ABSTRACT

Background: Over the last two decades, a national movement has developed for greater civic engagement in health professions schools, as has a focus on training health professions students for leadership in community and population health. Service-learning (SL) has been adopted to address both of these goals. SL is a pedagogical method build on community-academic partnerships. Through SL, students deliver services in response to community identified needs, and develop competencies for community and population health and an ethic of service. SL partnerships may also build capacity in academic and community partners for future partnerships, and enhance community partners’ ability to address community health priorities. As SL becomes increasingly prevalent in health professions education, questions of how to sustain SL and how to maximize its quality are increasingly important.

Goals: This dissertation research has three overarching goals:

1. To assess the sustainability and long-term impact of SL in health professions training, and to identify important influences on sustainability;

2. To explore how sustained SL programs in the health professions have been implemented and maintained in different institutional contexts, and to identify strategies for success and lessons learned from their experiences; and

3. To examine how students can provide co-leadership to advance SL in health professions training.

Methods: Manuscripts 1 and 2 address the first and second goals, respectively. They report findings from a ten year follow-up study of the Health Professions Schools in Service to the Nation (HPSISN) program. Implemented from 1995 to 1998, HPSISN
supported community-academic partnerships for SL and the integration of SL into the curriculum at 17 US health professions schools. To address the first goal, in-depth interviews were conducted with 23 individuals from 16 of the 17 HPSISN schools. Documents about the HPSISN-supported SL programs were also collected and reviewed. To address the second goal, a comparative case study was conducted with two of the HPSISN schools that had institutionalized SL. In-depth interviews were conducted with administrators, faculty, SL staff, students, and community partners at each school, for a total of 47 interviews. Documents about each institution, its SL program, and community partner agencies for SL were also reviewed. To address the third goal, a case study was conducted of a student advocacy group at the Johns Hopkins Bloomberg School of Public Health that provided leadership to advance SL at the School. Methods for this research included participant observation, document review, and member validation.

**Findings:** Manuscript 1 had four major findings. First, ten years after grant funding ended, 13 of the 17 participating SL programs had routinized or institutionalized SL, demonstrating a high level of sustainability. Second, major influences on program sustainability clustered in the academic environment, rather than the community-academic partnership or community setting. Third, important influences on program sustainability were the ability to identify how SL advanced institutional priorities and the ability to adapt SL to changes in the academic and community environments. Fourth, there were important long-term impacts of SL for academic institutions and community agencies as related to increasing capacity for SL and community-academic partnerships.

Manuscript 2 had four major findings. First, institutional culture and priorities have a strong influence on the goals of SL, which, in turn, shape the design and
implementation of SL and its strengths and weaknesses. Second, supportive institutional
policies and infrastructure for SL are ideal to foster program sustainability, but in the
absence of this support, other strategies can be used to sustain SL. Third, an ideal way to
maximize the quality of SL as a teaching method is to incorporate it into core courses.
Fourth, in order to maximize the quality of SL partnerships, infrastructure is needed that
supports the partnership process.

Manuscript 3 had three major findings. First, students can provide unique
leadership for SL in the health professions by engaging in advocacy methods that
advance SL. Second, students’ leadership for SL can lead to innovations that advance the
quality of SL. Third, working together, faculty, SL staff, and students can enhance all of
their efforts to advance SL.

Conclusions: These findings will inform efforts to advance the quality and sustainability
of SL in the health professions and to promote the inclusion of students as co-leaders to
advance SL. They have implications for the leadership of academic administrators,
faculty, and students, as well as the activities of national health professions education
associations, accrediting bodies for health professions training, and national organizations
promoting civic engagement in higher education.

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<tr>
<td>AAHE</td>
<td>American Association for Higher Education and Accreditation</td>
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<td>ACPE</td>
<td>Accreditation Council for Pharmacy Education</td>
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<tr>
<td>AHC</td>
<td>Academic Health Center</td>
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<td>AHRQ</td>
<td>Agency for Healthcare Research and Quality</td>
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<td>AMSA</td>
<td>American Medical Student Association</td>
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<td>American Public Health Association</td>
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<td>APTR</td>
<td>Association for Prevention Teaching and Research</td>
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<td>ASPH</td>
<td>Association of Schools of Public Health</td>
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<td>CAPTE</td>
<td>Commission on Accreditation in Physical Therapy Education</td>
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<td>CBPR</td>
<td>Community-based participatory research</td>
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<td>CBPH</td>
<td>Community Based Public Health</td>
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<td>Community-Campus Partnerships for Health</td>
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<td>CEPH</td>
<td>Council on Education for Public Health</td>
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<td>CNCS</td>
<td>Corporation for National and Community Service</td>
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<td>Environmental Justice Partnership</td>
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<td>HealthSTAT</td>
<td>Health Students Taking Action Together</td>
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<td>HPSISN</td>
<td>Health Professions Schools in Service to the Nation</td>
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<td>HRSA</td>
<td>Health Resources and Services Administration</td>
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<td>IARSLCE</td>
<td>International Association for Research on Service-Learning and Civic Engagement</td>
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<tr>
<td>IOM</td>
<td>Institute of Medicine</td>
</tr>
<tr>
<td>JHSPH</td>
<td>Johns Hopkins Bloomberg School of Public Health</td>
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<td>LCME</td>
<td>Liaison Committee on Medical Education</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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<tr>
<td>NERCHE</td>
<td>New England Resource Center for Higher Education</td>
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<td>NLNAC</td>
<td>National League for Nursing</td>
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<td>SL</td>
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<td>SOURCE</td>
<td>Student Outreach Resource Center</td>
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<td>SPARC</td>
<td>Students for a Positive Academic partnership with the Community</td>
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<td>UFS</td>
<td>Unite for Sight</td>
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CHAPTER 1: INTRODUCTION

Service-learning (SL) is a form of experiential learning that is built on community-academic partnerships. Through SL, academic institutions develop partnerships with community agencies, and together they identify community needs that can be met by students. Students engage in projects that simultaneously address these needs and achieve learning objectives. The types of activities that students engage in vary by their professional degree program, educational level, educational objectives and community needs. Structured preparation for the service experience and facilitated reflection during and after the experience are defining characteristics of SL that enable students to link the service experience to learning outcomes (Seifer, 1998b).

SL in health professions education has the potential to produce important benefits for everyone involved, including students, faculty and SL staff, community agencies, and academic institutions. In students, it may enhance the achievement of learning goals, particularly as related to community and population health competencies. It may also foster in students a long-lasting interest in some of our most important public health priorities, including addressing the problem of the uninsured, reducing health disparities by race and socioeconomic status, and pursuing environmental justice, and may instill in students an ethic of civic professionalism. Through SL, community agencies receive direct health services that respond to community-identified needs, and through partnerships with academic institutions, they may also develop the capacity to address community health and related social problems, and to engage in future community-academic collaborations (Cashman & Seifer, 2008; Eyler & Giles, 1999; Seifer, 1998b). SL may also develop community engagement skills in SL staff and faculty members and
build institutional infrastructure for future community-academic partnerships for research and practice. Finally, SL may help to develop mutual understanding and change the ways academic institutions and communities relate to one another. This may improve “town-gown” relations. It may also shift the culture of academic institutions, creating more socially-engaged institutions with an enhanced ability to use their resources to contribute to the health of their communities (Cashman & Seifer, 2008; IOM, 2003a; Seifer, 1998b).

For all of these reasons, SL has been endorsed by leading national health organizations, including the Pew Health Professions Commission (O’Neil, 1993; O’Neil and Pew Health Professions Commission, 1998); Institute of Medicine (Institute of Medicine [IOM], 2003a); W.K. Kellogg Foundation (n.d.), and Robert Wood Johnson Foundation (Bulger, Osterweis, Rubin, 1999; Rubin, 1998). With these endorsements, and the growing body of scholarship demonstrating the value of SL for health professions education -- particularly as related to fostering student competencies for community and population health -- SL is becoming increasingly prevalent in health professions education.

Nevertheless, there are still many challenges to implementing and sustaining SL in health professions education. These include the challenges inherent in community engagement at many research institutions, such as the lack of faculty incentives to engage in SL and competing priorities for faculty time. They also include challenges that are present regardless of an institutional focus on teaching or research, including competing priorities for student training due to accreditation guidelines and the growing body of knowledge that students are expected to master, and the challenge of changing established ways of teaching and engaging with the community.
This dissertation aims to produce new knowledge that can support the advancement of SL in health professions education. Its findings are equally appropriate to institutions at varying stages in their relationships with SL, whether they are considering implementing SL for the first time, are concerned with enhancing the quality of existing SL initiatives, or are focused on sustaining already strong SL initiatives. This research includes three manuscripts, each of which addresses one of the following overarching goals:

4. To assess the sustainability and long-term impact of SL in health professions education, and to identify factors that influence sustainability;

5. To explore how sustained SL initiatives in health professions education have fostered the quality and sustainability of SL, and to produce strategies for success and lessons learned from their experiences; and

6. To examine how students can provide leadership to advance SL in health professions education.

This dissertation has seven chapters, including three manuscripts, each of which addresses one of these research goals. Following this introduction, Chapter 2 reviews the literature on the sustainability and quality of SL, as well as the literature on student leadership for SL. It then goes on to describe how this research contributes to the literature in each of these areas. This chapter also provides background information about each of the two cases studied in this research: 1) The Health Professions Schools in Service to the Nation (HPSISN) program, featured in the research to address goals 1 and 2, and 2) student leadership to foster SL at the Johns Hopkins Bloomberg School of Public Health, featured in the research to address goal 3.
Chapter 3 provides detailed methods used for this research, including study
design, research questions, and methods for data collection and analysis. Chapters 4, 5
and 6 comprise the three manuscripts that are at the heart of this dissertation.

Manuscripts 1 and 2, presented in Chapters 4 and 5, address the first and second research
goals, respectively. They report findings from a ten year follow-up study of the Health
Professions Schools in Service to the Nation (HPSISN) program. Implemented from
1995 to 1998, HPSISN was a coordinated national demonstration program that supported
the integration of SL into the curriculum at 17 US health professions schools or
programs. It was designed to implement the recommendations of the Pew Health
Professions Commission regarding SL in health professions education. HPSISN was the
first, and remains the only, demonstration program for SL in health professions education
in the US. As such, it provides a unique naturally-occurring cohort of early adopters of
SL that is ideal to examine the long-term sustainability and impact of SL in health
professions education.

This research was conducted in two phases, each of which addressed one research
goal. Manuscript 1 reports on phase 1 of this study. This phase of the research consisted
of a qualitative study of the ten-year sustainability and impact of SL in the cohort of
schools and programs that participated in HPSISN. This research included interviews
with 23 faculty members, staff, and administrators involved with 16 of the 17 HPSISN-
supported SL initiatives. These individuals reported on the history of these SL initiatives
from the time the HPSISN grant ended in 1998 until their interviews in 2007 and 2008.
This phase of the research also included an analysis of documents about the HPSISN
program and about the HPSISN-supported SL initiatives. This research assessed the
level of sustainability of SL in each HPSISN-supported school or program. It then explored in detail the facilitating factors and challenges that influenced the sustainability of SL and the relative importance of these influences on sustainability. Finally, this phase of the research assessed the long-term impact of these SL initiatives, considering the impact for each group of stakeholders in SL.

Manuscript 2 reports on phase 2 of this study. This phase of the research consisted of an embedded comparative case study of the implementation, design, and sustainability of two of the HPSISN-supported SL initiatives that were successfully sustained. Data collection for each case study included site visits, document analysis, and qualitative in-depth interviews with administrators, faculty, SL staff, students, and community partners for SL. A total of 47 individuals participated in interviews for this research. This phase of the research explored in depth how these SL initiatives were designed and implemented, the strategies they used to foster the quality and sustainability of SL, the challenges they encountered to maximizing the quality and sustainability of SL, and their responses to these challenges.

