TRACK 1

Integrating Student Learning Objectives with Community Service Objectives through Service Learning in Health Professions Schools Curricula

written by

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Creating healthier communities and overcoming complex societal problems require collaborative solutions that bring communities and institutions together as equal partners and build upon the assets, strengths and capacities of each. Community-campus partnerships involve communities and higher educational institutions as partners, and may address such areas as health professions education (i.e. service-learning), health care delivery, research, community service, community-wide health improvement, and community/economic development. Founded in 1996, Community-Campus Partnerships for Health is a non-profit organization that fosters community-campus partnerships as a strategy for improving health professions education, civic responsibility and the overall health of communities. In just four years, we have grown to a network of over 700 communities and campuses that are collaborating to achieve these goals.

Community-Campus Partnerships for Health's 4th annual conference was designed to broaden and deepen participants' understanding of the policies, processes and structures that affect community-campus partnerships, civic responsibility, and the overall health of communities. The conference also aimed to enhance participants' ability to advance these policies, processes and structures.

This paper – one of nine commissioned for discussion at the conference – played an integral role in the conference design and outcomes and would not have been possible without the generous support of the Corporation for National Service and the WK Kellogg Foundation. On the conference registration form, participants chose a track that interested them the most in terms of contributing to the development of recommendations and possibly continuing to work on them after the conference. Participants were then sent a copy of the commissioned paper corresponding to their chosen track, to review prior to the conference. At the conference, participants were assigned to a policy action team (PAT). Led by the authors of that track's commissioned paper, each PAT met twice during the conference to formulate key findings and recommendations. These key findings and recommendations were presented at the conference's closing session and are reflected in the conference proceedings (a separate publication). These will be considered by CCPH's board of directors as part of its strategic planning and policy development process, and are expected to shape CCPH policies and programs in the coming years.

The complete set of nine commissioned papers is available on CCPH's website at http://futurehealth.ucsf.edu/ccph.html

1. Integrating student learning objectives with community service objectives through service-learning in health professions schools curricula – Kate Cauley
2. Working with our communities: moving from service to scholarship in the health professions – Cheryl Maurana, Marie Wolff, Barbra J. Beck and Deborah E. Simpson
3. Promoting collaborations that improve health – Roz Lasker
4. Public policies to promote community-based and interdisciplinary health professions education – Janet Coffman and Tim Henderson
5. Building communities: stronger communities and stronger universities – Loomis Mayfield
6. Community-based participatory research: engaging communities as partners in health research – Barbara Israel, Amy J. Schulz, Edith A. Parker, and Adam B. Becker
7. Racial and ethnic disparities in health status: framing an agenda for public health and community mobilization – Gerard Fergerson
8. Social change through student leadership and activism – David Grande and Sindhu Srinivas
9. Advocating for community-campus partnerships for health – Charles G. Huntington

Introduction

Clinical training opportunities in hospitals are shrinking. Hospitals are closing, patient census is generally down, length of stay is increasingly shorter. The range of disease conditions for hospital patients is more limited because hospital patients are more acutely ill at point of admission. Additionally, students seldom have the opportunity to follow the patient into even preliminary stages of recovery. The Balanced Budget Act is having an impact on hospitals' ability to continue to treat indigent patients, and the numbers of hospitals willing to continue opportunities for health professions education have decreased. Clinical training opportunities in private practice settings are also shrinking. Solo and small group practices have dwindled, and large group practices are frequently part of managed care organizations where time intensive student training is no longer tolerated in light of pressures to increase patient volume. Even in major teaching institutions the economic bottom line is increasingly becoming the standard by which priorities are determined.

In response, medical schools, colleges of nursing, allied health programs, clinical psychology and social work programs, dental and pharmaceutical programs--most of which have traditionally provided clinical training in institutional settings including hospitals, and long term care facilities--are moving into a wider variety of clinical settings. Often these settings are unfamiliar to faculty, and require establishing new partnerships, redefining roles and responsibilities, and designing different kinds of preparation for students prior to their clinical experiences. In non-hospital settings faculty must also revisit evaluation procedures providing more opportunities for synthesis and integration of clinical experiences. In short, as health care financing and health care service delivery systems continue to change, health professions education is changing just as quickly. This provides an excellent opportunity to introduce health professions schools and faculty to the concept of service learning.

