Published in final edited form as:

J Public Health Manag Pract. 2016 ; 22(2): 190–193. doi:10.1097/PHH.0000000000000237.

Characteristics of Academic Health Departments: Initial Findings from a Cross-Sectional Survey

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Abstract

Academic Health Departments (AHDs) represent collaborative relationships between public health academia and practice. The purpose of this study was to gain a better understanding of AHD characteristics, to document the extent of collaboration between organizations in an AHD, and to explore the benefits of AHDs. An electronic survey on the AHD was sent to members of the Academic Health Department Learning Community – a virtual learning community with 338 members. There were 110 valid responses to the survey, with 65 indicating they were currently in an AHD partnership. Thirty-two percent of AHDs had been established > 10 years; 64% were engaged in joint research activities; and, while 92% of respondents placed a high value on improving the competencies of students, almost half placed a high value on improving the competencies of faculty. This study can be a springboard for further research on the impact of AHDs on practice, academia, and ultimately community health.

Keywords

Academic Health Department; public health practice; public health systems and services research

Introduction

The Academic Health Department (AHD) is “an arrangement between an academic institution and a governmental public health agency which provides mutual benefits in teaching, research, and service, with academia informing the practice of public health, and

the governmental public health agency informing the academic program.”¹ In many ways, the AHD serves as the corollary for the arrangement between a medical or nursing school and a teaching hospital: the place where theory, textbook, and classroom merge to create the science and art of practice. Unlike its counterpart in medicine, though, the academic preparation of public health professionals and the settings in which public health practice have taken place remained largely disconnected for most of the past century.² There are only a few isolated examples of academic-practice linkages from the early-mid 1900’s – including Johns Hopkins School of Hygiene and Public Health and Baltimore City Health Department in establishing the Eastern Health District in 1932, and collaborations between Columbia University School of Public Health and Washington Heights District Health Center of the New York City Department of Public Health.³

What we know about AHDs is still largely confined to case studies.¹ There have been no census surveys of either academic institutions or public health agencies to document the actual prevalence of AHDs or to assess characteristics of AHDs collectively. The purpose of this present study was to gain a better understanding of AHD characteristics, to document the extent of collaboration between organizations in an AHD, and to explore the benefits of AHDs.

Methods

Target audience

A survey instrument on the AHD was targeted for the Academic Health Department Learning Community (AHDLC) – a virtual learning community established in 2011 by the Council on Linkages Between Academia and Public Health Practice and staffed by the Public Health Foundation.⁴ Membership in the AHDLC is open to all who are interested, and represents academic institutions; local, state, and federal governmental health agencies; national public health organizations; private organizations and foundations; and many individuals who list no specific affiliation. At the time of survey distribution, the AHDLC had 338 members; however, only 13% had completed a voluntary AHDLC membership profile, showing that 29 members were currently participating in an AHD, while 16 had indicated they were not part of an AHD. Among the 145 AHDLC members who had provided agency or institutional affiliation, there were representatives of 52 public health departments (state or local), 46 academic institutions, and eight national-level organizations (such as the National Association of County and City Health Officials).

Survey instrument development and testing

A survey instrument was developed based in part on a research gap analysis between what was known about AHDs and what was needed to document the added value of AHDs with respect to quality, accreditation, research, and health reform.¹ The survey was structured around domains of AHD relationship characteristics, including the use of formal written partnership agreements; functions of the AHD; engagement activities of public health practice organizations with either schools/programs of public health or other types of academic institutions; and potential and experienced benefits of the AHD.

An initial draft survey instrument was reviewed by all five members of the research team and underwent cognitive response testing with eight experts in the field of public health academia and practice who were very familiar with the AHD concept. The cognitive response testing, which primarily focuses on reducing respondent error⁵ and improving content validity, took place by telephone interview, involving 2–3 members of the research team for each interview. After several iterations of survey refinement, a final survey instrument was loaded into a Qualtrics © online platform⁶ and the hyperlink was made available to members of the AHDLC via e-mail, initially by AHDLC staff. Three subsequent e-mail requests to complete the survey were distributed; final attempts to reach potential respondents were made by telephone calls to the AHDLC members. Data were analyzed using descriptive statistics such as frequency distributions, measures of central tendency, and measures of variability. Research approval was granted through the IRB of the University of Tennessee.

Results

One hundred and ten respondents completed surveys. Using the full AHDLC membership as the denominator, this resulted in a response rate of 33%; however, counting only the number of organizations represented by the 338 members, and removing national-level professional organizations represented among AHDLC members, the likely potential respondents were reduced to approximately 265, resulting in an adjusted response rate of 42%. Of the 110 respondents, 65 (59%) reported that their organization participated in an AHD; of these, 40% had participated in an AHD for 2–5 years, while 32% had participated in an AHD for more than 10 years (Table 1). Of the 54 respondents who provided personal information, 70% (n=38) reported working in an academic institution, and 24% (n=13) reported working in a public health practice setting.

The most frequently-cited characteristics of the AHD relationship included collaborative public health education/training (85%) and joint research projects (64%). The most frequent type of formal written agreement was a memorandum of understanding or agreement (67%); however, 28% of respondents noted other types of activities beyond formal agreements, including shared provision of services and facilities, and collaborative education and training. Of the small number of respondents who provided information about shared personnel (n=11), the most common responses related to managerial/clerical staff and researchers.

