student handbook**
   http://www.mphpublichealthpractice.uw.edu/pdfs/student-handbook.pdf
5. **Capstone handbook**
   http://www.mphpublichealthpractice.uw.edu/pdfs/capstone-handbook.pdf
6. **COPHP faculty and alumni/alumnae publications**
   https://catalyst.uw.edu/workspace/uwcophp/51028/376367
7. **Selected alumni and employer job placements**
   http://www.mphpublichealthpractice.uw.edu/alumni/

Appendix B-COPHP Peer Review Process

Community Oriented Public Health Practice Program
Faculty Peer Review for 2014 - 2016
(Revised May 2014)

Background and purpose:

- We want to improve our teaching through an informal peer review process.
- We want to be careful that this process does not add a significant time commitment for faculty.
- Feedback will be in conversation. There will be no written reports with this process unless the observed faculty requests it.

Process:

1. The program director will pair faculty by having the facilitator in each block be observed by the facilitator of the block that is three blocks following the one being reviewed.
2. The observed faculty will work with the observer to chose a day in the block and a time within that day. Criteria to consider are:
   - What day of the block will allow the most variety of activities?
   - What day (and time within the day) of the block will afford observations opportunities of most use to the observed faculty?
3. The paired faculty will meet before the class to go over what is planned for the class and to share ideas about the observation. (See the CIDR document on classroom observations).
4. The observer will attend all or part of the class session.
5. The paired faculty will meet (or talk on the phone) after the class to discuss the observation. (See the CIDR document on giving feedback).
6. The observer will chose (at random) two student postings from the block to review written feedback.
7. The paired faculty will meet (or talk on the phone) to discuss the review of written feedback. (See the CIDR document on giving feedback).

Appendix C-COPHP Learning Objectives Compared to University of Washington MPH Competencies

#	Generic MPH Competencies	Block	Learning Objectives
1	Describe the factors influencing the **balance** between **individual** susceptibility and **population** determinants of health.	Population Health Health behavior & promotion	Define population health. Compare mortality measures. Critique the role of public health in producing a health nation. Compare female health status to that of men and draw conclusions that could apply to other comparative health status analyses. Synthesis the theoretical basis for health related behaviors. Apply sound judgment when making decisions about problem identification, audience segmentation, and intervention selection. Apply sequenced planning models to design communication campaigns.
2	Demonstrate creativity, inquisitiveness, and evidence-based rigor in the application of public health **problem-solving skills**.	All blocks	Write and post for reading by fellow students and faculty two 5-page research paper per week on learning objectives assigned. Question conventional wisdom. Identify potential solutions to a community problem within a short time frame.
3	Critically **read and evaluate quantitative and qualitative research findings** contained in medical, public health, and social science literature.	Community Development Quantitative block	Explore community development literature and leading thinkers in relation to community development knowledge, skills and practices for public health practitioners. Participate in an epidemiology journal club. Explain and interpret biostatistical concepts in journal articles. Interpret methods, results and limitations of statistical analyses found in public health reports.

Appendix C contd.....

#	Generic MPH Competencies	Block	Learning Objectives
4	Work effectively in and with **diverse cultures and communities** (cultural competency).	Population Health Community Development Health Behavior	Define concepts of community. Develop reasons why evidence-based ideas about population health are not mainstream in the U.S. Demonstrate an understanding of community processes necessary for mediating and negotiating with political stakeholders. Demonstrate community competence. Describe the role of societal hierarchy in determining health. Define cultural competence frameworks and how they relate to health promotion and disease prevention practice.
5	Apply appropriate **analytic tools and emerging technologies** to defining, describing, and intervening public health problems.	Population Health Community Development Quantitative skills block (biostat & epi) Evaluation	Describe health disparities, health inequities, social determinants of health. Demonstrate how to observe and assess a community. Demonstrate skills in infectious disease epidemiology (outbreak investigation, prevention and control of infections). Measure disease prevalence and incidence and other ways of assessing the burden of disease. Apply biostatistical principles and methods to the analysis of epidemiologic data. Demonstrate an understanding of the concepts surrounding variables—their various types and ways to analyze them. Select and interpret appropriate graphical displays of data. Describe and interpret measures of association. Make predictions with simple regression models, and use contextual knowledge about potential confounding factors to interpret these. Demonstrate an understanding of how to use a statistical program for the computer. Identify the various evaluation designs, the types of data required for each, and their strengths and weaknesses.