Definitions

The concept of service learning is difficult to clearly articulate, and is often confused with community service, volunteering, experiential learning, internships and other kinds of non classroom based learning experiences. Consequently it becomes important to begin with an understanding of the philosophical foundations of service learning, and the methodological history of service learning, and then to explore the application of service learning, particularly in health professions education. The philosophical foundations of service learning, to a large extent the philosophical underpinnings of higher education in this country from the founding of the first college/university, are rooted in a responsibility to the populace. For example, the mission school movement which first extended educational opportunities to the poor, Benjamin Franklin's focus on public education as a means to foster citizenship and service, and the extension education programs spawned by the Land Grant Institution movement of the 1860's were all philosophical pre-cursors to service learning. Dewey's *new education* defining: "inquiry as thought intertwined with action" (Dewey, 1916 & Schon, 1995), and Kurt Lewin's actionable theory, "theory constructed, applied, tested and revised in particular situations of practice" (Rhoads & Howard, 1998) are more recent expressions of similar philosophical principles.

The term service learning was first coined by Bill Ramsay and Bob Sigmon, who were developing a Manpower Development Internship program and were looking for a term which would define the accomplishment of tasks which meet genuine human needs in combination with conscious educational growth (Southern Regional Education Board, 1969). Service learning as a term re-emerged in the late 1980s as it became apparent "that for service to broadly infuse the academic culture and to have a deeper cognitive and civic dimension it would have to be closely linked to the central educational enterprise of higher education". Service learning marked the shift from community service to service that was integrated with academic study, a pedagogy of action and reflection that connects student

academic study with problem solving experiences in local community settings. (McAleavey, 1996).

Methodologically, the National Community Service Trust Act of 1993, which established the Corporation for National Service, defines service learning as “a method under which students learn and develop through active participation in thoughtfully organized service experiences that meet actual community needs, that are integrated into the student’s academic curriculum or provide structured time for reflection , and that enhance what is taught in school by extending student learning beyond the classroom and into the community,”(1993). Kendall, (1990), provides some useful distinctions between service learning and experiential education when he summarizes that service learning:

> Engages people in responsible and challenging actions for the common good.
>
> Is committed to program participation by and with diverse populations.
>
> Clarifies the responsibilities of each person and organization involved.
>
> Articulates clear service and learning goals
>
> Includes training, supervision, monitoring, support, recognition and evaluation to meet service and learning goals
>
> Provides structured opportunities for people to reflect critically on their service experience

Finally, service learning programs are distinguished from other approaches to experiential education by their intention to equally benefit the provider and the recipient of service as well as to ensure equal focus on both the service being provided and the learning that is occurring. (Furco, 1996). Although clerkships, clinicals, practicums and internships in health professions education programs may encompass many of the underlying philosophies and methodological principles found in service learning, seldom are these principles the building blocks on which clinical experiences for students are developed. As the venue increasingly shifts from institutional to community based settings, the teaching

methodology of service learning provides a critical focus on intentional and systemic changes needed for successful training programs in health professions education.

Service Learning Protocol for Health Professions Schools

In application, service learning can be viewed as a useful tool to assist health professions faculty and students as they navigate the uncharted waters of community and neighborhood based clinical training. Core elements essential to service learning include the partnership between faculty and service site, a responsiveness to the community and to community identified needs, and attention to critical thinking and reflection. In an attempt to translate the philosophical and methodological components of service learning to principles of application in health professions education these authors have developed the Service Learning Protocol for Health Professions Schools (SLPHPS). The SLPHPS is not actually a protocol, more a set of guidelines and explanations intended to support health professions faculty in the transition from institutional based clinical training to community and neighborhood based experiences. While hospital and institutional based clinical training will remain an important component of health professions education, the learning community is expanding and the following may prove useful.

