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Bridging Academic–Legislative Divides: Models of Policy-Relevant Health Research and Practice by the University of California

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Abstract

Problem: This paper argues that it is necessary to strengthen Asian American, Native Hawaiian, and Pacific Islander (AA and NHPI) community-based participatory research (CBPR) models that integrate a health policy agenda through dynamic legislative partnerships.

Purpose: We utilize a case study approach and examine three health research partnership models that impact legislative design and action: The California Program on Access to Care (CPAC), the California Health Benefits Review Program (CHBRP), and the University of California Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP).

Key Points: In-depth examination reveals the difficulties of engaging in research that collaborates with multiple parties simultaneously and the specific benefits and challenges in each case.

Conclusions: New directions are needed to deepen legislative engagement potential in CBPR and the translation of policy research that considers the health of all AA and NHPI communities.

Keywords

Policy research, Asian American, Native Hawaiian and Pacific Islander, community engagement, health policy

California is a trendsetter both demographically and legislatively. Legislatively, California is uniquely known for its widespread use of the initiative process, yet is often also the bellwether for legislative reform.¹ Demographically speaking, one in seven Californians are AA and NHPI, making California the state with the largest, most diverse AA and NHPI population in the nation.² Despite its large size in the aggregate, the diversity of health needs and inequities facing ethnic subgroups within the larger categorization of AA and NHPI is often overlooked, primarily because of data collection processes that aggregate AAs and NHPIs into one or two AA or NHPI ethnic/racial groups while ignoring or overshadowing the many needs of smaller groups.³ As a result, many policymakers are unaware of the varied health needs and inequities across diverse AA and NHPI communities.⁴

This is particularly important with regard to the formation of health policy that improves provision of health services. Without adequate knowledge of the needs and demand for health services amongst the many subgroups within AAs and NHPIs, particularly medically underserved communities, California legislators will continue to overlook the specific needs of these distinct ethnic communities.

Given California's unique position and legislative challenges, especially with respect to its diverse populations, this paper focuses on the need to strengthen CBPR models that focus on civic and political engagement specific to AA and NHPI ethnic populations.⁵⁻⁷ In this paper, we argue that it is necessary to strengthen civic engagement aspects of CBPR by incorporating legislators in more dynamic partnerships with researchers and community members. At the same time, we

also encourage researchers interested in CBPR to consider the various degrees of civic engagement that may be achieved with diverse parties and to consider the strengths and weaknesses of engaging in multiple, simultaneous partnerships. In short, to influence health legislation that impacts AA and NHPI communities, it is important to understand the challenges and benefits researchers face when engaging in collaborative research with both community stakeholders and legislators. The state of existing CBPR literature has focused primarily on civic engagement practices of researchers and community stakeholders.⁸⁻¹¹ Herein, we focus on a specific gap in the literature about these collaborative efforts, the relationship between researchers and legislators.

PURPOSE

This paper seeks to clarify ways to strengthen civic engagement aspects of CBPR, asking two interrelated questions: (1) What levels of relationships may result from different approaches to academic researcher–community–legislative partnerships? and (2) What research and policy outcomes can be reasonably expected?

To approach these larger questions, we utilize a case study approach of three health research partnership models spearheaded by researchers across the University of California (UC) that are aimed to motivate evidence-based policy and legislative design: The California Program on Access to Care (CPAC), the California Health Benefits Review Program (CHBRP), and the University of California Asian American and Pacific Islander Policy Multicampus Research Program (UC AAPI Policy MRP). These models serve as case studies to explore the various opportunities and challenges of CBPR for civic engagement for the promotion and evaluation of both health policies and AAs and NHPs health. These cases are based on the reflections of the authors, many of whom participated in the visioning/shaping of these models or in day-to-day management and collaboration in these efforts. In other words, data have been accumulated over many years and are based on knowledge of the co-authors as well as on reflections of additional partners.