Appendix C contd.....

#	Generic MPH Competencies	Block	Learning Objectives
6	Describe major quantitative, qualitative, and mixed methods research **study designs** and their advantages and limitations.	Quantitative skills block (biostat & epi) Evaluation	Investigate real public health problems using analytic epidemiology study designs. Design a study, create data collection protocols, collect and analyze data, and write a report about a selected public health problem. Design an appropriate analytic plan and apply appropriate descriptive and inferential biostatistical approaches to executing that plan. Design an evaluation to answer a specific evaluation question for a program or policy.
7	Identify and respond with integrity to **ethical and social issues** in diverse contexts and promote accountability for the impact of **policy** decisions upon public health practice at local, national, and international levels.	All blocks	Investigate the role of income disparity in health inequities. Define how rural and urban health problems and solutions may differ. Evaluate the ethical factors in public health screening programs. Demonstrate an understanding of principles involved in ethical and sensitive conduct of health promotion and disease prevention practice and research. Create a working definition of social justice, and test various community perspectives on this concept. Demonstrate an ability to apply ethical principles in leadership and management challenges. Balance competing interests in weighing environmental health permitting decisions. Design evaluation designs that respect stakeholder interests while producing independent results.
8	Demonstrate professional and **ethical behaviors** within the appropriate management structure (academic, governmental, or other), including ability to work effectively with professionals from other disciplines.	Community Development Policy	Demonstrate ethical means for gathering data on communities and populations. Describe the various ways in which public agencies are beholden to private sector interests as they develop financing policy.

Appendix D-Student Feedback Form

3/15 Revised COPHP Block Feedback -- Sample Survey

Your instructor and COPHP are interested in your learning experience in this block. Please take 5 to 10 minutes to respond to the following questions. Your feedback will be helpful both to your instructor and to the program in ongoing program improvement. All responses will be kept anonymous.

Note: The first three pages are for feedback on the block as a whole, and the fourth page is for feedback to the instructor.

Question A.

	Excellent	Very Good	Good	Fair	Poor	Very Poor
A1. The course as a whole was:	○	○	○	○	○	○
A2. Amount you learned in the course was:	○	○	○	○	○	○
A3. Use of class time was:	○	○	○	○	○	○
A4. Interest level of class sessions was:	○	○	○	○	○	○
A5. Reasonableness of assigned work was:	○	○	○	○	○	○

Question B.
Relative to non-PBL courses you have taken:

	Much higher		About the same		Much lower
B1. The intellectual challenge presented was:	○	○	○	○	○
B2. The amount of effort you put into this course was:	○	○	○	○	○

B3. Your involvement in this course (doing assignments, attending class, etc.) was:	○	○	○	○	○
B4. Your confidence in having mastered the material was:	○	○	○	○	○

Next >>

3/15 Revised COPHP Block Feedback -- Sample Survey

Question C.
COPHP Progress Towards Becoming an Anti-racist Organization

	Strongly Agree					Strongly Disagree
C1. I felt heard by other students in the classroom.	○	○	○	○	○	○
C2. I felt heard by faculty in the classroom.	○	○	○	○	○	○
C3. Faculty fostered an environment where microaggressions could be addressed.	○	○	○	○	○	○
C4. The cases and the classroom discussion included accurate representations of different cultural perspectives.	○	○	○	○	○	○

C4. Other comments?

<< Previous **Next >>**

Questions or Comments?
Contact Karen Freisem at kfreisem@uw.edu

3/15 Revised COPHP Block Feedback -- Sample Survey

Question D.

D1a. On average, how many hours per week have you spent on this course, including attending classes, doing readings, reviewing notes, writing papers, and any other course-related work?

Hours:

D1b. From the total average hours above, how many do you consider were valuable in advancing your education?

Hours:

D2. What aspects of this block (including the PBL process and the cases) were especially helpful to your learning?

D3. What aspects of this block (including the PBL process and the cases) hindered learning or could be improved?

D4. Other comments?

3/15 Revised COPHP Block Feedback -- Sample Survey

Question E.