1) *Establish ongoing relationships between faculty and service sites that insure educational training of students and continuous service in response to community identified needs.*

The nature of the relationship between the health professions colleges/departments/schools, their faculty and students, and the sites at which clinical training is completed, is changing. These expanded relationships within a broader teaching and learning community are not as well or as consistently defined as they have been in hospitals and long term care settings. In more broadly defined community settings, it is important for students and faculty to be more attentive to developing a relationship with a particular site and clearly

articulating specific roles and responsibilities of students, faculty and site staff and supervisors. Maintaining ongoing interaction with the site, planning in advance for student rotations, and adapting to the less structured routines of the non-hospital based sites are all important strategies to pursue. Consequently, more up front time is frequently required to get the sites established, and a different approach to developing and maintaining the relationship in order to facilitate meeting both training and service objectives may be required. Additionally, feedback mechanisms need to be developed and maintained for ongoing communication and evaluation. Not unlike hospital settings each community-based site has its own sets of political agendas, and personality, and sites will vary broadly in experience with training students. The partnership established between faculty and the site supervisor is a critical component of successful community based training programs using service learning.

2) *Develop an orientation component to clinical training that focuses on the population being served and the community in which the service is provided.*

It is important to apply the same level of rigor developed for appropriate orientation to a hospital setting, i.e., specific needs of patients, and orientation to equipment and procedures, to non-hospital settings. In non-hospital settings special emphasis should be placed on: a) orientation to basic clinical procedures provided on site; b) orientation to the services routinely provided on site; c) orientation to the patient population and their cultural health beliefs and practices; d) orientation to the community and community resources in which the service is located; and e) orientation to community identified health concerns. Comprehensive orientation is critical in preparing students appropriately for clinical training in the expanded learning community.

3) *Develop a reflection component in which students have an opportunity to integrate the service and learning aspects of their experience.*

Although any clinical training opportunity is carefully evaluated and reviewed, it is often useful, particularly in unfamiliar settings, to go one step further, that is to engage in active reflection with students about their clinical experiences. Traditionally, during grand rounds or peer review, students review diagnoses, procedures, outcomes of treatment, etc. Equally important are discussions about issues such as health concerns which affect particular communities, resources which enhance health in the community, barriers to accessing care, socio-cultural and/or economic reasons for non-compliance with treatment regimens, ways in which the provider can extend service delivery, and available health promotion and disease prevention services. In community based settings where there is a broader diversity of patient populations and disease states, facilitating the students' integration of treatment and procedures with the larger environment of the patients' community becomes more significant.

4) Actively promote the ethic of service as an integral part of professional practice.

Though clearly articulated in each of the health professions ethical codes, service to the community is sometimes a difficult concept for students to understand. Health professionals, by nature of their work are providing service to the communities in which they work. However, in today's rapidly changing health care environments health professionals are under increasing pressures and time constraints to provide quality care. Discussions with faculty, supervisors and mentors about experiences of service, i.e., opportunities to use professional training and education beyond the confines of the provider's office in ways which support individuals and communities taking responsibility for their own health, are useful for health professions students as they encounter a variety of patient populations and systems of health care service delivery and financing during their clinical training experiences. Service learning calls for health professions colleges/departments/schools to actively work to instill the ethic of service into educational and training activities, preparing a workforce committed to increasing access and utilization of health care services for all citizens.

Rationale

Although there are service learning programs in hundreds of higher education institutions, service learning in the health professions schools has been slow to take hold. Health professions students who train in hospitals typically work with underserved patients. Health professions faculty and schools understandably equate serving underserved patients in the hospital setting with community service, but often incorrectly assume community service and service learning are one and the same. However, faculty and students from schools who have integrated service learning into the health professions curricula, and the community partners who work with students using the teaching methodology of service learning offer some compelling reasons for broader utilization of service learning in the health professions schools. These include: the changing health care environment which requires a broader range of skills in tomorrows' health professionals; fiscal constraints which require significant changes in clinical training programs and the role of the academic health center; and students who report gaining increased knowledge and experience through service learning.