Each of the models discussed have been selected because they are health policy research projects that, despite differences in approach and desired outcomes, incorporate some level of partnership between faculty researchers at the UC, community

stakeholders (AA and NHPI as well as more general community participation), and California state legislators and staffers. Specifically, each case illustrates a different approach to how CBPR may be utilized for civic engagement that aims to improve legislative outcomes for AA and NHPI health. The cases discussed illustrate a range of legislative relationships from consultative, to legislatively mandated, to collaborative partnerships.

Generally speaking, CBPR models for health research result in close, collaborative relationships between academic researchers and community stakeholders. Although at times CBPR may also incorporate high levels of civic engagement and advocacy,⁸⁻¹¹ to engage more fully with legislators with an eye to shaping policy through research, stronger partnerships must be cultivated. In the next section, we discuss how each approach represents a different level of engagement among community members, legislators, and researchers, and discuss the strengths and weaknesses for CBPR researchers in each case. Although community engagement is discussed, the primary focus for each case is on the challenges and benefits of researcher–legislator relationships.

KEY POINTS

This section provides a brief description of each organization and associated health research partnership model, followed by a comparative discussion of the strengths and weaknesses of each (Table 1).

California Program on Access to Care

Overview. The CPAC was originally created in 1997 by the California State Legislature and initially housed under the UC Office of the President. It has since partnered with UC Berkeley, yet continues its efforts across the UC system.¹² CPAC's primary role is to fund policy research on healthcare topics that concern California's most vulnerable populations.¹²

Because CPAC's mission and the research it funds are more complex than can be discussed in this short paper, we focus on one recent project, the Ethnic Health Assessment Project (EHAP)¹³ as an example of how CPAC develops close consultative relationships with ethnic communities and legislative partners to move forward a health policy agenda. Four EHAP grants were funded (AA and NHPI, African American, Latino, and Native American) and each EHAP involved a

Table 1. Description of Case Example Legislative Relationships

Organization	AA and NHPI Focus	Type of Relationship	Strengths	Weaknesses	Recommended Use
CPAC, specifically the EHAP	Limited; part of a broader agenda to highlight health needs of multiple ethnic groups	Consultative community-legislative-research relationship	<ul style="list-style-type: none"> • Some AA and NHPI Focus During the EHAP Process • Relatively Stable in Terms of Funding Relationships (and its ability to fund additional projects) • EHAP Project Consulted with Legislators and Community Organizations 	<ul style="list-style-type: none"> • Voluntary nature of community and legislative consultation does not require adoption of legislative recommendations • Legislative participation hinged on prior relationships built with key officials and aides 	Provision of evidence-based research products to community members for lobbying and advocacy efforts
CHBRP	No	Mandated legislative-research relationship	<ul style="list-style-type: none"> • Legally mandated relationship between researcher and legislators results in strong, stable, consistently funded relationship • Researcher role is highly influential in legislative process 	<ul style="list-style-type: none"> • Mandate requires health impact team to consider minority populations, yet does not require this aspect for other assessments including utilization and cost analysis • Researchers provide analysis specific to requests • Requests for analysis occur in a specific time frame 	A well-described and transparent mechanism through which researchers provide oversight of proposed health legislation
UC AAPI Policy MRP, specifically the 2009 Health Report	Yes	Partnering legislative-research relationship (joint project design)	<ul style="list-style-type: none"> • Most focused on AA and NHPI populations • Strong partnering relationships cultivated over time leads to legislator buy-in and trust • Partnering approach leads to research products geared toward shaping legislation (rather than reacting to it) 	<ul style="list-style-type: none"> • Vulnerable due to continued fundraising efforts and legislative term limits • Fast turnaround (from concept to publication) expected by legislators difficult for research faculty to accommodate • Voluntary nature of relationship requires constant attention to ensure legislators maintain interest 	Development of long-term legislative relationships to influence policy and discourse on an issue before and during development of legislation

Abbreviations: CPAC, California Program on Access to Care; CHBRP, California Health Benefits Review Program; EHAP, Ethnic Health Assessment Project; UC AAPI Policy MRP, University of California Asian American and Pacific Islander Policy Multicampus Research Program.

partnership between an ethnic health organization and a UC faculty researcher with ethnic health expertise. The key focus areas—(1) demographic profile, (2) environmental health, (3) population health, and (4) health care reform—were developed through open discussions and consensus building between the community advisory committee, ethnic health organizations, and the UC researcher.