	Excellent	Very Good	Good	Fair	Poor	Very Poor
E1. The instructor's effectiveness in facilitating my learning was:	○	○	○	○	○	○
E2. Instructor's openness to student views was:	○	○	○	○	○	○
E3. Instructor's interest in whether students learned was:	○	○	○	○	○	○

D4. What did this instructor do that was especially helpful to your learning?

D5. What did this instructor do that may have hindered learning or could be improved?

Thank you for providing your feedback!

<< Previous Submit responses

Appendix E-Orientation Week Schedule

SCHOOL OF PUBLIC HEALTH

2014 COPHP ORIENTATION

Thursday (9.18.14)	Friday (9.19.14) School of Public Health New Student Orientation 2014	Saturday (9.20.14)	Monday (9.22.14)	Tuesday (9.23.14)
1:30 PM- 3:00 PM *Faculty Meet & Greet* **UW Tower** **T-22 Boardroom** (4333 Brooklyn Ave NE, Seattle, WA 98105) **Special Note**: If you have your Husky card, you can tap in, if not sign-in at the front desk.	**11:00-11:30 AM** **HOGNESS LANDING** *SPH Incoming Graduate Student Orientation Check-In* **11:30-12:40 PM** **HOGNESS AUDITORIUM** *Welcome from the Dean Introduction from the Office of Student Affairs* *Tips for Graduate Students from the Student Public Health Association* *Union Presentation* *Transition: Hogness to Portage Bay Event Area* **12:40-2PM** **PORTAGE BAY EVENT AREA** *Lunch; Health Sciences Common Book discussions with faculty, alumni, & current students* *Transition: Portage Bay Event Area to SCC 300-Lobby*	**6:00 PM- 9:00 PM** *Potlucks at "Amy's"* 1606 E Columbia St. Seattle, WA 98122 Amy's #: 206-706-0989 **Please sign-up to bring a dish at:** Perfect Potluck **Find a Meal (enter)** **Last Name: COPHP** **Password: e_14**	**10:00 AM- 12:00 PM** *CASE 0* Meet in South Campus Center **Hagopian (Group A)** └ meets in SCC 350 **Bezruchka (Group B)** └ meets in SCC 224 **Krishnaswamy (Group C)** └ meets in SCC 308	**10:30 AM- 1:00 PM** *Library Resources* **Health Science Library** **Classroom C** **Tentative Schedule:** **Overview** **Mendeley**- Ross Howell & Sarah Mitchell **PubMed Research & Systemic Review Research**- Ariel, Heather and Ryan
3:10 PM- 4:20 PM *Second Year Tips & Tricks* Facilitated by CORE members **Stay in UW Tower** **T-22 Boardroom**			**12:15 PM-1:15 PM** Brown Bag Lunch (Bring your own, or visit the South Campus Center Café) **Meet at SCC Terrace**	
3:10 PM-4:20 PM **Faculty Meeting*** **UW Tower Cafeteria North (4th**				
4:30 PM- 6:00 PM *COPHP Faculty & all Student Reception* **UW Tower Cafeteria North (4th Floor)** **Students, if you are consuming alcohol please bring you STATE ID.**	**SOCC 300** *Round Robin Resource Fair* *Transition: SOCC 300 to Portage Bay Event Area* **3:00-5:00 pm** **PORTAGE BAY EVENT AREA** *Student Public Health Association Happy Hour* Be sure to confirm schedule of activities at: http://sph.washington.edu/students/orientation/		**1:15 PM-2:30 PM** ***Campus Tour*** **Tour guide: Hannah Calas** **Meet at George Washington Statue** uw.edu/maps/?lndmk-5	

*ONLY COPHP FACULTY NOT A STUDENT ACTIVITY

Appendix F-Sample Practicum Project Description

MPH in Community Oriented Public Health Practice
Practicum Placement Request Form
Public Health—Seattle & King County

1. Project Name
Jail Health Services Diabetes Project

- Describing the Population of Patients with Diabetes
- Examining the Linkages Between Corrections and Public Health Clinics in King County

2. Practicum Site Location/Address
Jail Health Services, King County Correctional Facility, 500 Fifth Avenue, Seattle.

3. Briefly describe the section or program that will house the practicum project (*e.g.* Family Planning/CHS). What are the overall goals of the section or program? Provide link to additional information about your section.