Changes in Health Care Service Delivery

As health care service delivery moves increasingly to managed care, health care providers are required to work with a larger number and more diverse patient populations who present with a greater variety of health care concerns. Knowledge about a wider range of disease conditions, cultural health beliefs and practices, and community resources to support primary care services are increasingly important to the health care provider. Recent studies of health professionals indicate that these are the knowledge areas of professional training programs most frequently cited as being particularly weak (Cantor, Baker, & Hughes, R. 1993)

Health professions educators are working to be responsive to these shifts in service delivery and provider education by exposing students to a wider variety of patients in a broader arena of clinical environments, often in areas where health

care services have not typically been available. For example, faculty from the University of Cincinnati, having been awarded a service learning curricular development grant, placed medical students in a youth services center providing health screenings, education and referral services for adolescents. Professional psychology students at Wright State University worked with children and families in a Headstart program to provide educational assessments and interventions for behavioral difficulties. Nursing students from the University of Akron provided health education and basic primary care services for men at an urban homeless shelter. In pre and post knowledge and attitude measures conducted through the Center for Healthy Communities these students demonstrated significant changes in knowledge of community resources and cultural health beliefs and practices (CHC Annual Report, 1999). In fact, it has been reported that 90% of health professions students surveyed indicated service learning had increased awareness of community needs (Gelmon, Holland, & Shinnamon, 1998).

Changes in Health Care Financing

Changes in health professions education are closely related to changes in health care financing. National trends such as the shifts to community based ambulatory settings, managed care, and the implications of the Balanced Budget Act of 1997 have significant economic implications for health care financing which in turn has an impact on health professions education, in many cases limiting opportunities for health professions education in hospitals, academic health centers and long term care facilities. Academic health centers, for so long primary training facilities for health professions schools across the country, are restructuring fiscally and in some cases closing down. Historically, the center of critical research, a resource for specialty care services and part of the community safety net, academic health centers are struggling with the same fiscal constraints as many hospitals. Concurrently, academic health centers are being called on to be more responsive to their surrounding communities, and to shift their focus to more community responsive research, bringing the knowledge

generated in the academy to bear on the pressing health, social and economic needs in the community.

The impact on health professions schools has fostered some innovative responses which often include working in partnership with state agencies, legislatures and a growing number of community partners. For example, in Tennessee graduate medical education training dollars now follow the residents to community based ambulatory training sites outside of the hospital. In West Virginia, an annual allocation from the state legislature supports student training in rural health centers which extends primary care services throughout the state. In Michigan the Innovations in Health Professions Education Pool has been established which makes grant funds available to consortia which include a hospital, a university, and a managed care organization in order to foster innovations in health professions education. In Ohio health professions students are involved in a state-wide evaluation of Medicaid outreach programs.

In forging these new partnerships, as health professions schools respond to changes in health care financing, service learning has provided useful guidelines for defining roles and responsibilities, better integrating student learning objectives with community service objectives, extending health care services and education through a growing student workforce in the community, and preparing community responsive and competent health care professionals.

Changes in Educational Outcomes

Faculty and students involved in service learning are often in the forefront of establishing and expanding partnerships with the community, and these kinds of partnerships are beginning to demonstrate significant educational benefits for students. The successful service learning partnership values equally the contributions of the faculty and students, and the contributions of the community partner which in turn strengthens both the service provided and the learning experience for the student. Students in clinical training using service learning

consistently report learning more from their service learning experiences compared to other clinical training experiences, and gain valuable knowledge about the communities in which they are working.

At Wright State University in Ohio, medical students in a third year ambulatory pediatric clerkship each spent four hours a week in a public school working with elementary school children. At the end of their clerkship the students in the service learning experience in the public schools had seen significantly higher numbers of children with more commonly diagnosed disease conditions than their counterparts in a hospital based ambulatory care clinic. Anecdotally, students report more opportunities to work with patients with chronic conditions, as well as more experience in primary prevention programs. Finally, students report more opportunities in service learning to be connected to their patients, and to see the impact of care through the improved health of their patients.