Eleven public health practice partners in AHDs responded to questions about engagement activities with different types of academic institutions - accredited schools or programs of public health, other four-year or graduate-level academic institutions, or two-year colleges (data not shown). Most respondents noted engagement across the spectrum of academic institutions, with the highest level of engagement for accepting students from all types of institutions as trainees, interns, or volunteers. The lowest levels of engagement were noted for faculty/staff having conducted program evaluations with practice agencies, and for academic institution staff serving on a practice advisory group.

Practitioners and academicians both rated the importance of education/training, research, and service to the AHD; ratings were also provided on the importance of potential benefits of the AHD as well as the degree to which such benefits had been experienced (data not shown). There was universal agreement (100%) on the importance of education/training, and high agreement (91%) on the importance of research and service/outreach. The highest ratings for both potential and experienced benefits were for improving the competencies of students (92% rating that the benefit was very important, and 64% that the benefit had been experienced to a large or very large degree) and for improving public health graduates' preparation to enter the workforce (87% and 59%, respectively). The greatest difference between potential and experienced benefits was for increasing capacity for performing core public health functions (72% and 29%, respectively).

Discussion

This study included the largest number of AHDs studied collectively to date, providing estimates of AHD relationship characteristics, functions, and potential and experienced benefits of the AHD. Although limited by the relative low response rate (especially for public health practitioners), this exploratory study adds at least four key findings to the literature on AHDs:

1. One-third of AHDs studied have been in existence for over 10 years. This should provide ample opportunity for stronger research on the added value of the AHD to teaching, service, and research, as well as on the impact of the AHD on community health.
2. Almost 2/3's of AHDs are actively conducting joint research activities – thus the engagement of partners within AHDs goes beyond the focus on students and service learning.
3. Engagement between public health practice and academia in AHDs is not limited to accredited schools or programs of public health, but includes other four-year and two-year institutions. This is critical for the vast majority of local health departments that are not proximate to accredited schools and programs of public health.
4. Beyond the value that AHD partnerships bring to improving the competencies of students and public health practitioners, almost half of AHDs indicated that improving the competencies of faculty was very important, while nearly a third indicated that such benefits were being experienced to a large or very large degree.

Limitations

There are several limitations to this study. First, there was no certain method to determine a denominator for calculating the true response rate among those who actually participate in AHD relationships, and thus the study provided no meaningful estimate of the prevalence of AHDs. Second, the resulting small sample size for some subgroups limits both analysis and interpretation. Third, there is a possible selection bias because the members of the AHDLC may be different in attitudes about academic-practice linkages compared to non-members.

Fourth, there may have been duplicate answers – e.g., responses from both the academic and practice partners from the same AHD. Fifth, data were self-reported, with no attempt to independently verify the accuracy of information provided. Taken together, these limit the generalizability of the study findings, although such findings may still be useful as a first attempt to characterize AHDs collectively.

Conclusion

This cross-sectional study on AHDs is the first known attempt to characterize the landscape of AHDs. Despite limitations, the results of this initial inquiry suggest that AHDs are thriving collaborations that offer mutual benefits to academia and public health practice. Our intent was to further inform the specification of a model AHD, recognizing that AHDs currently exist along a wide continuum. Important next steps will include establishing better methods for determining the actual prevalence of AHDs and to begin exploring a research agenda in order to further demonstrate the AHDs' added value to the public health practice and academic enterprises.

Acknowledgments

This study was supported in part by Robert Wood Johnson Foundation's funding for the National Coordinating Center for Public Health Systems and Services Research at the University of Kentucky. The authors wish to thank Tiffany Lee Smith and Chenoa Allen for assistance in survey testing and contacting potential survey respondents. We also thank the members of the Academic Health Department Learning Community who provided the survey responses.

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Table 1**Organizational and Participant Characteristics of Academic Health Departments**

Item	Percent
Organizational Characteristics	
Length of time in AHD partnership (n= 65) *	
Under 1 year	5%
2–5 Years	40%
5–10 years	23%
Over 10 years	32%
Relationship specifications and activities ** (n=34) ***	
Formal written partnerships	73%
Memorandum of Understanding/Agreement	67%
Letter of Agreement	38%
Contract	38%
Other	17%
Collaborative public health education/training	85%
Joint research projects	64%
Compensation for services provided	36%
Shared personnel	33%
Shared provision of public health services	24%
Shared financial resources	18%
Shared facilities	18%
Other	15%
Participant Characteristics	
Affiliation (n= 54)	
Academic setting	70%
Practice	24%
Other	6%
Academic partner primary appointment (n= 22)	
Public Health	68%
Nursing	18%
Medicine	9%
Other	5%
Practice partner primary appointment (n= 12)	
City/County Health Department	63%
Multi-County/District Health Department	27%
State Health Department	9%

* 65 of the 110 respondents who indicated they were currently participating in an AHD

** Multiple responses possible

*** Subsequent (n) are provided for only those respondents who provided complete information on that specific component of the survey