Manuscript 3, presented in Chapter 6, addresses the third goal of this dissertation. It reports findings from a case study of a student advocacy group that provided leadership to advance SL at the Johns Hopkins Bloomberg School of Public Health (JHSPH). Data collection consisted of participant observation, document review, and member validation. This research explored how students can provide leadership to implement SL in health professions education by contributing to organizational change processes and by introducing innovations into the design of SL. It examined the ways students’ contributions differ from those of administrators, faculty, and staff members; challenges
to student leadership for SL; and ways that faculty and SL staff can partner with students to maximize the benefits of student leadership for SL. Finally, Chapter 7 summarizes the main findings from this research, highlighting findings that are unique from the existing literature; discusses the implications of these finding for practice and policy; reviews the strengths and limitations of this research; and suggests directions for future research that might build on its strengths and address its limitations.

In the last few years there have been important increases in national support for SL, including new support for SL in health professions education. In 2005 the Carnegie Endowment for the Advancement of Teaching established an elective classification for Community Engagement, for which dozens of colleges and universities have successfully applied (Carnegie Foundation, 2007). Many of these institutions include colleges, schools or programs providing health professions education. In 2004, SL was endorsed by the Association of Schools of Public Health (ASPH) particularly to teach skills for public health practice (ASPH, 2004). In addition, the accrediting agencies for schools of pharmacy and medicine endorsed SL in 2006 and 2007, respectively (Accreditation Council for Pharmacy Education [ACPE], 2006; Liaison Committee on Medical Education [LCME], 2008).

This year ushered in an historic expansion of federal support for the service movement. In April 2009 President Obama signed the Serve America Act into law. It authorized the creation of new programs within the federal Corporation for National and Community Service (CNCS), an agency that provides support for SL in K-12 and higher education on a national scale. Among other new programs, this legislation authorized an important longitudinal study of SL and created higher education Campuses of Service
that recognize institutions with exemplary SL opportunities (Parsi, 2009). In the 2010 federal budget, President Obama requested $1.149 billion for the Corporation – a 29% increase over the 2009 budget – to fund these new programs (Goren, 2009). Together, the increase in national funding for service and the Serve America legislation have been called “a once-in-a-generation expansion of [the] size and scope” of support for national service, that responds to “a growing consensus that service is a vital part of the solution to our greatest national challenges” (Goren, 2009).

As SL continues to grow in health professions education, important questions for practice and research are how to sustain SL, how to maximize its quality, and how to include all stakeholders – including community partners and students – in work to advance SL in our field. This dissertation research aims to contribute to our knowledge about how to achieve these goals.
CHAPTER 2: BACKGROUND AND LITERATURE REVIEW

Background, Literature Review, and how this Research Advances the Science

SL in health professions education is shaped by the same concerns as SL in higher education more broadly. For this reason, this chapter begins by orienting the reader to SL in US higher education. It defines SL, discusses the goals of the pedagogy, and provides a brief history of SL in the U.S. and a discussion of current trends. It then describes SL in health professions education, specifically.

The chapter then goes on to situate this dissertation research in the literature. It describes three current priorities for research on SL in higher education and health professions education – sustainability, quality, and the inclusion of students in advancing SL – and describes how the three dissertation manuscripts address each of these priorities. It summarizes the literature that grounded each manuscript and identifies how the manuscripts build upon the literature to advance our knowledge in these areas. Finally, this chapter ends with background information about the two case studies featured in this research: the Health Professions Schools in Service to the Nation (HPSISN) program, and the student organization, SPARC (Students for a Positive Academic partnership with the East Baltimore Community) at the Johns Hopkins Bloomberg School of Public Health.

Definition and Goals of Service-Learning

SL is a form of experiential learning that is built on community-academic partnerships. Through SL, academic institutions develop partnerships with community agencies, and together they identify community needs that can be met by students. Students engage in projects that address these needs and also serve to advance learning
objectives. The types of activities that students engage in vary by their professional degree program, educational level, educational objectives and community needs.

Structured preparation for the service experience and facilitated reflection during and after the experience are defining characteristics of SL that enable students to explicitly link the service experience to learning outcomes (Seifer, 1998b). Another hallmark of SL is reciprocity (Jacoby, 1996a). Reciprocity is conceived in two ways. First, all participants – faculty, students and community partners – are seen as co-learners in SL and co-creators of knowledge through the SL process. Second, all participants should receive benefits from SL. High-quality SL includes all of these characteristics.

SL has the potential to enhance student learning outcomes as related to curricular objectives, and to teach knowledge and values that are not included in traditional curricula. Experiential training may provide the opportunity to learn practical skills that are more difficult to acquire in the classroom setting. It is estimated that, with traditional lecture-based teaching methods, students retain only 10% of what they hear, 15% of what they see, and 20% of what they both see and hear. In comparison, with SL, students retain 60% of what they do, 80% of what they do with guided reflection, and 90% of what they teach to others (Ciaccio & Walker, 1998). A central goal of SL is to cultivate an ethic of civic engagement in students. Exposure to new community settings and different populations may expand students’ understanding of the diversity of US society, and help them to develop a broader and more inclusive definition of the “community” of which they are members (Jones, 2003; Mintz & Hesser, 2006). SL may also enlighten students about the social determinants that shape our welfare and contribute to a
commitment to social justice. Finally, it may empower students to identify how they can personally contribute to society as active citizens (Eyler & Giles, 1999).

SL also has both immediate and long-term benefits for participating academic institutions and community agencies and their employees. SL provides direct services to community partner agencies, and often to their clients, that respond to community-identified needs. SL may influence faculty members’ scholarship, both by changing their attitudes toward community engagement and building capacity to engage in community partnerships for research and scholarly practice. Meanwhile, community-academic partnerships for SL may build capacity for future community-academic partnerships among faculty members and staff at participating community agencies. It may also build the infrastructure for these partnerships at both academic institutions and community agencies. SL partnerships may also enhance community partners’ capacity to address needs and priorities independent of and in collaboration with academic partners. Finally, SL partnerships may improve “town-gown” relations by developing mutual understanding and changing the ways academic institutions and communities relate to one another. In the long- and short-term, SL may create more socially-engaged academic institutions, with a greater ability to contribute to community health and wellbeing (Cashman & Seifer, 2008; IOM, 2003a; Seifer, 1998b).

A Brief History of Service-Learning in the US

SL has a long history in U.S. education, with roots in the experiential education movement of the early 20th century, founded by the philosopher and educator, John Dewey. Dewey believed that learning could best be achieved, and knowledge acquired, not just through study of the great books – the stance taken by his major opponents of the
day – but through real-world experience. He argued that experience combined with reflection was the most productive means to learn, and that only through experience could we translate knowledge into understanding (Dewey, 1916). He also believed that through experiential education, universities could educate their students to become civically engaged members of society. He wrote: “I believe that education is the fundamental method of social progress and reform. … [T]hrough education society can formulate its own purposes, can organize its own means and resources, and thus shape itself with definiteness and economy in the direction in which it wishes to move” (Dewey, 1897). SL is built upon these principles and goals of experiential learning.

Over the 20th century, SL ebbed and flowed in a cyclical manner in US higher education. Applications of Dewey’s ideas about experiential education first became widespread in the 1930s. It was also during that decade, in response to the social fallout of the Great Depression and the rumblings of upcoming war, that the first nationally organized student movement formed (Chambers & Phelps, 1993). As the economy rebounded in the 1940s, student civic engagement tapered off. But student activism, including service, reemerged in the 1960s. Faculty and students looked for ways to engage with the pressing issues of the day, and found outlets not only through political activism, but also through service and SL. By the mid-1980s, however, faculty members were lamenting a student body motivated more by personal financial concerns than civic values (Fretz & Longo, in press).

The most recent wave of SL began during that time. Students who saw the “me generation” stereotype as unfair and unrepresentative of themselves catalyzed the movement. They were soon joined by leaders in higher education (Liu, 1996;
Zlotkowski, Longo & Williams, 2006). In 1984, Wayne Meisel, a recent graduate of Harvard University, walked 1500 miles and visited 70 campuses from Maine to Washington, D.C. At each stop he delivered a call to service that inspired hundreds of students who wanted to engage with their communities but lacked the support and opportunities to do so (Liu, 1996). That year, Meisel founded the Campus Outreach Opportunity League (COOL), an organization that for two decades was a national leader in fostering student engagement, including SL. In 1985, the presidents of Brown, Georgetown and Stanford Universities founded Campus Compact, a membership organization of presidents of two- and four-year higher education institutions committed to fulfilling the civic purposes of higher education through campus-based civic engagement (Campus Compact, n.d.). Campus Compact aimed to foster civic and political engagement among students through structured campus-based opportunities.

In the two decades since that time, the SL movement in US higher education has flourished. Still a national leader for SL in higher education, Campus Compact now has a membership of over 1100 university and college presidents and an infrastructure of 35 state offices. The organization provides support to member institutions to create opportunities for public and community service that develop students’ citizenship skills, develop effective community partnerships, and integrate SL into the curriculum (Campus Compact, n.d.). Of member institutions, 86% have centers for SL and community engagement, and 98% offer SL courses (Campus Compact, n.d.). Some also offer majors, minors, and a new career track for directors of community engagement in higher education (Fretz & Longo, in press).
A field of scholarship on SL has also developed. There are a growing number of peer review journals dedicated to SL and community engagement that serve to encourage the production of scholarship on SL. From the 1997 to 2006 the American Association for Higher Education (AAHE) published 21 edited volumes each of which described how SL was being implemented in a different discipline or profession, from architecture to medicine, history, nursing, philosophy, Spanish, and many others (AAHE, 1997-2006). Each year, there are dozens of conferences about SL or community engagement in higher education that explore topics including: the partnership process that is at the heart of SL; the impact of SL on students, community agencies and academic institutions; particular methods for implementing SL, such as international immersion experiences, which are increasingly popular; and the use of SL in particular disciplines. Of particular note, the International Association for Research on Service-Learning and Community Engagement (IARSLCE) provides an outlet for scholarly work on SL.

Over the last two decades there has been a remarkable scale-up of federal support for SL. In 1993 the federal Corporation for National and Community Service (CNCS) was established under legislation signed by President Bill Clinton. In addition to the national service programs AmeriCorps, VISTA (Volunteers in Service to America), and SeniorCorps, the Corporation operates the Learn and Serve America program, which supports the implementation of SL in K-12 and higher education nationally, and the conduct and dissemination of research on SL. It annually enables over one million students to engage in SL (CNCS, n.d.).

President Obama has ushered in an historic expansion of federal support for the service movement. In the 2010 federal budget, President Obama requested $1.149 billion
for CNCS – a 29% increase over the 2009 budget (Goren, 2009). In April 2009 he also signed into law the Edward M. Kennedy Serve America Act. In addition to establishing new service programs at CNCS, such as a volunteer corps to work on conservation, education, health care and veterans issues, it created many new forms of support for SL at the Corporation. In particular, it authorized an important longitudinal study of SL. It also created higher education Campuses of Service that recognize institutions with exemplary SL offerings (Parsi, 2009). Together, this increase in national funding for service and the Serve America legislation have been called “a once-in-a-generation expansion of [the] size and scope” of support for national service, that responds to “a growing consensus that service is a vital part of the solution to our greatest national challenges” (Goren, 2009).

**Current Trends in SL**

Similar to prior waves of the SL movement, SL today is shaped by contemporary social trends and historical events. In particular, over the last two decades a culture of volunteerism has developed in the U.S., and there has been remarkable growth in social entrepreneurism globally (Kristof, 2008). In addition, in the young lives of the Millennial generation, there has been a great deal of social upheaval at home and internationally, including the Columbine and Virginia Tech shootings, the September 11, 2001 attacks, the wars in Afghanistan and Iraq, and Hurricane Katrina. These social trends and historic events have shaped the attitudes of today’s young people (Jacoby & Hollander, 2009).