Jail Health Services is responsible for the provision of medical, dental and mental health services provided to the inmate-patients in the King County Jails. This includes the two facilities: King County Correctional Facility in downtown Seattle and the Maleng Regional Justice Center in Kent.

The Jail Health Services Mission Statement is as follows:

To assess and stabilize serious health problems for the detained population of the King County Correctional Facility and the Maleng Regional Justice Center with a focus on transition from jail.

The mission of Jail Health Services is carried out through the following commitments:

Foundation

1. Maintain a professional workforce
2. Use sound operational principles & maintain essential infrastructure
3. Unity of practice across sites
4. Work as an interdisciplinary team

Understanding

1. Monitor performance and conduct QA/QI activities
2. Be responsive to unique characteristics of our population
3. Use best information in making care and business decisions

Clinical Services

1. Identify patients with serious health problems
2. Assess the condition of all individuals entering the jail and be aware of changes in a person's condition
3. Evaluate risk and initiate interventions

Outcomes

1. Facilitate stabilization and continuity of care for our patients

4. Describe the practicum project in 1–2 paragraphs. Please address these points:

What is the purpose of the project?

- What activities would the student engage in (*e.g.*, developing brochures, attending community meetings, conducting surveys or interviews, doing data analysis)?
- What are the specific deliverables associated with this practicum (*e.g.*, production of a brochure, a needs assessment report, a policy analysis)?
- What do you think the student will learn during this practicum?
- How many students would you like for this project (maximum of two)?

The purpose of this project would be to assist Jail Health Services in better understanding the characteristics of the incarcerated diabetic population and to examine possible strategies for developing stronger linkages with the Public Health clinics for this patient population. The project would ultimately aim to improve provider follow-up at the clinic visits and track key indicators for the care of diabetic patients. This project would align with several of the commitments in the JHS strategic framework, including responsiveness to the characteristics of our population, identification of patients with serious health problems and stabilization and continuity of care for our patients.

The student activities would include helping to determine key diabetes indicators. Data sources would include existing data from the electronic health record and from patient interviews using a student-developed data collection tool. This data would be used to create a descriptive report on the diabetic patient population in the two King County correctional facilities. The student would be involved in the dissemination of this data to the JHS clinical

staff and developing associated recommendations. Strategies for improving linkages with King County Public Health clinics for continuity of care will be explored.

The specific deliverables would include a data-collection tool and a descriptive report with recommendations. The student would learn how to use existing data and determine how to obtain additional data to thoroughly describe a specific at-risk population. The student would develop skill in compiling the data, analyzing it for recommendations, and sharing it with the health professionals that provide the direct patient care to the population studied. The student will learn about the challenges and opportunities for public health interventions in a correctional setting. The scope of this project would be appropriate for one student.

5. Please estimate the percentage of time students will engage in the following activities:

Internet or Library Research (~10%)
Website development (N/A)
Observing public health staff (~5%)
Analyzing Data (~50%)
Field activities (*e.g.* trainings, focus groups) (~15%)
Preparing written materials (~20%)

6. List any essential skills students must have (*e.g.* SPSS, epidemiology skills, materials development, foreign language) as well as:

- Ability to work in a correctional environment.
- Some basic knowledge of diabetes.
- Some understanding of population-based approaches to chronic disease care.

7. List any desirable skills you would like your student to have.

8. Practicum students work 6 hours per week. How much of the practicum work should be done on-site or in the field? How much can be done off-site (*e.g.* UW library)?

On-site ~approximately 50% of the time, with on-site time more concentrated at the beginning and the end of the project
Off-site ~ approximately 50% of the time, particularly when analyzing the data

9. Work Hours/Schedule Requirements (please note if you have special requirements):

The expected student practicum hours would be during regular business hours, Monday through Friday.

10. Other Comments:

Must pass background check.

Appendix G-Practicum Self-Assessment Survey

What kind of job do you see yourself in after you graduate? What setting (e.g. local public health, state, federal, community-based agency, hospital)?

Think about yourself as a public health student and intern. What do you see as your greatest strengths? What do you think you have to offer a public health department?

Think about yourself as a public health student and intern. What do you see as your weaknesses? What do you need to learn?