Discussion of Researcher–Legislator Relationships. Although the UC researcher led and carried out the data collection and analysis of key indicators, an advisory committee of ethnic-specific stakeholders and legislators were involved in identifying health gaps and prioritizing goals for research. For the AA and NHPI EHAP, legislators assisted with the oversight of the research process and in the dissemination of information. For example, the former Legislative Director for Assemblymember Mike Eng, a point person on health for the Asian Pacific Islander Joint Legislative Caucus (a bipartisan group of California elected officials), was selected to participate in the committee. Additionally, a District Representative for Senator Lou Correa was selected to participate in the committee because of Senator Correa's membership on the state's Mental Health Services Oversight and Accountability Commission, the body that oversees California's landmark mental health law, the Mental Health Services Act, which seeks to expand services to underserved client populations to eliminate ethnic disparities in accessibility and cultural competency. These legislative aides were chosen because of the legislator's prior engagement with AA and NHPI health issues; as a result, their voluntary participation in the EHAP process served to strengthen existing ties between researchers and legislators. Legislators were also involved toward the end of the EHAP process; before public dissemination of results, community and legislative stakeholders were given the opportunity to provide input. Upon completion of the ethnic health assessments, results from the assessment were presented to California state legislators and community stakeholders via briefing sessions.

CPAC is a successful model of CBPR for civic engagement, and is especially commendable for its ability to create close consultative relationships among ethnic organizations, legislators, and UC researchers. The benefit here is a close relationship with ethnic stakeholders and legislators in addition to a policy-oriented product that is useful for community advocacy. However, a key weakness is that legislators have

no legal mandate that might assist in translating policy recommendations into action. In addition, the involvement of key legislative officials and legislative aides hinged on prior relationships built with these individuals as well as a vested interest of these policy makers in furthering research on AA and NHPI health. Although in this instance legislators were able and willing to participate, this relationship is dependent on the researchers continued cultivation of legislative interest and engagement.

California Health Benefits Review Program

Overview. The CHBRP was established in 2002 and responds to requests from the California State Legislature to independently analyze the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals.¹⁴ Reports provided to the legislature do not make policy recommendations, but provide evidence-based policy analyses of each proposed mandate to assist legislators in making informed decisions.^{14,15}

A task force of faculty from several UC campuses as well as select private universities, overseen by a small analytic staff in the UC Office of the President, completes each legislative analysis during a 60-day period, generally before the legislature begins formal consideration of the bill.¹⁴ To ensure the quality of analyses provided, a National Advisory Council composed of academic researchers with appropriate expertise reviews drafts before they are submitted.

Discussion of Researcher–Legislator Relationships. For each report provided, faculty teams focus specifically on impacts to medical effectiveness, utilization and cost, and public health.¹⁴ Although the mandate for the public health impacts team includes looking at subpopulations (i.e., minority groups), the potential for analyzing proposed legislation with respect to various ethnic populations such as AAs and NHPs is not fully operationalized because, as of this writing, the actuarial models that inform the utilization and cost analysis do not currently include this aspect.

The CHBRP model is a highly influential mechanism for shaping health benefits in California. Because the analysis conducted is mandated by the state before legislation is passed, an official relationship between faculty researchers and legislators has developed. However, this relationship is limited to a very specific time in the legislative process, which makes the

relationship somewhat one sided (i.e., researchers provide analysis specific to requests, but do not engage earlier in the process to shape emerging legislation). Despite limitations, this mandated legislative–researcher relationship is strong, stable, and has a clearly defined process and mutually understood outcomes.

In sum, although CHBRP is a stable model for evaluating health legislation’s effects on AA and NHPI and other ethnic communities (and thereby highlighting specific needs of this diverse community), it is limited by its mandate to working within a specifically defined moment in the legislative process where researchers respond to a bill that may or may not have had researcher–ethnic community participation in the earlier process of shaping emerging legislation.