Sometimes called “generation we,” today’s higher education students are the most civic-minded generation since WWII (Greenberg & Weber, 2008; Jacoby & Hollander, 2009). Research on current college students has shown they are more experienced with
volunteerism and community service than the prior generation, want to contribute to 
social change, and are imbued with a belief in the effectiveness of working together with 
others to make social change (Kiesa, et al., n.d.). Literature produced by higher 
education students suggests they have a strong understanding of the linkages between 
civic engagement and social change (Germond, Love, Moran, Moses, & Raill, 2006; 
Long, Saltmarsh, & Heffernan, 2002; Mohan & Mohan, 2007; Raill & Hollander, 2006; 
Vogel, Fichtenberg, & Levin, in press). As a combined result of current students’ 
attitudes and the development of resources for community service and SL in higher 
education, never before have so many higher education students been engaged in 
community service. Among Campus Compact member institutions, nearly one-third of 
students participated in campus-organized service projects and SL in 2006-2007 (Campus 
Compact, 2008).

The prevalence of SL today is also a reflection of a major shift in our collective 
understanding of the role of higher education in society. Whereas in 1994 Ernest Boyer 
described a general perception of higher education as a “private benefit, not a public 
good,” today there is a vigorous discussion of the “public purposes” of higher education 
(Boyer, 1994). Higher education institutions are being called upon to engage in society 
through all of their core activities, including research, teaching, and service (Astin, 1999; 
Boyer, 1990; Nyden, 2003). Community members, researchers, and funding agencies 
have all promoted the involvement of community members not just as research subjects, 
but as collaborators in research; they have also focused attention on how research 
participants and their communities may benefit directly from these collaborations 
(Emmanuel, Wendler, Killen, & Grady, 2004; Green & Mercer, 2001; O’Fallon &
Among faculty members there is a growing desire to use their research pursuits to produce direct benefits for participating communities, for example, to reduce social injustices such as harmful environmental exposures and health disparities (Nyden, 2003; Minkler & Wallerstein, 2003; O’Fallon & Dearry, 2002; Viswanathan, et al., 2004). This is reflected in the growth of community-engaged research, variously known as participatory action research and community-based participatory research (CBPR).

Students, too, are looking to engage with communities through their academic activities. In 2008, the *Guide to Service-Learning Colleges and Universities* (Student Horizons) was published to help students identify institutions with high quality SL experiences and programs. In 2005, the Carnegie Foundation for the Advancement of Teaching created a new elective classification for Community Engagement that “affirms that a university or college has institutionalized Community Engagement into its identity, culture, and commitments” (Carnegie Foundation, 2007). Institutions may receive the classification in Curricular Engagement and/or Outreach and Partnerships. Similar to the *Guide to Service-Learning Colleges and Universities*, the Carnegie Classification enables students to identify institutions where they can receive high quality teaching grounded in SL, along with an institutional environment that supports community engagement by students and faculty.

Along with this shift in our expectations of the social role of higher education, the very definition of “scholarship” has been expanded to include scholarly practice in the community. In 1990, Boyer authored the landmark publication, *Scholarship Reconsidered: Priorities of the Professoriate*, in which he introduced the concept of the
“scholarship of application,” also known as the “scholarship of engagement.” It describes how scholarly inquiry can be applied to pressing social issues. In categorizing application as scholarship, he suggested that engaged scholarship could be of equal rigor, and scholarly value, as traditional forms of scholarship. Boyer’s publication catalyzed a radical rethinking of what constitutes scholarship, and has had ramifications across higher education, including health professions education. In public health and nursing schools and programs, in particular, there is now an emerging focus on community-engaged practice as legitimate scholarship. Information on practice-based scholarship and training for practice careers can now be found on the websites of leading schools of public health (Harvard School of Public Health, n.d.; Johns Hopkins Bloomberg School of Public Health, n.d.; University of Michigan School of Public Health, n.d.).

The growing acceptance of engaged scholarship has led a number of higher education institutions, including many that provide health professions education, to revise their promotion and tenure criteria to recognize engaged scholarship (Jordan & Community-Engaged Scholarship for Health Collaborative, 2006; Portland State University, 1996). The Community-Engaged Scholarship for Health Collaborative, convened by Community-Campus Partnerships for Health (CCPH), has created the Community-Engaged Scholarship Toolkit to help health professions faculty plan and document their community-engaged scholarship and produce strong portfolios for promotion and tenure (Jordan & Community-Engaged Scholarship for Health Collaborative, 2007).
SL in Health Professions Education

In health professions education, the growth of SL has been part of a trend toward increased institutional civic engagement. It has also been a response to a two-decades-long movement to reform health professions education to address changes in the healthcare system, emerging population health priorities, and a perceived loss of civic professionalism in health professionals.

Similar to higher education institutions more broadly, health professions schools and programs have been identified as a vital public resource and have called upon to use their resources to support the wellbeing of society, particularly of their local communities (Institute of Medicine [IOM], 2003a; IOM, 2004). In its 2003 publication, The Future of the Public’s Health in the 21st Century, the Institute of Medicine (IOM) called on public health schools and programs to identify how they could use their intellectual resources to support the health of their local communities. It encouraged further progress in creating links with the practice and community sectors, collaborating with community partners, pursuing practice-based and community-based research, and providing lifelong learning opportunities to health workers in the field.

Both the IOM and the Association of Schools of Public Health (ASPH) have promoted the scholarship of engagement as a way for health professions schools and programs to invest in community health (ASPH, 1999; IOM, 2003a). The IOM recommended that health professions schools and programs revise their promotion and tenure policies in order to recognize and reward engaged scholarship (2003a). The IOM also highlighted SL as a way that health professions schools and programs could use their
resources to engage with, and thereby provide service to, their local communities (2003a).

SL is also a response to a twenty-year movement to reform health professions education. It is one of many community-engaged pedagogies in health professions education, many of which became popular to achieve similar aims, including field experiences, co-op experiences, and practicums. In 1989, the Pew Charitable Trusts convened the Pew Health Professions Commission to consider how health professions education in the U.S. would need to be reformulated in the coming decades. The Commission identified that the rise of managed care, the growing importance of preventive health and population medicine (a response to the rise of chronic disease), and the increasing prevalence of outpatient care would all require new skills in health professionals (O’Neil, 1993). It also recognized that the growing number of persons disenfranchised by the healthcare system due to uninsurance or poor access to care and the problem of health disparities were major challenges that would need to be addressed by future health professionals (IOM, 2003a; O’Neil, 1993). Over the course of a decade, the Commission produced a series of reports that catalyzed and shaped the contours of a national conversation on reforming health professions education to respond to these changes in our society.

The Pew Commission believed that to operate within the changing dynamics of healthcare and population health, future health professionals would need to be trained in community and population health competencies. The Commission developed the well-known Pew Competencies, or “Twenty-one Competencies for the Twenty-First Century,” which it believed all future health professionals would need (Appendix A). These
competencies included such knowledge and skills as: cultural sensitivity; an understanding of the social determinants of health; critical thinking, reflection, and problem-solving; and competencies for population health, community partnerships, interdisciplinary teamwork, and lifelong learning (O’Neil and Pew Health Professions Commission, 1998). The Commission stated, “the skills, attitudes and values of the nation’s 10 million health care workers have a fundamental impact on health care. The kind of care these individuals provide, how they provide it, what they value, how they interact with patients, how they define quality, and how efficiently they work determines, to a great extent, the quality, cost and availability of health care” (O’Neil, 1993).

Of particular note, the Pew Competencies identified that future health professionals would need to be equipped not just with the skills to provide high quality care, but with the ethics and skills needed to be leaders in population health. They included: having a “personal ethic of social responsibility and service,” and the skills to “advocate for public policy that promotes and protects the health of the public,” “partner with communities,” and “improve access to health care for those with unmet health needs.” Other influential bodies in both the public and private sectors embraced the Pew Competencies and incorporated them into their own recommendations for health professions education reform (Seifer, 1998a).

More than a decade later, these themes are still prevalent in the literature on health professions education. In 2003 and 2004, the IOM reiterated the need for future health professionals to be trained in core community and population health competencies (2003a; 2004). This was a main thrust of its report, "Who Will Keep the Public Healthy? Educating Public Health Professionals for the 21st Century (2003b). There continues to
be discussion of the need to reform health professions education to address the problem of the erosion of civic professionalism in health professionals (Gruen, Pearson, & Brennan, 2004; Tallis, 2006).

In its report, *Health Professions Education for the Future: Schools in Service to the Nation*, the Commission recommended that all health professions schools implement SL as a means of training students in community and population health competencies, and fostering an ethic of social responsibility and service (O’Neil, 1993). Health professions schools and programs are now using SL to address both of these goals. In addition, scholars have endorsed SL as an educational method to foster an ethic of civic professionalism in future health professionals, whether they pursue careers in clinical practice, research or community health (Hood, 2009; Yoder, 2006; Seifer, 1998b).

A growing body of literature describes how SL is being used to train students in community health competencies including: communication skills (Sauer, 2006; Young, Bates, Wolff, & Maurana, 2002); cultural competency (Albritton & Wagner, 2002; Bentley & Ellison, 2007) and an understanding of the social determinants of health (Brown, Heaton & Wall, 2007; Kinder, Cashman, Seifer, Inouye & Hagopian, 2000). It also describes how SL is being used to educate students in skills for community-based careers, including an appreciation for the role played by community health organizations in supporting population health (Seabrook, Lempp & Woodfield, 1999); and skills for health promotion program design, implementation and evaluation, and policy advocacy (Cohen & Milone-Nuzzo, 2001; Gregorio, DeChello & Segal, 2008; Reising, Shea, Allen, Laux, Hensel, & Watts, 2008). Finally, the literature provides evidence that SL is being used successfully to foster an ethic of civic professionalism (Aston-Brown,
Branson, Gadbury-Amyot, & Bray, 2009; Carufel-Wert, Younkin, Foertsch, Eisenberg, Haq, Crouse, & Frey, 2007; O’Toole, Kathuria, Mishra, & Schukart, 2005; Zauderer, Ballestas, Cardoza, Hood, & Neville, 2008).

Informed by the recommendations of the Pew Commission and the IOM and the growing body of evidence demonstrating the educational value of SL, in recent years the accrediting agencies for schools of medicine and pharmacy have endorsed SL (Accreditation Council for Pharmacy Education, 2006; Liaison Committee on Medical Education, 2008). The Association of Schools of Public Health (ASPH) also recently recommended that member schools adopt SL to train students in skills and competencies needed for practice-based careers (2004).

**SL Research Priorities in Higher Education and Health Professions Education**

The major successes of the SL movement to date have been the adoption of SL in a variety of disciplines in higher education; the establishment of resources to nurture scholarship on SL; and the growth of local and national infrastructure to support SL, including SL civic engagement centers on campuses, Campus Compact, and CNCS. As SL becomes more widespread as a result of these successes, two priority areas for research are to learn about: 1) how we can foster the sustainability of SL, and 2) how we can maximize the quality of SL, so it produces maximum benefits for everyone involved (Hollander, 2007). It is thought that, along with other factors, enhancing the quality and benefits of SL will contribute to the diffusion of SL to additional disciplines.

A third priority that is related to maximizing the quality and benefits of SL is to imbue reciprocity into every aspect of SL, including the design, implementation, and evaluation of SL (Cruz & Giles, 2000; CCPH, n.d.; Gelmon, Holland, Driscoll, Spring, &
While reciprocity is widely held to be a core principle of SL, the literature has focused in large part on faculty roles in SL (Fretz & Longo, in press). There is now a growing call for greater involvement of both community partners and students in all aspects of SL.

Involving these stakeholders is seen as a way to maximize both the sustainability and the quality of SL. Continued student interest in SL, for example, is ultimately at the foundation of the sustainability of SL (Zlotkowski, et al., 2006). Involving students as colleagues in SL can ensure this continued interest. Student co-leaders for SL can also introduce innovations into SL that enhance its quality, for example by creating new SL immersion experiences and designing new SL opportunities in such a way that it creates greater benefits for community partners (Mohan & Mohan, 2007; Moskowitz, Glasco, Johnson, & Wang, 2006; Peabody, Block, & Jain, 2008). Meanwhile, involving community partners in the design and operation of SL may enhance the quality of the partnership process, and this may, in turn, enhance the benefits of SL for everyone involved, and, ultimately, the sustainability of SL.