Do you speak any languages other than English? Which ones? How fluent?

The following are typical public health practicum skill areas. Please circle the ones you've had experience with:

Questionnaire Development	Literature Reviews
Interviewing	Grant Writing
Coding	Curriculum Development
Data Entry	Educational Materials Development
Data Analysis	Media Campaign Development
SAS Statistical Analysis	Community Organizing
SPSS Statistical Analysis	Public Speaking
Website Development	Focus Group Facilitation

Circle the computer programs you can use:

Desktop Publishing	SPSS
Excel	Stata
PowerPoint	Word
SAS	

What areas of public health are you most interested in? Circle up to 3.

Adolescent Health/School Health
Asthma

Cancer Prevention
Chronic Disease Prevention
Emergency Preparedness
Environmental Health
Epidemiology
Health Education
Health Disparities
HIV/STD Prevention
Immunizations
Injury Prevention
International Health
Nutrition/Physical Activity
Rural Health

Anything else I should know:

Appendix H-Service Learning Contract

Agency/University/Student Practicum Agreement

(University of Washington School of Public Health)

ODIR 1604

The Practicum Field Experience is based on an agreement between the University, the student and Public Health – Seattle & King County. Each has specific responsibilities that are necessary to make Field Experience an effective service learning experience. Those responsibilities are:

The University

The University will:

- Select students capable of providing service to the field agency and its clients while engaged in field experience
- Provide students with classroom and assigned learning activities that will enable them to function in their field experience assignments
- Develop and conduct field experience orientation activities for students and agency supervisors
- Provide regular advising to students in collaboration with agency supervisors
- Develop and conduct regular student/faculty and student/supervisor/advisor learning conferences
- Organize and conduct special seminars in response to specific educational needs identified by students, the agency and the university
- Evaluate the student's performance in collaboration with agency supervisors
- Evaluate the quality of the service-learning associated with field experience in collaboration with the agency supervisors and the students
- Make modifications in future curricula to address educational problems identified in evaluations of fieldwork experiences

The Agency

The agency providing the fieldwork experience will:

- Designate a work unit or project within which the student will conduct service-learning activities during field work
- Develop outcome objectives for the field experience assignment to guide the student team in their activities
- Designate a project site supervisor for each student or student team
- Provide regular supervision to students in collaboration with university advisors
- Provide adequate work space, support and supplies to enable the student to function effectively as a field work student in the agency
- Participate in student/supervisor/advisor learning conferences
- Evaluate the student's performance in collaboration with university advisors
- Evaluate the quality of the service-learning associated with field experience in collaboration with the university advisors and the students

- Negotiate modifications in agency systems to address service-learning problems identified in evaluations of field work experiences

The Student

The student will:

- Actively participate in classroom seminars and assignment activities to develop knowledge and skills to enhance effective participation in field experience activities
- Carry out duties assigned by the agency supervisor in the Practicum Field Experience
- Participate in student/supervisor/advisor learning conferences
- Evaluate the quality of the service-learning associated with the Practicum Field Experience in collaboration with the university advisors and agency supervisors
- Make recommendations regarding opportunities for improvement of the Practicum Seminars and Field Experience
- Make recommendations regarding opportunities for improvement of university support of the Practicum Field Experience student activities

Practicum Field Experience
Service Learning Agreement
January 3, 2012 – June 1, 2012

This form should be completed after your interview with your site supervisor.

Student Name
[redacted]
Phone/e mail
[redacted]

Name of Agency/Project/Site Supervisor:
[redacted]
Public Health-Seattle & King County
HIV/STD Program
Health Education Team

Address
[redacted]

Your Primary Service Deliverables
A written summary report with references, as well as an oral presentation. Both should outline a user friendly definition of sexual health, best practice interventions, and recommendations for addressing sexual health in health departments.

Your Primary Learning Objectives
This project is a first step on the part of Public Health's HIV/STD Program to address that strategic goal. It aims to:

- Define sexual health and public health's role in promoting sexual health.
- Identify best practice interventions.
- Develop recommendations for addressing sexual health in public health departments, community based organizations and partnering systems.