University of California Asian American and Pacific Islander Policy Multicampus Research Program

Overview. The purpose of the UC AAPI Policy MRP is to “promote and coordinate applied and policy research on topics relevant to California’s growing Asian American and Pacific Islander population” by serving as the bridge among UC researchers, community organizations, and legislators.¹⁶ The UC AAPI Policy MRP is specifically focused on bringing legislative attention to the diverse needs of AA and NHPI Californians.

Herein we focus on one successful endeavor of this organization, the 2009 “The State of Asian American, Native Hawaiian, and Pacific Islander Health in California Report.”³ This health report is indicative of the UC AAPI Policy MRP’s focus on engaging legislators via a collaborative research process. In 2007 and 2008, faculty from several UC campuses came to Sacramento (the state capital) to discuss health issues with members of the Asian Pacific Islander Joint Legislative Caucus (a bipartisan group of California elected officials), and representatives from foundations and civic organizations. The faculty group, named the UC AAPI Policy MRP Health Working Group, composed of faculty from UC Berkeley, UC Davis, UCLA, and UC San Francisco, met to brainstorm possible needs for research by state legislators and community organizations and how best to work together across UC campuses to deliver a useful and timely product.

The well-received 2009 UC AAPI Policy MRP health report became the impetus to further shape policy debates to meet emerging needs for AAs and NHPIs. Additional public

health efforts included a legislative town hall in Los Angeles convened by California Assemblymember Mike Eng’s office in November 2009 that focused on AA and NHPI mental health.¹⁷ The report also motivated the reintroduction of a bill by Assemblymember Eng that was first introduced by California Assemblymember Ted Lieu in a previous session. AB 1737 (Eng) in 2010 would have mandated the collection of data by California agencies and commissions of additional AA and NHPI subgroups that matched the U.S. Census ethnic categories.¹⁸ Although AB 1737 (Eng) did not pass, Assemblymember Eng introduced AB 1088 in 2011, which not only mandates the collection of data as detailed in AB 1737, but also requires state agencies and commissions to make the data publicly available on their websites and AB 1088 was signed into law October 2011.⁴

Discussion of Researcher–Legislator Relationships. Like CPAC, the UC AAPI Policy MRP shares concerns for the public health needs of California’s population, but the UC AAPI Policy MRP focuses explicitly on AAs and NHPIs. And, unlike CHBRP, whose work is fixed within a very specific timeframe of the legislative process, the UC AAPI Policy MRP attempts to shape the legislative process by creating a longstanding, collaborative relationship with state legislators. In so doing, the emphasis is on learning about the interests and needs of legislators, so that research can be designed, conducted, and disseminated to meet their needs and timeframe for the legislative process. This co-development of legislation in turn may increase legislator “buy-in” and support for the content, presentation, and publicity of documents.

The complexities of working with so many stakeholders make trust building and communication difficult, however. For example, although the UC AAPI Policy MRP is structured to provide flexibility regarding where in the legislative process it attempts to shape debate, challenges arise because of the disconnect between academic research timelines and legislative cycles. The turnover of research and legislative staff can also create challenges for trust building and delay research timelines. In terms of legislative determination of report release dates, timing (including matching legislative agenda setting cycles, but also the sometimes rapid speed with which legislators may need information) is critically important. A political consultant* in Sacramento at the beginning of the process to generate the 2009 health report argued that faculty

live in a world whose timing did not match with legislators and their needs. In fact, he argued, and even scolded, that it was the job of researchers to work harder to match their processes to that of the legislative process if researchers were serious about being relevant to the legislative decision-making process. From a researcher perspective, creating a policy document from initial ideas/meetings to final product in nine months or less may be daunting, especially given that scholars are more familiar with taking more time to ensure accuracy and to create new knowledge, all the faculty contributors were volunteering their time, and the report was reviewed by faculty and educators from several different institutions and agencies.

Furthermore, the collaborative partnerships between researcher and legislator are voluntary (there is no legal stipulation mandating legislative participation). As a result, researchers must spend considerable effort establishing themselves as credible and respected sources of information and ideas to attract interest from legislators to introduce legislation based on their research and also so that legislative partners will continue their financial and political support. Despite these many challenges, or perhaps because of them, a close collaborative partnership has developed between UC AAPI Policy MRP researchers and state legislators.