These priorities – sustainability, quality, and co-leadership – are perhaps even more important to advance SL in health professions education. SL is less widespread in health professions education than in higher education more broadly. One reason is the challenges posed to the uptake of SL at research institutions, such as academic health centers (AHCs), where the institutional culture, and typically promotion and tenure guidelines, value research over teaching or service (Furco, 2001; Hollander, 2007). Another challenge to the uptake of SL in health professions education is distinguishing SL from clinical training in community settings, or other forms of community-based
learning (Gelmon, Holland, & Shinnamon, 1998; Seifer, 1998b). Confusion about the distinct characteristics and benefits of SL, as compared to other community-based learning methods, may contribute to reluctance to implement SL. The cultures of different health professions also influence whether or not SL is easily implemented. For example, SL has been widely embraced among nursing schools and programs, while uptake is slower in other health professions education.

Maximizing the quality of SL and demonstrating its benefits for various stakeholder groups may help to foster the continued adoption of SL in health professions education. Health professions curricula are guided by detailed accreditation guidelines, and it is important to demonstrate the value of SL to teach required content areas and achieve educational objectives for accreditation. In addition, it is important to demonstrate the value of SL to better prepare health professionals both for healthcare practice and for professional roles in the community. These aims can only be achieved by fostering high quality SL that produces its intended learning goals. Likewise, with the increasing emphasis on community partnerships in community-based health research, creating high-quality community-campus partnerships for SL may support the adoption of SL. Finally, demonstrating the contributions of these SL partnerships to community health and to build capacity for ongoing partnerships for practice and research in both academic and community partners – results that are linked to sustainability – may also support the adoption of SL, because these are often priorities of health professions schools and programs.
How this Research Contributes to the Literature on SL in Health Professions

Education

The three manuscripts included in this dissertation aim to address each of these priorities for SL: 1) sustainability, 2) quality, and 3) co-leadership for SL among faculty members, community partners, and students. The following sections summarize the literature about each of these priorities, and identify how this dissertation contributes to the literature.

Priority 1: Sustaining SL

A major priority of this wave of the SL movement has been sustainability. The importance of sustaining SL is reflected in the title of a CNCS publication, *Make it Last Forever: The Institutionalization of Service Learning in America* (Kramer, 2000). This focus was informed by the experiences of the SL movement of the late 1960s and 1970s. That wave of the SL movement was initially robust. It informed the creation of the Office of Economic Opportunity’s National Student Volunteer Program, VISTA, and the Peace Corps. But the majority of the university-based SL initiatives founded during those decades were not sustained. Causes included problems integrating SL into the missions and goals of the participating academic institutions and community agencies, unequal relationships between academic and community partners, and lack of evidence of students’ learning and service outcomes (Jacoby, 1996a). The failure to sustain and expand the earlier movement led to a universal interest in planning for sustainability in this wave of the SL movement.

Sustainability is important to achieving many of the goals of SL. Capacity building in community partner agencies, improvements in community health and
wellbeing, and development of infrastructure and expertise in community and academic partners to foster additional forms of partnership all take significant time investments. Sustainability is also important to the efficiency and quality of SL. Lapses in SL may lead academic institutions to unnecessarily replicate initial investments in SL planning and infrastructure development. Perhaps more detrimental, they may undermine community partners’ trust and willingness to collaborate for SL or other partnerships (Shediac-Rizkallah & Bone, 1998).

A growing literature provides strategies for sustaining SL in higher education. In general, it focuses on how to institutionalize SL, meaning, how to integrate SL into the policies and procedures, infrastructure, and priorities of an academic institution (Goodman and Steckler, 1989). This literature includes a small number of empirical studies (Bell, Furco, Ammon, Muller & Sorgen, 2000, as cited in Furco, 2002; Bringle & Hatcher, 2000; Furco, 2002; Gray, et al., 1998, as cited in Furco, 2002; Holland, 1997). They identify the following factors as important to institutionalize SL: support for service in an institution’s mission and vision (Holland, 1997); support for SL in faculty promotion, tenure, and hiring policies (Holland, 1997); a formal strategic plan for the institutionalization of SL (Bell, et al., 2000, as cited in Furco, 2002); support for SL among top administrators and faculty (Furco, 2002); internal funding for SL (Bringle & Hatcher, 2000); the presence of a SL or civic engagement center, and the central location of the center in the organizational structure (Bringle & Hatcher, 2000; Gelmon, Holland & Shinnamon, 1998; Gray, et al., 1998, as cited in Furco, 2002). Other literature also calls for the active support of the university president, including both “rhetoric and action,” funding for faculty participation, the hiring of specialized SL staff, and the
integration of SL into the curriculum (Eyler & Giles 1997; Furco and Holland, 2004; Jacoby, 1996b; Jacoby & Hollander, 2009).

This empirical work and the literature based on the experiences of practitioners also highlight the importance of the buy-in of faculty, students, and community partners to institutionalize SL (Furco, 2002; Gelmon, Holland & Shinnammon, 1998; Hutchison, 2005; Rubin, 1996; Zlotkowski, et al., 2006). This literature recommends strategies to foster this buy-in, including: identifying a model for SL that is consistent with the organizational culture and mission of both academic and community partners (Rubin, 1996; Torres, 2000); linking SL to other organizational priorities, something Furco calls “institutional hooks” or “leverage points” (Furco, 2002); operating SL out of preexisting program offices in order to identify the value of SL to other institutional objectives (Furco & Holland, 2004; Rubin, 1996); publicizing the value of SL internally and externally (Hutchison, 2005); engaging in a “partnership process” for communication and decision making (Torres, 2000); and conducting regular evaluations of SL that involve all stakeholders, including community members and students (Torres, 2000; Gelmon, 2003).

**How this Research Contributes to the Literature on the Sustainability of SL**

More research is needed to explore what factors influence the sustainability of SL beyond aspects of institutionalization. In particular, contextual factors outside of the academic institution and the way that SL is designed and implemented may be influences, but their influence has not been explored as deeply. These contextual factors may include the roles and resources of participating community agencies and students; “town-gown” relations; national trends in higher education; and trends within any one field or discipline that participates in SL.
In addition, the existing literature on SL has been criticized for its lack of a conceptual or theoretical basis (Aronson, 2006; Serow, 1997). Rather, the design of much of the inquiry on sustaining SL has been informed by the accumulated wisdom of SL practitioners. While this is certainly a valid starting point for empirical research, it may nonetheless restrict our inquiry to areas that are already known. Aronson (2006) recommends that to enhance the rigor of research on SL, we should apply concepts from related fields. These might include theoretical approaches and conceptual frameworks. For example, a better theoretical understanding of sustainability might help us to broaden our understanding of the concept of “sustainability” beyond the outcome of institutionalization. In addition, a conceptual framework that considers multiple broad categories of influences on sustainability might expand our understanding of the influences on sustainability. Manuscript 1 in this dissertation attempts to advance the research on the sustainability of SL in these ways.

A Better Theoretical Understanding of Sustainability

This research created a method for defining degrees of sustainability. The literature on sustaining innovations in organizational settings and the literature on community-based public health programs provide multiple ways to define or measure sustainability. The breadth of definitions they provide reflects the understanding that sustainability is not an endpoint, as may be suggested by the term “institutionalized,” but is, in fact, a matter of degree. From these two bodies of literature, this research adopted three definitions of sustainability: durability, routinization, and institutionalization. Durability is the simplest and most widespread definition of sustainability. It refers to program continuation (Shediac-Rizkallah & Bone, 1998). As cited in Pluye and
colleagues (2004), Scheirer writes that a sustained program is a set of durable activities and resources aimed at program-related objectives (Pluye, Potvin, & Denis, 2004). This definition suggests that sustainability can exist outside of institutionalization.

In contrast, a popular way that sustainability is measured in the literature on sustaining innovations in organizations is the extent to which an innovation has been integrated into the workings of an organization. This is the same way the concept is understood in the SL literature. In the organizational change literature, this concept is described as two degrees of the same process, and is called routinization, or, at a higher degree, institutionalization. According to Yin, routinization refers to the point at which an innovation “has become a stable and regular part of an organization’s routinized activities” (Yin, 1979, p. 55). These are the organizational procedures and behaviors for which sustainable resources are mobilized, including: program planning, creation of objectives, developing rules for operation, allocation of resources, and program monitoring/evaluation (Pluye, Potvin, & Denis, 2004; Pluye, Potvin, Denis, & Pelletier, 2004). For SL these resources would include: allocation of faculty and staff whose job descriptions include SL, training of these faculty and staff, and budget resources designated for program equipment and implementation that might extend to funding for faculty and student leaders.

Goodman and Steckler (1989) use the term institutionalization to include the same indicators of sustainability, and add to them the existence of policies and infrastructures that support the innovation. In the case of SL, these would include hiring, promotion, and tenure policies; the incorporation of SL into the curriculum; and the existence of infrastructure to support SL, for example a SL coordinating center. Goodman and
Steckler describe institutionalization as a process of “mutual accommodation” (1989). Other authors highlight the importance of imbuing the innovation with value: “It is when the structures surrounding a change also change to support it that we say that a process is ‘institutionalized’ – that it is now part of legitimate and ongoing practice, infused with a value and supported by other aspects of the system” (Kanter, 1983, as cited in Goodman & Steckler, 1989). One can see how this typology of degrees of sustainability – durability, routinization and institutionalization – is helpful to categorize the factors that the SL literature has identified as key indicators of sustainability.

A Conceptual Framework for Influences on Sustainability of SL

For this research, inquiry into the influences on sustainability is structured on a conceptual framework from the literature on sustaining community-based public health programs. This conceptual framework, proposed by Shedia-Rizkallah and Bone (1998), includes three major categories of factors that influence sustainability: 1) project design and implementation factors; 2) factors within the organizational setting, and 3) factors in the broader community environment, as depicted in Figure 1. It also depicts the interactions among these categories of influences. This conceptual framework is useful to structure a holistic empirical inquiry into the influences on sustainability of SL.
Enhancing the Inquiry with Concepts from Related Literatures

This research also attempts to expand the inquiry on sustainability of SL by exploring themes within each of the categories of influences in the conceptual framework that are present in multiple related literatures. These include the literature on sustaining SL as well as the literatures on sustaining organizational change and community-based public health programs, and the literatures on community partnerships for health and CBPR. This design allows the research to consider themes that have perhaps not yet considered in the research on SL. As described above, the category of sustainability was
conceptualized as including three measures of sustainability: 1) durability, 2) routinization, and 3) institutionalization.

The category of program design and implementation factors included four concepts that emerged across these literatures as important to program effectiveness and sustainability. These were: 1) the structure of SL at the institution, including the design of SL in the curriculum and the infrastructure available to support SL, 2) the structure and process of the community-academic partnerships at the heart of SL, 3) the presence of strong leadership and 4) adaptability. As described above, the SL literature describes the importance of having dedicated staff and a SL coordinating center that is ideally positioned in a central location in terms of the organizational structure. Many authors also state the importance of integrating SL into the curriculum. The literature on community partnerships for health suggests aspects of community-academic partnerships for SL that may be related to program sustainability. One is the presence of a strong action plan (Butterfoss & Francisco, 2004). Another is that the structure of community-academic partnerships matches their goals (Cheadle, Senter, Solomon, Beery, & Schwartz, 2005; Mitchell & Shortell, 2000). Mitchell and Shortell (2000) suggest that issue-oriented partnerships like SL should have more centralized decision making, formal membership and formal coordination. In contrast, they write that coalition-based partnerships should have more decentralized decision making, diffuse membership and informal coordination.