Your Primary Responsibilities and Duties

- Review sexual health articles and develop a user friendly definition of sexual health.
- Review State MSM HIV Prevention Planning Committee document(s).
- Identify UW faculty with an interest in this issue and include key informant interviews.
- Conduct key informant interviews (including David Fleming, Charissa Fotinos, MSM providers, MSM community members, Dave Kern, Kari Kesler, Ron Stall, Rae Larson, Kari Lerum and others) to get feedback on sexual health definition, identify sexual health priorities, explore public health's role in sexual health promotion.

- Survey local health departments to determine how they are addressing sexual health, and what they think they should be doing.
- Identify international efforts in the promotion of sexual health for the purpose of HIV prevention.
- Identify key target populations.
- Identify partners who can promote sexual health (e.g. school systems, faith).
- Participate as a member of the HIV/STD health education team.
- Attend health education team meetings. And when necessary or interested, attend Community Health Outreach Worker meetings and the MSM Provider Salon meetings.

READ CAREFULLY

As a service learner, you are given the opportunity for a unique and valuable experience. To undertake this assignment as a representative of the University of Washington School of Public Health, your instructor and yourself, you must agree to

1 Fulfill your agreement as to your duties, hours and responsibilities to the best of your ability.

2 Be professional-- punctual, polite, and respectful of agency policies, rules and regulations.

3 Respect the confidentiality of clients and staff of the agency.

4 Give notification in advance if you must miss or be late for an agency appointment. If advance notification is impossible, call as soon as possible thereafter.

I have read and agree to the agreement and the guidelines as outlined above.

[redacted] 1/3/2012

Student Signature Date

I have read the agreement and agree to supervise or provide supervision for the student above.

[redacted] [redacted] 1/3/12

Agency Supervisor Date

I have read the agreement and agree to provide consultation to the site supervisor and academic supervision to the student.

Amy Hagopian 3 January 2012

Faculty Advisor

University of Washington Date

Appendix I-Sample Daily Learning Objectives

Following are daily learning objectives from the NeighborCare–LARC case in the Evaluation block:

Day 1

1. How are school-based clinics currently funded and governed in Seattle? How are they structured, organized, managed, and staffed? Describe the relationship in Seattle between Public Health, the Families and Education Levy, and the sponsoring medical entities.
2. What are the laws concerning confidential care for minors?
3. What are long-acting reversible contraceptives? How do they work? How are they promoted or discouraged for teens?
4. What is the political and economic history of school-based clinics in the U.S.? In Seattle? How does this differ from other areas? How do contraceptives play a part in the politics of school-based clinics, in Seattle and elsewhere?
5. What is the typical scope of services in school-based clinics? Are clinics associated with improved behaviors and school performance? How do services vary by the sponsoring medical entity, and is this fair?
6. How does NeighborCare operate its high school clinics in West Seattle? How are other clinic sponsors different in other schools?
7. What data do school-based health clinics generate? What variables might be available for assessing the uptake of contraceptive services in teen clinics?
8. What is the role of the privately funded health educator/outreach worker in relation to contraceptive uptake in the school-based health centers? Why is it privately funded instead of part of the levy program?
9. What is the link between early or unplanned pregnancy and school completion? What disadvantages do the children of teens face?

Day 2

1. What is an evaluation approach, model, or design? What types of evaluation exist, and why is each conducted? Which types are stronger (that is, more likely to point to cause and effect)?
2. How do you go about developing an evaluation question? What are the variety of methods you would have to employ to answer different types of questions? How are

the two related? What might some questions be for this case?

3. Taxonomy of Evaluation: What do the terms "outcomes and outputs" mean in evaluations? How about "formative" and "summative?" What is a "participatory" evaluation and how is it different from traditional evaluation? How are monitoring and evaluation different from each other?
4. What is a logic model and program theory? What would those look like for this case? Explain how the "program theory" is used in designing and conducting a program evaluation.
5. What are the common threats to evaluation validity and reliability, and how can you protect your evaluation from these?
6. What kinds of approaches are appropriate for conducting evaluations with minority or chronically underserved populations? What are some common class, gender, or culturally based barriers to good program evaluation?
7. What data need to be available in an evaluation, and what are variables?
8. Because outcomes are much harder to measure than amount of effort expended, is it okay to just measure level of effort? When programs address proximate issues (*e.g.*, hunger, need for a mat to sleep on) rather than underlying causes of health problems (*e.g.*, structural economic problems), how do evaluators address that? Do they simply decide whether the proximate problems were effectively addressed by the program, or do they have an obligation to address the underlying issues?