Strategies for Integrating Service Learning into Health Professions Schools Curricula

Health professions schools and faculty interested in being responsive to both student educational goals and community identified health care concerns will find a teaching methodology in service learning which facilitates an integration of student learning objectives and community service objectives. Drawing on the experiences of health professions programs which have successfully integrated service learning into the curriculum a number of useful strategies have been identified.

First, the primary barrier to integrating service learning into health professions school curricula is a natural inertia that provides routine resistance to change. Most people are not interested in change until it becomes required, and even then may resist as long as possible. Consequently, when service learning can be seen as facilitating necessary changes, rather than as something new which *should be* incorporated it is more likely to be viewed as a useful tool. For

example, as health professions programs respond to changes in health care service delivery and financing through routine curricular reform, service learning can be integrated as a way to facilitate the transition from primarily institutional based clinical training programs to expanded community and neighborhood based programs. Additionally, as professional accreditation boards require programs to increase community based clinical rotations, service learning can be integrated to provide guidelines for establishing partnerships and new training sites. Finally, as students increasingly call for a broader range of clinical training opportunities, service learning can be integrated into core curricular and elective courses used to respond to student interest.

Second, health professions schools administrators are generally interested in techniques to strengthen community-campus relationships particularly when these relationships contribute to ensuring access to clinical training sites and populations for research. When health professions schools incorporate service learning, and increase the number of community based clinical training sites, the school is often seen as the source of additional workers who extend services, and community site supervisors are often extended faculty privileges like access to the library or clinical teaching status. Over time these partnerships facilitated by service learning provide not only excellent educational opportunities for students but also strengthen relationships with the community more generally.

Third, it is important to find ways to affirm and support faculty members who are interested in integrating service learning into the curriculum, particularly as programs are just getting started. Two strategies which have been useful in health professions schools across the country have included continuing education credit for faculty development seminars in service learning and small grants awarded to faculty to develop service learning curricula. Programs supported by federal, state and private initiatives provide both training and grant making programs open to health professions faculty. For example, the Community Campus Partnerships for Health holds an annual faculty

development workshop in service learning; and through the Center for Healthy Communities in Ohio there is a regional faculty development training program in place for the Midwest. Through organizations such as Campus Compact and programs supported by the Corporation for National Service, grants are available to develop service learning courses in higher education. When faculty can get continuing education credit and grant-writing experience through an engagement with service learning, the work of integrating this teaching methodology into the curriculum is greatly facilitated.

Conclusion

The integration of service learning into health professions education is an increasingly important issue as national trends in health care services delivery shift to community based settings, ambulatory services, and managed care. These new policies, practices and settings are changing both health career paths and the knowledge base required for serving communities and populations. These new delivery environments necessitate changes in educational preparation so that future professionals develop the necessary competencies required for work in these varied settings.

Service learning is a useful teaching methodology to assist health professions schools and faculty as they move through these changes. Additionally, faculty and students will find that applying the core elements essential to service learning which include the partnership between faculty and service site, a responsiveness to the community and community identified needs, and attention to critical thinking and reflection, improves the educational experience for the student and strengthens the community academic partnerships that are increasingly important to the clinical training experiences of future health care providers.

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Kate Cauley has been the Director of the Center for Healthy Communities for the past four years. She has a joint faculty appointment at the Wright State University in the Schools of Medicine and Professional Psychology. During the past four years the Center for Healthy Communities has continued to extend primary care service delivery to the underserved in the surrounding community by annually placing over 600 health professions students in community based sites using the Service Learning Protocol for Health Professions Schools. Additionally, through the Center for Healthy Communities, statewide training programs in service-learning are provided to Health Professions Faculty in Ohio and curricular development grants are awarded statewide for new service-learning programs. Kate is also a member of Community-Campus Partnerships for Health's Mentor Network of trainers and consultants.

The Center was instrumental in securing for the School of Medicine the outstanding community service award in 1997 from the American Association of Medical Colleges. And in 1998, The Center was selected by the Health Services Research Administration of the United States Department of Health and Human Services to serve as a model program for community health care delivery for underserved populations.

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