The literatures on community partnerships for health and CBPR identify key characteristics of a good partnership process that supplement what the SL literature recommends. These include: 1) a foundation of trust, 2) common goals and interests, and
3) equal responsibilities, privileges and power. They also echo the SL literature in recommending an open communication process that is used for process evaluation and continual improvement (CCPH, 2006; IOM, 2003a; Israel, Schultz, Parker, & Becker, 1998; Torres, 2000; Roussos & Fawcett, 2000). The CBPR literature suggests that building such a partnership involves developing representation standards, creating partnership goals and core values, and formalizing operating standards to ensure equity (Israel, et al., 2005; Minkler, 2005; Parker, et al., 2003; Wallerstein & Duran, 2006). For examples of principles of partnerships, see Appendices B and C.

The SL literature and related literatures universally cite leadership as critical to sustainability (Roussos & Fawcett, 2000; Shediac-Rizkallah & Bone, 1998). Leadership is generally described in two ways: the presence of program champions and buy-in from administrative leaders. Effective program champions have mid- to senior-level positions in the organization and have a sense for the compromises necessary to build support for an innovation (Shediac-Rizkallah & Bone, 1998). They have skills in communication, negotiation, and networking with a broad range of stakeholders (Roussos & Fawcett, 2000). Leadership may occur through a single person, or through a core group.

Finally, the organizational change literature describes the importance of adaptability in how a programmatic innovation is designed and implemented if it is to achieve long-term sustainability (Goodman & Steckler, 1989; Pluye, Potvin, & Denis, 2004; Shediac-Rizkallah & Bone, 1998). Goodman and Steckler (1989) identify three ways that a program may adapt and yet still be sustained: renewal, diffusion, and spin-offs. Renewal refers to major changes in a program that are undertaken to increase program effectiveness and viability. Pluye and colleagues write that a renewed program

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may change all of its component parts many times, and yet remain recognizably itself. Program sustainability ends when renewed routines become unrelated to program objectives (Pluye, Potvin, & Denis, 2004). Diffusion refers to the adoption of an innovation by other organizations while it is also maintained by the original organization, while a spin-off occurs when a program shifts to a different organizational home (Goodman & Steckler, 1989).

The next category of influencing factors in the conceptual framework is factors in the organizational setting. Again, drawing on the literatures on SL and the aforementioned related fields, three important themes emerge in this category: 1) organizational culture, 2) organizational stability, and 3) a history of collaboration between partnering organizations. The importance of organizational culture reflects the findings in the SL literature, described above, that an institution’s mission and vision; its faculty hiring, promotion and tenure policies; and the presence of leadership from top administrators are critical to institutionalization. These factors reflect congruence between organizational culture and SL, also called a normative match. Goodman and Steckler (1989) posit that a normative match is necessary between the objectives of the innovation and the culture of the organization in order for institutionalization to occur. The same notion can be applied to the institutionalization of SL in community partner agencies. Their mission and vision, organizational goals and organizational structures can support or undermine the sustainability of SL partnerships (Mitchell & Shortell, 2000; Torres, 2000).

Another factor that has been cited as important to program sustainability is the stability of the host organization. Characteristics of stability include relatively high skill
level, organizational maturity, availability of resources, and the absence of any major co-occurring change processes that might create instability (Shediac-Rizkallah & Bone, 1998). This concept applies to both academic and community partners for SL. Finally, a history of collaboration between the organizations, whether good or bad, will influence the sustainability of community-academic partnerships for SL.

The final category of influencing factors included those in the broader environment. Where SL is concerned, this category includes both the academic and community environments. The literature suggests three important factors in this category: 1) accreditation criteria, 2) availability of external funding, and 3) community conditions. The literature on sustaining SL in any particular institution stresses the roles of institutional culture and availability of funding. But when considering the sustainability of the movement as a whole, national leaders focus on the importance of state and federal policies and funding, as well as the policies of organizations that shape trends in higher education (Jacoby & Hollander, 2009). These include the Pew Health Professions Commission’s and the W.K. Kellogg Foundation’s work to shape the future of health professions education (O’Neil & the Pew Health Professions Commission, 1998; W. K. Kellogg Foundation, n.d.); the Carnegie Foundation’s new elective classification for Community Engagement, the endorsements of accrediting agencies and professional organizations.

By extension, these factors may be important influences on the sustainability of SL at any single institution. In fact, according to Pluye and colleagues, the standards of these organizations are more powerful influences on sustainability than routinization (Pluye, Potvin, & Denis, 2004). They write that some researchers argue that innovations
cannot be sustained until they are supported at the policy level. In the literatures on community based public health programs, lack of long-term funding is generally cited as the primary cause of sustainability failures (Pluye, Potvin, & Denis, 2004; Roussos & Fawcett, 2000). While these conditions in the academic environment are critical to sustaining SL, conditions in the community may influence the sustainability of SL through their influence on community partnerships. For example, changing social and economic conditions, shifting community priorities, and major community events may all have an impact on community agencies and their participation in SL.

**Additional Contributions to the Research on Sustainability**

In addition to the theoretical and conceptual innovations described above, this research adds to the empirical literature on sustaining SL in three other ways. First, by focusing this study on the HPSISN cohort, it produces findings that are specific to health professions education, which is a new contribution to the literature on sustaining SL. Second, most studies of SL have a time horizon of only a few years, but this research involves a ten year follow-up, allowing it to adequately assess sustainability and influences on sustainability. Furco (2002) writes that most research on SL examines impacts only within a three-year time window, because most funding for this research is attached to implementation grants. But Furco and Holland (2004) estimate that five to seven years are needed to institutionalize SL, and that if research is to assess this outcome, it must be informed by the same timeline. Third, the research reported in Manuscript 1 led to further inquiry, in Manuscript 2, exploring the influence of the institutional culture of the academic institution on the sustainability of SL. Manuscript 2 explored in depth the experiences of two health professions institutions that successfully
sustained SL in very different institutional settings. It adds to the literature by exploring in detail different ways to foster the sustainability SL given different organizational contexts. In doing so, it responds to Furco’s comment that “there is likely to be no universal road for institutionalizing SL in higher education” (2002, p. 60).

**Priority 2: Enhancing the Quality of SL**

It is widely understood in the SL movement that to ensure the sustainability of SL and maximize its benefits to all stakeholders the field must focus on the quality of SL. A large literature from the field of education provides principles for implementing high-quality SL in higher education. These principles for high-quality SL focus on two areas: 1) how to structure SL as an educational experience, and 2) how to operate community-campus partnerships for SL (Eyler and Giles, 1997; Eyler and Giles, 1999; Jacoby and Associates, 1996; Jacoby, 2003; Jones, 2003). This literature includes a number of lists of SL principles that have been widely used as benchmarking tools for self-assessment. The Wingspread Principles of Good Practice for Combining Service and Learning (Honnet & Poulsen, 1989) provide principles to maximize the quality of the educational experience delivered through SL and the quality of the community-campus partnership for SL. The Campus Compact Benchmarks for Campus/Community Partnerships (Torres, 2000) and the CCPH Nine Principles for Good Community-Campus Partnerships (CCPH, 2006) provide principles to maximize the quality of the community-campus partnership process. A number of publications also provide principles specifically for implementing high-quality SL in various health professions, including public health, health administration, medicine, nursing, dentistry, physical therapy, and occupational therapy (ASPH, 2004; Bailey, Carpenter, & Harrington, 2002; Cashman & Seifer, 2008;
Cauley, et al., 2002; Hoppes, Bender, & DeGrace, 2005; Seifer, 1998b; Stefl, Gelmon, & Hewitt, 2006; Yoder, 2006).

Taken together, these literatures identify key principles for implementing high quality SL in health professions education. Principles for structuring SL as an educational experience include: providing facilitated opportunities for student preparation and reflection; encouraging co-learning among faculty, community partners and students; providing meaningful service; and creating SL experiences of long enough duration and intensity to produce learning outcomes. Principles for how to operate community-academic partnerships for SL include: creating equitable, collaborative partnerships between academic and community participants; investing in relationships through ongoing communication, commitment, and power-sharing; involving a diverse array of community partners; creating reciprocal benefits for everyone involved, including benefits that go beyond service to capacity building; and finally, engaging faculty, students, and community partners in evaluating SL. The literature on SL in health professions education also highlights three additional principles for high quality SL that address both the quality of teaching with SL and the quality of partnerships. These are: 1) distinguishing SL from clinical education, 2) integrating SL into the curriculum, and 3) extending SL partnerships into opportunities for engaged research and practice.

In the education field, there is a substantial body of literature that describes how institutions are implementing these principles for high-quality SL in practice. Many publications include case studies that highlight how SL is being implemented in the curriculum across the disciplines and professions (Madden, 2000). Nowhere is this better
represented than the AAHE series of monographs on SL in 21 disciplines and professions (AAHE, 1997-2006). Another focus is how to operationalize principles for high-quality SL in various learning formats – both in the curriculum and co-curriculum, through short-term and longer-term experiences, and through intensive SL (Jacoby and Associates, 1996). A smaller number of publications have also begun to explore how principles for SL partnerships are being applied in practice (Mintz & Hesser, 1996; Jacoby and Associates, 2003; Torres, 2000).

There is also a growing literature that documents the use of SL in health professions education. In general, this literature focuses on start-up experiences, the initial design and implementation of SL, and the short-term impact of SL, generally consisting of student learning outcomes and services provided to community partner agencies (Baumberger-Henry, Krouse, & Borucki, 2006; Brown, Heaton & Wall, 2007; Elam, et al., 2003; Gregorio, DeChello and Segal, 2008; Hamner, Wilder, Byrd, 2007; Hayward & Weber, 2003; Young, Bates, Wolff, & Maurana, 2002). This is true even of articles that report on SL initiatives that have been sustained for a period of five years or longer (Bittle, Duggleby & Ellison, 2002; Kemsley & Riegle, 2004; Kushto-Reese, Maguire, Silbert-Flagg, Immelt, & Shaefer, 2007; Mihalynuk, Odegard, Kang, Kedzierski, & Crowley, 2007).

This literature provides valuable guidance for other health professions institutions considering implementing SL. But to learn more about how to implement principles for high-quality SL, it is helpful to look to the experiences of long-term sustained SL initiatives that have had the opportunity, over time, to enhance the way they implement these principles. However, only a small number of articles examine these experiences
These few articles provide an example of the value of this inquiry to better understand how to implement principles for high-quality SL. They offer useful strategies with regard to how to maintain the strong connection between SL and curriculum goals, even as curriculum goals change over time (Davidson & Waddell, 2005); how to implement in practice challenging principles of SL partnerships including relationship-building, power-sharing, and communication (Greenberg, Howard & Desmond, 2003; Meyer, Armstrong-Coben, & Batista, 2005); and how to enhance the benefits of SL partnerships for students, faculty members, and community partners despite the challenge of student turnover (Andrus & Bennett, 2006).

For example, to maintain the connection between SL and learning objectives in an interprofessional SL course at the University of Florida Health Science Center as it expanded to include additional professions, faculty from the participating colleges engaged in continual collaboration over seven years to refine course content to ensure SL continued to meet learning objectives for all of the participating professions (Davidson & Waddell, 2005). A SL initiative in medicine at the Columbia University Medical Center implemented principles around developing relationships, creating open communication, demonstrating commitment, and sharing power in a number of ways. Faculty and students partnered with a single community agency that was the host for all SL, a community partner was appointed to a faculty position with curriculum design and teaching responsibilities, and the academic partners hosted a series of lunchtime discussions between members of the faculty and members of the community that focused...
on the interactions between the culture of the community and the culture of medicine (Meyer, Armstrong-Coben, & Batista, 2005). A SL initiative in public health at the University of Maryland addressed early challenges with power-sharing by creating a board of directors for SL where voting community partners always outnumbered voting academic partners (Greenberg, Howard & Desmond, 2003). Finally, the University of Rochester sustained an interdisciplinary SL initiative for undergraduate and graduate health professions students for seven years. In order both to improve faculty retention and enhance the quality of SL, the structure of SL was eventually changed from one- and two-semester SL projects to longitudinal partnerships between faculty and community partners, which students cycled through. These sustained partnerships better retained faculty, contributed to faculty members’ own work, and created higher quality experiences for community partners and students (Andrus & Bennett, 2006).