Appendix J-Sample Case Facilitator Notes

Since we have three faculty for each "block," or course topic area, the writing of cases is typically distributed among the faculty. The case writer is encouraged to write "facilitator notes" for fellow faculty, to guide them in how they work through the case with students. The following facilitator notes from one case within the Policy block provide some insights into the ways facilitators prompt students to grasp issues in particular ways.

The first set of notes concern the case "You Never Die of Just One Thing," which takes place in Ghana.

Day 1

1. I like them to frame their Learning Objectives for each case as questions, but not all faculty share my appreciation for the well-framed research question. Others like statements, such as, "Describe the role of the Ministry of Health in Ghana." We can thumb-wrestle about this some time.
2. COPHP student will be tempted to start getting into the macro-political questions right away. Try to restrain them, promising this will come in Day 2.
3. Another tendency is to try to lump all the diseases into a single LO. I always nudge them away from that, by saying things like, "Hm. You're enrolled in a public health master's degree program. These are the biggest public health diseases in the world, even though you won't see them at Seattle's Swedish Hospital very often. Aren't they worth spending a little undivided attention on? You won't get them anywhere else in the program." One reason to encourage them to separate out these diseases is that it will help them in the assignment. But we don't tell them that.
4. They may have trouble lumping the things they *should* lump, though, through shear ignorance of what goes with what. PMTCT goes with HIV into a single LO. Malaria and bednets go together. How anemia affects the economy doesn't have to be its own LO, that can go with anemia. DHS is the Demographic and Health Survey, it's simply a source of data for the diseases. In this case, it's not worthy of its own LO.

Day 2

1. Notes: This is a wide-ranging day, and you should encourage students to think broadly about global health aid and whose interests are served. We plant seeds to lead them to two critics in the field. The key thing I want them to get from Amartya Sen is that it's not enough to make more food (or food fortification) available. There's rarely a

shortage of food that's the problem. The problem is people can't afford to buy it because they're poor. This gets them to the economics of importing and exporting food.

2. Don't let them skip the attributable risk assignment. Cross your fingers that someone with attention to detail and an eagerness for quantitative methods takes it on, because how efficiently they grasp this concept will depend on how well this LO is written. And the concept is critical to the assignment on Day 3.
3. I like it when the discussion of food insecurity in Ghana starts to wander into the territory of pre-colonial history. Were Ghanaians hungry before the Portuguese, Dutch and British colonialists arrived? What happened to introduce food insecurity to these populations?
4. The footnote takes them to Anthony Ofosu, who was once a Population Leadership Fellow at the UW (2001-2002). He's now Deputy Director in charge of Monitoring and Evaluation in the Ghana Health Service. We always alert him to be available to respond to student questions should they reach out to him.
5. The "good evaluation question" is a little prelude to next quarter's class. Not critical, but nice.

Day 3: Assignment

1. We bring all the groups together to debrief the assignment the Monday morning after it's due. You may be able to shorten your afternoon class that day, as a result.
2. The point of the attributable risk assignment is to illustrate that the causes of anemia (or any problem you're trying to solve) matter. If you aim your resources at trivial causes, thus ignoring the main cause, you're wasting time and money. The GAIN people want Ghana to focus on food fortification for obvious reasons—some nefarious, some simply because it's easier than tackling malaria.
3. Once they understand the important thing, they should be able to write a persuasive, informed memo to the Minister.
4. I usually encourage them to start brainstorming in class how they will tackle the numbers, starting with the worksheet. They're rusty by fall quarter of 2nd year—they haven't had epi or biostat since winter quarter. A little panic sets in. They'll go scurrying for their sources.
5. If you're coaching the facilitator for the day, don't show the assignment, but emphasize that students will benefit from a good understanding of attributable risk, if they'd like to bring some resources to class.

The second set of notes concerns a case addressing minimum wage policy in Seattle.

Day 1 and 2

The purpose of the LOs on Days 1 and 2 is to get them immersed in the issues surrounding the minimum wage as a public health issue. We want to be sure they have a sufficient grasp of the issues to write smart products.