Although the relationships between individual legislators and key researchers involved with the UC AAPI Policy MRP have strengthened over time, without a legislative mandate, these relationships are restricted by time constraints. Term limits in California (6 years for assembly members and 8 years for state senators) result in a short window of opportunity for researchers to develop strong relationships with legislators, conduct appropriate research, and attempt to utilize such research to further the health needs of AA and NHPI Californians. For example, although the UC AAPI Policy MRP has cultivated a close working relationship with Assemblymember Mike Eng, because of term limits it is uncertain who will take the place of Assemblymember Eng as a strong legislative champion once he leaves office in 2012.

The UC AAPI Policy MRP has been successful in working with current legislators given overlapping interests between

the involved individuals; however, such a relationship will be difficult to replicate, resulting in significant challenges for long-term legislative change. Although relationships with legislators may be time limited, the Asian Pacific Islander Joint Legislative Caucus does provide an institutional entity with which the UC AAPI Policy MRP has cultivated a more permanent relationship. That said, whereas the caucus as an institution provides a reliable venue through which relationships may be built, the individual legislators and their interests in AA and NHPI health are subject to change.

CONCLUSION

Each of the examples discussed provides possible models for replication by other researchers interested in shaping health policy responsive to the needs of AA and NHPI communities via CBPR focused expressly on civic engagement. By looking at each in-depth, however, it becomes clear that it is difficult for researchers to engage multiple parties in collaborative research. In addition we cannot stress enough the importance of clearly defining outcomes and goals before engaging in any particular model for CPBR.

If the goal is to assist community stakeholders by providing them evidence-based research products they can then utilize for advocacy and lobbying purposes, then a consultative CBPR model such as that undertaken by CPAC is likely adequate because it prioritizes the relationship between community and researcher while also encouraging legislator buy-in and disseminating results to policy makers. Alternatively, if the goal is to shape the discourse on an issue before legislation is even developed, then a legislative partnership is necessary much earlier in the process. In this case, a model closer to the UC AAPI Policy MRP is more appropriate because it encourages trust building and collaboration with legislators throughout the research process. This is a time-consuming process, however, and should be considered only for those with long-term, rather than short-term, goals. Further, given that it has no formal legal mandate and considering legislator term limits, such a model (like many similar CBPR models) is subject to the ebb and flow in the interest level and commitment of the various partners. Finally, the CHBRP model holds great potential for those interested in pushing forward

* Bill Wong, who was legislative staff member to several California State elected officials including State Assemblymember Judy Chu, State Assemblymember Mike Honda, and State Senator Hilda Solis.

well-described and transparent mechanisms through which researchers can participate in the analysis of proposed health legislation. Yet, although this model is the most stable of the three, its mandate to undertake objective issue analyses does not emphasize community participation and is significantly limited to the mandated mechanisms governing the relationship between legislator and researcher.

Despite the strengths of CBPR models promoting civic engagement to address the health disparities of AA and NHPI communities, much more work can be done to improve and strengthen existing models. The three models illustrated in this paper, ranging from consultative to legislatively mandated, illustrate the depth and diversity of legislative relationships that can be cultivated via CBPR. Despite challenges inherent in each, the partnership models illustrated here may result in demonstrated policy change as evidenced by legislative bills proposed and joint efforts to pass such bills. The UC AAPI Policy MRP's continuing engagement and joint efforts with legislators and community stakeholders supported and helped to motivate recent legislative actions with the introduction of California Assembly Bill 1088 by Assemblymember Mike Eng (signed into law in October 2011, this bill requires California agencies and commissions to collect and record data on AA and NHPI subgroups to match the U.S. Census ethnic categories and also requires that such data be made publicly accessible online).⁴ These CBPR lessons, particularly between researchers and legislators, can serve as examples for AA and NHPI communities in other states looking to integrate CBPR and civic engagement to advance AA and NHPI health.

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