How this Research Contributes to the Literature on the Quality of SL

To enhance our understanding of how to maximize the quality of SL in health professions education, more research is needed that explores the experiences of long-term sustained SL initiatives that have had the opportunity, over time, to enhance the way in which they implement principles for high-quality SL. This research should not only build upon the work in the four articles described above, but also introduce innovations in the design of the research that might enhance its findings. In particular, the four articles described above all consist of single case studies authored by the key faculty and community leaders of these SL initiatives. Research that captures the perspectives of all stakeholders in SL, including academic administrators, faculty members, SL staff, students, and community partners, might provide additional guidance for how to
implement high-quality SL. In addition, it is important to explore the strategies used by SL initiatives in different institutional settings to maximize the quality of SL. Scholars have asserted that contextual factors, most especially those in the institutional environment, are critical influences on SL (Gelmon, Holland, Driscoll, Spring, & Kerrigan, 2001).

This dissertation research contributes to the literature by exploring these two areas of interest. As described above, Manuscript 2 reports on in-depth case studies of the experiences of two HPSISN-supported SL initiatives that were successfully sustained from 1995 to the time this research was conducted in 2009. The goal of the research summarized in this manuscript was to explore how sustained SL initiatives in health professions education have fostered the quality and sustainability of SL, and to produce strategies for success and lessons learned from their experiences. The two cases were selected to meet three criteria that were assessed in the research conducted for Manuscript 1: 1) they had successfully institutionalized SL, so they could describe strategies they had used to achieve this outcome; 2) they focused on the quality of SL, and they shared strategies they had used to foster the quality of SL, and 3) they implemented SL in very different institutional settings, so they could describe strategies to foster the sustainability and quality of SL that were appropriate to different settings or were relevant across settings. In addition, each case was selected because it could ensure the participation of a wide range of stakeholders in SL. Each case study included the participation of three community partner agencies, as well as members of all of the stakeholder groups described above.
Priority 3: Fully Engaging Community Partners and Students in SL

As described above, the literature providing guidance on implementing SL describes the importance of reciprocity among participating faculty members, students and community partners. This involves not only being co-recipients of the benefits of SL, but also acting as co-learners and co-creators of knowledge in the SL partnership. Community partners and students also should be actively involved in shaping the way SL is designed and implemented, and in evaluating SL. There are significant challenges to implementing these guidelines, however. These must be addressed for SL to be fully collaborative and reciprocal. As described above, doing so may also improve both the sustainability and quality of SL.

Engaging Community Partners, and How this Research Contributes to the Literature on Community Partners’ Perspectives on SL

Many of the early sets of principles for SL did not reflect the perspectives of community partners, but instead focused on the roles of students or faculty (Mintz & Hesser, 1996). Filling this gap, in 1998, CCPH developed its Nine Principles for Good Community-Campus Partnerships, provided in Appendix B (CCPH, 2006). Shortly thereafter, in 2000, Campus Compact published the Campus Compact Benchmarks for Campus/Community Partnerships (Torres, 2000). However, while the principles for SL introduced a focus on community collaboration over a decade ago, the academic literature on SL continues to emphasize faculty members’ roles in SL and perspectives on SL, and gives much more limited attention to the roles and perspectives of community partners and students (Fretz & Longo, in press).
In a special issue of the *Michigan Journal of Community Service Learning* that proposed directions for new research in the field, Cruz and Giles (2000) called for a focus on community partnerships, and the inclusion of community partners’ views in this research. Since then, there has been some progress in the scholarship in these areas. A small literature examines SL partnership dynamics (Bringle & Hatcher, 2002; Bringle, Clayton, & Jones, 2008; Miron & Moely, 2006), and community partners’ perceptions of the impact of SL (Ferrari & Worrall, 2000; Miron & Moely, 2006; Sandy & Holland, 2006; Worrall, 2007).

But more research is needed that addresses community partners’ roles and incorporates community partner perspectives. In particular, including community perspectives would likely enhance research findings on how to maximize the quality of SL partnerships. In addition, community partners’ perspectives have not been included in the research on sustaining SL. This may be a result of the fact that that literature focuses primarily on how to institutionalize SL in the academic institution. The roles of community partners in sustaining SL deserve further exploration.

Manuscript 2 addresses the underrepresentation of community voices in the literature on the sustainability and quality of SL. It reports on two in-depth case studies of the quality and sustainability of SL, for which data collection included interviews with community partners from three community agencies. In total, community partners contributed 15 (32%) of the 47 interviews conducted for these two case studies. The other 32 interviews included administrators (n= 9), faculty members (n=13), SL staff (n=3) and students (n = 6).
Engaging Students as Co-leaders for SL, and How this Research Contributes to the
Literature on Student Co-leadership for SL

Throughout the 1990s, the main strategy that was used to advance SL in higher education on a national level was to focus on building a critical mass of support among faculty. The national movement rightly recognized that for faculty to adopt SL, they had to have evidence of its value as a pedagogical method, and at research institutions, they also had to identify its relevance to scholarship (Hollander, 2007; Zlotkowski, et al., 2006). In fact, later, empirical research identified that faculty support for SL was the most important predictor of institutionalizing SL in a cohort of over 40 institutions (Furco, 2002). However, there was a failure to also recognize that students might play a critical role in advancing SL, given their contributions to advancing the movement in its early years. As a result, during the 1990s there were not equal investments in fostering student leadership for SL.

There is now a sense that the SL movement has “plateaued,” and that to continue to advance it must look to new strategies (Saltmarsh, Hartley, & Clayton, 2009). Some national leaders for SL believe that student leaders for SL can make important contributions to the next phase of the movement. They are particularly optimistic because of this generation of students’ high level of commitment to service. In Students as Colleagues: Expanding the Circle of Service-Learning Leadership, Zlotkowski and colleagues assert, “just as the service movement once needed resources that students alone could not supply, so the movement has now reached a point where it needs resources that students alone can supply” (Zlotkowski, et al., 2006, p. 3). They argue that student co-leadership for SL can enrich the quality of engaged learning experiences and
ensure continued student interest in SL. The Wingspread report, *Engagement in Higher Education: Building a Federation for Action*, suggests that students may be among the strongest advocates for greater state and federal funding for engaged learning, since they can provide the most convincing testimony about the educational benefits of SL (Sandmann and Weertz, 2006). There is also a belief that student co-leaders may help to ensure that SL and other forms of civic engagement in academia have meaningful benefits for community partners (Bruckhardt, Holland, Percy, & Zimpher, 2004).

A number of recent conferences on civic engagement in higher education reflect this new orientation to student co-leadership for SL. Since 2005, the American Association of Colleges and Universities has hosted three student conferences related to students’ leadership role in promoting engaged learning and student civic engagement. Other conferences explicitly identify students as colleagues. The annual National Outreach Scholarship Conference, now in its tenth year, serves as a forum for “critical examination of the civic purpose of colleges and universities,” and explicitly invites student participation (University of Georgia, n.d.). CCPH has had a longstanding interest in supporting student co-leadership for civic engagement, and has recently increased the visibility of this support. At its 2006 annual conference, CCPH collaborated with the American Medical Student Association (AMSA) to offer a track on student leadership development. At its 2007 conference, it included an “emerging leaders track,” designed by a committee of graduate students from across the health professions, that highlighted community-engaged practice and research conducted by students. Finally, the IARSLCE has had a focus on supporting and encouraging student leadership for SL research since the Association’s inception in 2001. It hosts an active graduate student network, includes
sessions for and by graduate students at its annual conferences, and recently instituted a dissertation award.

Only a limited literature about SL in either higher education more broadly, or health professions education in particular, explores the leadership that students might provide for SL. Referring to the literature on SL in higher education, Fretz and Longo (in press) write, “A survey of some of the most influential literature in this area reveals a lack of thinking around the role(s) that students can play in development and implementation of community engaged efforts.” But the literature that does exist describes how students are providing leadership to implement SL at their institutions and, in doing so, are also introducing innovation into how SL is designed. The volume *Students as Colleagues: Expanding the Circle of Service-Learning Leadership* includes 19 chapters authored or co-authored by undergraduate students that document their contributions to SL on their campuses (Zlotkowski, et al., 2006). These students have provided leadership to develop and teach courses and intensive SL experiences, build infrastructure for SL, and develop community partnerships for SL and related activities, such as CBPR. In many of these cases, students provided initial leadership and then created partnerships with faculty and administrators to achieve their goals. A small but compelling body of literature demonstrates how health professions students, in particular, are introducing SL innovations at their institutions (Albritton & Wagner, 2002; Mohan & Mohan, 2007; Moskowitz, Glasco, Johnson, & Wang, 2006; Peabody, Block & Jain, 2008; Vogel, Fichtenberg, & Levin, in press). These literatures suggest that the innovations students are introducing into SL are also enhancing the quality of SL at their institutions.
There is a need for additional scholarly work that documents the ways health professions students are providing leadership for SL, and the products of their leadership. In particular this literature should examine both the methods that students can use to foster SL and the products of student leadership for SL, both of which may be different from the contributions of faculty and staff. There is also the need to explore how health professions institutions can support these students – through faculty-student partnerships and professional development, for example – to maximize the benefits their institutions receive from student leadership for SL.

Manuscript 3 contributes to the literature in these ways. It begins by summarizing the small body of literature documenting student leadership for SL in health professions education. It then presents a case study of student leadership for SL at the Johns Hopkins Bloomberg School of Public Health (JHSPH). This case study describes the methods that a student organization used to foster SL, and the product of their work: a Certificate in Community-Based Public Health (CBPH) that is grounded in a two-term SL experience in the local community. Whereas the existing literature on student leadership for SL in health professions education focuses mainly on the products of student efforts – for example, the student-run health clinics students have established or the extracurricular SL opportunities they have created – this manuscript introduces a new focus on how students can contribute to the organizational change processes involved in advancing SL in these settings. It also highlights the importance of partnerships among faculty, administrators, SL staff and students to support student leadership for SL.
A Final Note on the Limitations of this Research to Address Community and Student Perspectives

As made clear earlier in this chapter, there are three main stakeholder groups for SL: academic institutions and their members, including academic administrators, faculty member, and SL staff; community agencies and the communities they serve; and students. While Manuscript 2 includes community voices and Manuscript 3 focuses on students’ voices and experiences, both of these groups are conspicuously absent from Manuscript 1. The sample for the research reported in this manuscript only included academic stakeholders. This manuscript, which focuses on the sustainability of SL and factors that influence sustainability, also examines the long-term impacts of SL for all stakeholders.

Recognizing that the literature examining the impact of SL has a strong focus on students, this research intended to also explore the impact of SL on the other stakeholder groups. This rationale and restrictions on the resources available for this study, led to the creation of a sample that included only academic stakeholders. As a result, this research primarily focused on the experiences and perspectives of these academic stakeholders, both as related to the sustainability of SL and the long-term impact of SL. These research participants largely reported on the long-term impact of SL for academic and community partners. They spoke much less frequently about the long-term impact of SL for students, something which they could only report anecdotally.

Background Information on the Cases Featured in this Research

This section of the chapter provides additional background information about the two cases featured in the three manuscripts at the heart of this dissertation work. The
first case study is of the HPSISN program. Manuscripts 1 and 2 report on a study of the ten year sustainability and impact of HPSISN. The second case study examines student leadership for SL at JHSPH. Manuscript 3 reports on this case study.

**The HPSISN Program**

The Health Professions Schools in Service to the Nation (HPSISN) program was created to implement on a broad scale the Pew Health Professions Commission’s recommendation that all health professions schools implement SL to train students in community and population health competencies, particularly an ethic of public service (O’Neil, 1993). From 1995 to 1998, HPSISN provided funding and technical assistance to 17 health professions schools and training programs across the United States to integrate SL into the curriculum. HPSISN had three aims:

1. To strengthen partnerships between health professions schools/programs and communities which address unmet health needs;

2. To instill an ethic of community service and social responsibility in health professions schools/programs, students and faculty; and

3. To equip the next generation of health professionals with community-oriented competencies necessary to practice in a changing health care environment.