This is one of the few cases where we address **economic issues**, and students have requested more of this. Some concepts: effects on unemployment of higher wages; surplus value; whether higher wages contribute to or detract from the strength of the economy.

Students should be encouraged to **connect dots**: For example, the proportion of FTE employment is related to health benefits.

We don't discuss **campaigns** anywhere else in this course, so if we want to spend some time discussing how the Fight for Fifteen occurred, that wouldn't be a bad thing. Marilyn Watkins will be coming to seminar to talk about the initial statewide initiative campaign.

At the same time they are chasing down content knowledge on minimum wage, they should be conscious of developing specific skills related to policy analysis.

- What are reliable research methods for connecting policy to outcomes? We hope they'll find Jennifer Otten (Health Services faculty), who is part of the evaluation effort at the Evans School
- Defining terms matters. For example, whether tips are included in the minimum wage definition. Phasing in targets is another feature of policy development.
- Policy and law are one thing. Enforcing them is another.
- Unintended consequences: If the goal is to improve the lives of people with low incomes, does the proposed policy (raising minimum wage) have any effects we wouldn't want, such as making people ineligible for important health-related benefits because their incomes rise a tiny bit?
- The role of "think tank" organizations in relation to policy development has evolved over time and is rather important to understand

Appendix K-Strategic Plan Excerpts

1. BUILD ON OUR SUCCESS TO MAINTAIN AN EXCITING, THRIVING, ACADEMIC PROGRAM TO TRAIN PRACTITIONERS WHO WILL IMPROVE THE PUBLIC'S HEALTH

1. Encourage cases address real public health problems and engage community partners; ensure cases are engaging, timely, social justice focused, and updated regularly. Integrate subject matter and skills broadly across all our courses to mimic real public health practice—for example, use quantitative skills in policy course
2. Stay current with national developments on case-based and problem-based pedagogy
3. Globalize our curriculum to include more global health cases
4. Continue to regularly improve our courses through peer and student evaluation
5. Improve clarity and consistency by using checklists for syllabi, posting best practices, case numbering and other tools of our trade; ensure our cases are consistently formatted, include both daily case questions and final case learning objectives, and have facilitator notes
6. Ensure our practicum program is tightly aligned with Public Health Seattle King County to ensure our students are learning about real-world public health practice and PHSKC maintains satisfaction with student work
7. Encourage our students to do strong, academically rigorous capstone projects; help our students connect with community-based organizations and public health agencies where they can learn practical applications of public health knowledge and skills while developing useful capstone products
8. Develop strong group work and teambuilding skills in our students, including the ability to recognize and avoid micro-aggressions
9. Improve our cases to ensure they align with the UW School of Public Health's competencies for accreditation purposes
10. Maintain our great record of graduating students on time
11. Support the transition of our students to the paid workforce post-graduation by circulating job opportunity notices, writing letters of recommendation that explain the advantages of the pedagogy, and tracking graduate placements.

2. IMPROVE OUR FISCAL AND ADMINISTRATIVE SITUATION

1. With grave concerns about the adequacy of funding for graduate education, we will continually re-evaluate our program's "privatized education" relationship to the UW. We propose a formal faculty/administration joint review of both activity-based

budgeting (ABB) and Professional and Continuing Education (PCE) models.

We seek principled alternatives to the current arrangement, in which COPHP students pay the fully-loaded costs of their MPH education. All UW graduate students should expect State of Washington investment their education.

2. Gain deeper understanding of the fiscal situation of our program and Department of Health Services; maintain faculty governance control of our budget.
3. To keep tuition low, ensure overhead charges by PCE, the school, the UW and department of Health Services are as low as possible.
4. Attract and retain Health Services staff who are deeply committed to COPHP values and student success.
5. Ensure we are spending a respectable portion of our budget on faculty salaries. More than half the budget should go to compensate faculty for their time, attention to and investment in the learning process.

Appendix L-COPHP Case Subscription Information

In the near future, annual subscriptions to all of COPHP PBL cases will be available (approximately 30 over a two year curriculum). Cases will cover the entire syllabus of COPHP MPH curriculum with each block represented. PBL cases in the COPHP program are revised and replaced on an annual basis. **Please contact cophp@uw.edu if you are interested for more information.**

SUBJECT INDEX

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