(Gelmon, Holland, & Shinnamon, 1998)

Each school or program that participated in HPSISN engaged in four core activities. They: 1) established SL partnerships with community agencies to address unmet health needs, 2) integrated SL into the curriculum, 3) received technical assistance and participated in professional development activities through HPSISN, and 4) provided matching support, in cash or in kind, over the three-year grant period. Technical
assistance and professional development provided through HPSISN included an annual grantee meeting involving the principal investigator, key project faculty and community partners, and in some cases, students; an annual SL conference with a special one-day grantee-only meeting the day before; two regional SL conferences hosted by grantees that focused on important topics for implementing SL, including how to implement reflection and evaluation; on-site consultation through site visits from HPSISN program staff and evaluators; a listserv for HPSISN grantees; quarterly conference calls with the HPSISN program director; and a student leadership institute attended by one to two student leaders from each HPSISN institution.

Participating institutions were selected to represent a broad spectrum of characteristics in U.S. health professions education. They consisted of AHCs, large research institutions and small teaching institutions; and included both public and private and faith-based and secular institutions. The participating institutions were geographically dispersed across the United States and served both urban and rural areas. Some defined their sphere of influence as the local community while others defined their sphere of influence as both their local community and the nation. As a group, they included programs in allopathic and osteopathic medicine, nursing and nurse practitioner, physician assistant, pharmacy, public health, health administration, and dentistry, as well as fitness and nutrition. Twenty institutions were initially selected to participate in HPSISN, and 17 completed the program. (The three institutions that did not complete the program included a small private teaching college, a mid-size faith-based health sciences university that included an AHC, and a large public research university that also included an AHC. In these respects, they were representative of the diversity of the group.)
While the HPSISN program encouraged each participating institution to adopt the HPSISN definition of SL, institutions were given the freedom to tailor the definition to their own settings. In addition, they selected community partner agencies and SL focus areas that addressed both the HPSISN program goals and local health needs. As a result, the cohort included a diverse array of community partner agencies that served a variety of populations. The American Red Cross, Boys and Girls Clubs, churches, public schools, community health clinics, Head Start programs, hospices, local public housing authorities, Planned Parenthood offices, senior centers, youth centers, and the Salvation Army were just some of the many community partner agencies involved in HPSISN. SL partnerships addressed a wide variety of health and social issues, as summarized in Table 1, below.

HPSISN was a program of the Pew Health Professions Commission and the National Fund for Medical Education. It was supported by The Pew Charitable Trusts, CNCS, and the Health Resources and Services Administration (HRSA), and was administered by the Center for the Health Professions at the University of California-San Francisco. In 1996, the Center for the Health Professions established CCPH as a freestanding not-for-profit organization dedicated to fostering community-academic partnerships for health, including SL. CCPH took on responsibility for any future evaluation of HPSISN. The research reported in this dissertation was conducted with the support of CCPH. CCPH provided assistance in contacting the interview participants for the first phase of this study. It also procured funding for this study from CNCS.
### Table 1: HPSISN Grantees, 1995-1998, Detailed Description

<table>
<thead>
<tr>
<th>Grantee</th>
<th>Proposed Student Disciplines</th>
<th>Proposed Project Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Georgetown University</td>
<td>Allopathic medicine, nursing, pharmacy</td>
<td>School-based health education, health promotion and disease prevention in underserved African American community</td>
</tr>
<tr>
<td>George Washington University and George Mason University</td>
<td>Allopathic medicine, physician assistant, nurse practitioner, public health</td>
<td>School-based health education, health promotion and disease prevention in several communities of Washington DC, MD and VA</td>
</tr>
<tr>
<td>Northeastern University</td>
<td>Nursing, allopathic medicine, dentistry</td>
<td>Education and prevention of domestic violence, family support</td>
</tr>
<tr>
<td>Ohio University</td>
<td>Osteopathic medicine, health administration</td>
<td>School-based health education, health promotion and disease prevention in rural underserved communities</td>
</tr>
<tr>
<td>Regis University</td>
<td>Nursing, nurse practitioner</td>
<td>Education and prevention of teenage pregnancy, alcoholism, family violence</td>
</tr>
<tr>
<td>San Francisco State University</td>
<td>Nursing, nurse practitioner</td>
<td>School-based health education and mentoring of Hispanic youth</td>
</tr>
<tr>
<td>University of Connecticut</td>
<td>Allopathic medicine, public health, dentistry</td>
<td>Family health promotion and disease prevention</td>
</tr>
<tr>
<td>University of Florida</td>
<td>Allopathic medicine</td>
<td>Family health promotion and disease prevention, case management</td>
</tr>
<tr>
<td>University of Kentucky</td>
<td>Nursing, pharmacy, allopathic medicine, dentistry, physician assistant</td>
<td>Access to health care for homeless women and children</td>
</tr>
<tr>
<td>University of North Carolina</td>
<td>Allopathic medicine, nursing, nurse practitioner, dentistry</td>
<td>Health promotion/disease prevention and primary care for poor and homeless</td>
</tr>
<tr>
<td>University of Pittsburgh</td>
<td>Allopathic medicine, nursing, pharmacy</td>
<td>Health promotion/disease prevention and primary care for homeless men/families</td>
</tr>
<tr>
<td>University of Scranton</td>
<td>Nursing, nurse practitioner</td>
<td>HIV/AIDS education and health promotion, education about end-of-life decision-making for the terminally ill</td>
</tr>
<tr>
<td>University of Southern California</td>
<td>Nursing, dentistry</td>
<td>Oral health care for underserved urban minority children and families</td>
</tr>
<tr>
<td>University of Utah</td>
<td>Nursing, nurse practitioner, allopathic medicine, physician assistant</td>
<td>Health promotion/disease prevention for homeless and underserved families</td>
</tr>
<tr>
<td>University of Utah and Purdue University</td>
<td>Pharmacy</td>
<td>Companionship of homebound elderly, health education for the elderly on medication use and drug interactions</td>
</tr>
<tr>
<td>Virginia Commonwealth University</td>
<td>Nursing, nurse practitioner, public health, allopathic medicine</td>
<td>HIV/AIDS outreach, education, support, case management, and home care</td>
</tr>
<tr>
<td>West Virginia Wesleyan College</td>
<td>Nursing, fitness, nutrition</td>
<td>Health education, health promotion/disease prevention in a rural underserved community</td>
</tr>
</tbody>
</table>

Student Leadership for SL at JHSPH

The Johns Hopkins Bloomberg School of Public Health (JHSPH) is a large research and teaching institution located at an AHC in a low-income, underserved urban neighborhood called East Baltimore. The neighborhood faces many longstanding population health challenges. While there is a history of institutional research in the community, in the last ten years, the Johns Hopkins University, with leadership from JHSPH, has taken a number of important steps to support greater institutional investments in the health of the local community. In particular, it has created new infrastructure at JHSPH and the Johns Hopkins Medical Institutions to increase faculty and student engagement in the local community for research, service, and SL (Johns Hopkins Urban Health Institute, n.d.; SOURCE, n.d).

Students have been part of this progress toward greater civic engagement at JHSPH. In 2005, with support from faculty and staff allies, JHSPH students created SPARC (Students for a Positive Academic paRtnership with the East Baltimore Community), a student advocacy group that aimed to foster an institutional culture of civic engagement. SPARC was active from 2005 to 2008. One of SPARC’s main projects was to promote new community engaged training opportunities at the School of Public Health. SPARC supported ongoing efforts to create new curricular SL opportunities, and then led a partnership of students, faculty and staff members to create a Certificate in Community-Based Public Health grounded in SL. The Certificate provides a coordinated sequence of courses in community-based research and practice and culminates in a two-term SL experience. Any graduate students in the Johns Hopkins University system may enroll in the Certificate, with permission from the faculty sponsor.
The following chapter provides an in-depth description of the methods used for the research reported in each of the three manuscripts in this dissertation.
CHAPTER 3: METHODS

This chapter describes the methods used for the three manuscripts that follow. As described in Chapter 1, Manuscripts 1 and 2 report findings from a ten year follow-up study of the HPSISN program. Manuscript 1 reports findings from phase 1 of the study, while Manuscript 2 reports findings from phase 2 of the study. Manuscript 3 reports on a case study of student leadership for SL at JHSPH. Background information on the HPSISN program and student leadership for SL at JHSPH are provided in Chapter 2.

HPSISN Ten Year Follow-Up Study – Manuscripts 1 and 2

Study Design

HPSISN (1995-1998) was the first, and remains the only, national demonstration program for SL in health professions education in the U.S., or for that matter, in any discipline. As such, it provided a unique opportunity to explore the longitudinal experiences of a cohort of SL initiatives in health professions education implemented over a decade ago.

The ten year follow-up study of the HPSISN program consisted of a case study of the entire HPSISN cohort (phase 1) and an embedded comparative case study of two of the HPSISN-supported SL initiatives (phase 2). This study design is depicted in Figure 2, below.
The goals of phase 1 were: 1) to assess the sustainability and long-term impact of SL in health professions education, and 2) to identify factors that influence sustainability. The case study method was used for this research because it allows for deep inquiry that is highly suited to studying longitudinal processes and complex systems, and to answering explanatory “how” or “why” questions in these contexts (Yin, 2003).

The goals of phase 2 were 1) to explore how sustained SL initiatives in health professions education have fostered the quality and sustainability of SL, and 2) to produce strategies for success and lessons learned from their experiences. Phase 2 was

designed as an embedded comparative case study of two of the HPSISN-supported SL initiatives that had been sustained from the time HPSISN ended in 1998 to the time of this research in 2009. A sub-goal for this research was to explore different strategies for sustaining SL, given different institutional contexts. For this reason, the SL initiatives were selected for similarity in the outcome variable of institutionalization, but for variability in contextual factors that were found, in phase 1, to be influences on the sustainability of SL. Case selection criteria are described in further depth, below.

A comparative case study design was chosen for this research because it allowed for both depth of inquiry and some degree of breadth. First, it allowed for deep exploration of the relationships between variables within each case. Second, it allowed for comparisons across the two cases that helped to add confidence to the study findings. By studying cases that are different or similar in intentional ways, as in this case study, we may be able to understand why a single case has produced its particular findings (Miles & Huberman, 1994). When there is replication of some patterns and variability in other patterns, as related to the presence of similar or dissimilar independent variables – such as the differences in contextual variables in this study design -- this provides greater support for generalizability (Yin, 2003). The methods used for each phase of this study are described below.
Phase 1

Goals and Research Questions

As described above, the goals of phase 1 were: 1) to assess the sustainability and long-term impact of SL in health professions education, and 2) to identify factors that influence sustainability. Research questions for phase 1 were:

1. To what extent have the HPSISN-supported SL initiatives been sustained since the HPSISN program ended in 1998?

2. What factors have influenced the sustainability of the HPSISN-supported SL initiatives, as facilitating factors, challenges, or beneficial strategies? and

3. What have been the long-term impacts of the HPSISN-supported SL initiatives for the various stakeholder groups?

In order to address these research questions, qualitative data were collected from two sources: interviews with individuals who had been involved with the HPSISN-supported SL initiatives and documents that shed light on the HPSISN program and the SL initiative at each institution in the HPSISN cohort.

Conceptual Framework

The first phase of the HPSISN follow-up study was guided by a conceptual framework from the literature on sustaining community-based public health programs, depicted in Chapter 2, Figure 1 (Shediac-Rizkallah and Bone, 1998). This framework identifies three major categories of factors that influence sustainability: 1) program design and implementation factors, 2) factors within the organizational setting, and 3) factors in the broader community environment. The exploration of each of the categories of influences on sustainability was grounded in a review of the literatures on
the sustainability of SL, organizational change, community partnerships for health and CBPR.

**Definitions of Outcome Variables**

As described in Chapter 2, the assessment of sustainability was grounded in the literature on organizational change, which identifies three definitions of sustainability: durability, routinization, and institutionalization. This research also examined the impact of SL. Impact was defined as the impact of SL on the capacity, activities, and attitudes of each of the stakeholder groups that may benefit from, or be affected by, SL (Gelmon, Holland, Driscoll, Spring, & Kerrigan, 2001). As described in Chapter 1, these stakeholder groups include: students, faculty, SL staff, the employees of partnering community agencies who are directly involved with SL, and more broadly, the participating academic institution and community agencies and the communities served by these agencies.

**Sampling Strategy for Interviews**

The interview sample was designed to achieve two goals. First, it was designed to provide information on the experiences of each of the HPSISN-supported SL initiatives for the entire time period from 1998 until the time these data were collected in 2007-2008. Second, it was designed to capture information on each of the topics of interest in this research: sustainability, program design and implementation, organizational traits, influences in the broader environment, and impact.

To achieve these goals, this research used a combination of purposeful and snowball sampling. Purposeful sampling involves selecting participants who can speak to the account the research aims to develop (Mason, 1996). Each of the 17 original
principal investigators from the HPSISN program was invited to participate in an interview. It was hypothesized that many of these individuals would be able to provide perspectives on each of the topics of interest in this research for the entire time period being studied. When a principal investigator could not provide all of this information, snowball sampling was used to complete the information. The participant was asked to recommend one or more additional individuals at the HPSISN-funded institution who could provide the needed information and might like to participate in an interview. These individuals might be administrators, faculty or staff members.

Recruitment

The Executive Director of CCPH sent a letter of invitation to each HPSISN principal investigator. The letter explained the goals of the study and informed them that they would be contacted by the study investigator, Amanda Vogel. The study investigator sent a follow-up email to each principal investigator to schedule a telephone interview. When principal investigators recommended additional individuals for snowball interviews, the study investigator sent emails to these individuals to ask whether they would be able to provide the needed information about their institution and would like to participate in an interview. For each institution, one individual who met these criteria and was able to participate in an interview during the time frame available for data collection was invited to participate.

Data Collection

The study investigator drafted a semi-structured in-depth interview guide, and then piloted the initial draft with three individuals who direct SL initiatives at health professions schools that did not participate in HPSISN. These included two schools of
medicine and a school of nursing. The guide was revised based on these pilot interviews (Appendix D). It explored the degree of sustainability of the SL initiative, what factors influenced SL sustainability as facilitating factors or challenges, responses to these challenges, and the impact of SL on each of the various stakeholder groups. Interview questions were designed to assess each of the categories in the conceptual framework, and to reflect the theoretical approaches adopted for this research. They also reflected the literature reviewed in Chapter 2. Interviews were conducted between June 2007 and August 2008. They were conducted over the telephone and most lasted between 60 and 90 minutes.

This phase of the research was exempted by the JHSPH Institutional Review Board as Not Human Subjects (JHSPH IRB-1 Protocol #211). However, each participant received a disclosure statement describing the study purpose, design and procedures; risks, benefits and protections; anticipated products; and the voluntary nature of his or her participation. All of the participants agreed to have their interviews tape recorded.

Key documents were also collected and reviewed to shed light on the design and experiences of the HPSISN-supported SL initiatives. To begin, the investigator reviewed documents about the HPSISN program, including a published evaluation of the implementation and early outcomes of HPSISN (Gelmon, Holland, & Shinnamon, 1998), and peer reviewed articles describing the implementation of HPSISN and 1998 evaluation findings (Gelmon, Holland, Seifer, Shinnamon, & Connors, 1998; Gelmon, Holland, Shinnamon, & Morris, 1998; Seifer, 1998b). She also reviewed documents about the 17 HPSISN-supported SL initiatives. Nine of the HPSISN-supported SL initiatives had written case studies of their experiences for an edited collection, and these
case studies were reviewed (Seifer, Connors, & Seifer, 2002). Additional documents were reviewed for each one of the HPSISN-supported SL initiatives. These included: 1) the biographies or curricula vitae of the interview participants; 2) the websites of the institutions, their SL initiatives in health professions education, and the department(s), school(s), or college where SL in health professions education was located; 3) newsletter or newspaper articles about the SL initiative; and 4) academic publications that described the SL initiative.

Newsletter and newspaper articles and academic publications were located via the institutions’ websites and electronic searches using Google, Google Scholar, and PubMed. In addition, all interview participants were asked to recommend other publications about SL in health professions education at their institutions, and to send copies or identify where these could be located. Whenever possible, information about each HPSISN-supported SL initiative was reviewed before the interview, to inform the interview questions.

Analytic Approach

Transcripts were analyzed using thematic coding and memo-writing (Morse & Richards, 2002). With one exception, interviews were professionally transcribed and codes were developed to identify the major themes that emerged. One interview was not transcribed at the request of the interview participant. For that interview, however, the recording was still available for analysis. The study investigator listened to the audio recording and took notes on the major themes that emerged.

Coding followed a combined deductive and inductive approach (Miles & Huberman, 1994). A “start-list” of deductive codes reflected expected findings based on
the literatures on the sustainability and impact of SL and the related literatures on organizational change, community partnerships for health, and CBPR described in Chapter 2 (Miles & Huberman, 1994). The study investigator read all of the transcripts, and she applied this original set of codes. During this process, she revised some of these codes to reflect an emerging understanding of the data, and created new codes to reflect themes that emerged from the data. Some interviews were coded by hand, while others were coded using NVIVO qualitative data management software (version 7, QSR International, Cambridge, MA, 2007). As a result of this process, a final codebook was developed that included 42 codes and sub-codes (Appendix E). These codes were then re-applied to all of the transcripts using “low-tech” methods that involved cutting and pasting passages of text into Microsoft Word documents created for each of the 42 codes and sub-codes.

Other methods were also used to develop this analysis. Memo-writing was used to develop an understanding of emerging themes and to help identify the relationships among themes. Documents, including notes on the one interview that was not transcribed, were reviewed to clarify or supplement the content of study interviews. Finally, the investigator read extensively from the literature on sustaining SL in higher education to inform the emerging analysis.

Phase 2

Goals and Research Questions

As described above, the goals of this phase of the research were: 1) to explore how sustained SL initiatives in health professions education have fostered the quality and sustainability of SL, and 2) to produce strategies for success and lessons learned from
their experiences. “Quality” was defined as implementing the principles for high-quality SL described in Chapter 2, including principles for: 1) how to structure SL as an educational experience, and 2) how to operate community-campus partnerships for SL.

Goals and research questions for phase 2 grew organically from the findings in phase 1. This phase of the research was designed to explore in further depth the influences on SL sustainability. It was also designed to explore factors that emerged from phase 1 as important influences on the sustainability and impact of SL, specifically the organizational context and the quality of SL. Research questions for phase 2 were:

1. How have these sustained SL initiatives been implemented?
2. What strategies have they used to foster the quality and sustainability of SL?
3. What challenges have they encountered related to fostering the quality and sustainability of SL? and
4. How, if at all, have these challenges been addressed?

**Sampling Strategy**

**Cases**

The primary goals in selecting the two cases for this research were to explore different pathways to successfully sustain SL and to foster the quality of SL, given different institutional contexts. This approach could highlight strategies for success that are specific to different institutional contexts as well as others that are applicable across different institutional contexts. The decision was made to select two successfully sustained SL initiatives, rather than programs with different levels of success, in order to focus the research not on pathways to sustainability of SL or lack thereof, but instead on different pathways to the same end, given different influencing factors. Similarly, the
decision was made to select two SL initiatives that had demonstrated attention to quality, in order to identify different strategies to foster the quality of SL.

There were three related case selection criteria for this phase of the research. They were assessed for each institution that participated in phase 1. First, both cases had to have achieved a high level of sustainability for SL. In phase 1, three levels of sustainability emerged in the findings, and seven SL initiatives achieved the highest level of sustainability. Both cases were selected from this group. This way, the research could explore strategies for achieving this outcome. Second, in phase 1 interviews, interview participants from both cases had to have shared strategies their SL initiatives had used to foster the quality of SL. Third, the two cases had to vary significantly in their institutional culture, a factor that emerged in phase 1 as an important influence on sustainability of SL. This was reflected in institutional traits such as whether the institution was faith-based or secular, public or private.

Another goal for case selection was that the full range of stakeholders in SL – including academic administrators, faculty, students, SL staff, and community partners – needed to be available for interviews. Phase 1 had only included faculty, administrators, and staff as research participants, so the research findings necessarily reflected the point of view of academic partners. A goal for phase 2 was to include the viewpoints of all stakeholders in SL. It was also decided that for each case, at least three community partner agencies would need to be available to participate in the research. This design reflected the fact that different community agencies would likely have different experiences partnering for SL.
Community Partner Agencies

The decision to include three community agencies in each case study reflected a balance of research goals and logistical constraints. As described above, one aim was to represent a number of different community partner experiences with SL. It was thought that with three organizations, rather than two, patterns across and between organizations could be more easily identified. This number was also small enough to make it feasible to conduct site visits to community agencies as part of the five-day site visit conducted for each case study.

The three community agencies that participated in each case were selected for variability in characteristics that might be associated with the research questions, including how SL projects were implemented, strategies for success, challenges, and impact. These included: 1) the length of time the agencies had participated in the SL partnership, 2) the populations and health issues their SL partnerships addressed, and 3) the SL projects that students participated in at the agencies. Another case selection criterion for each community agency was that at least two persons – one administrator with knowledge of the SL partnership and one staff member who was directly involved in SL – had to be available for interviews. These individuals would likely provide different perspectives on the research questions, based on their professional roles. In addition, including at least two individuals per community agency would allow for some triangulation.
Interview Participants

There were two goals in selecting interview participants. The first goal was to represent the variety of organizational levels and groups within the academic institution and community partner agencies that had influence over the SL initiative or were involved in the initiative, something Creswell calls “maximal variation” (1997). This would allow for the collection of multiple perspectives on each of the research questions. For example, administrators and SL staff could provide different perspectives on the level of institutional support to sustain SL. Faculty, SL staff members, and community partners could discuss how SL was implemented, each from a different perspective. Meanwhile, faculty members, students, and community partners could all speak to the quality of SL. The second goal was to include individuals who had maximal knowledge about the SL initiative, for example, those who were most closely involved in implementing the initiative, or those with longitudinal perspectives on the initiative from the time it began to the time the research was conducted. Together, these two goals would help to create a complex picture of SL at the institution.

Recruitment

Cases

From the seven SL initiatives identified in phase 1 as having achieved the highest level of sustainability, the study investigator identified two that provided a high level of variability in their institutional culture as well as an opportunity to explore strategies for fostering high-quality SL. The Executive Director of CCPH and the investigator sent a joint letter to the HPSISN principal investigators affiliated with each of these SL initiatives to invite the initiative’s participation in an in-depth case study. The letter
explained the purpose and design of the research and invited a follow-up telephone conversation in order to: 1) assess the initiative’s interest in participating, and 2) evaluate the initiative’s ability to participate, based on the interest of community partner agencies and the availability of the range of interview participants needed for this research. Both of these initiatives agreed to participate and also met the case selection criteria. Each identified the director of the SL initiative as the contact person to help in the recruitment of community agencies and individual interview participants.

Community Partner Agencies

To recruit community agencies, the study investigator discussed the selection criteria for community agencies with the director of each participating SL initiative, and together they selected three agencies to invite to participate. The director of each SL initiative extended these invitations at first. The community agencies also received a letter of invitation sent by the Executive Director of CCPH and the study investigator that described the purpose and design of the study and invited a follow-up telephone conversation. However, no agency requested a follow-up conversation.

Interview Participants

Individual interview participants were selected through purposeful sampling and snowball sampling. As described above, purposeful sampling aims to include participants who can speak to the account the research aims to develop. For each case, a primary goal was to develop an account of SL that included the perspectives of all stakeholders in the SL initiative. A second goal was to inform the case through the perspectives of individuals with maximal knowledge of the SL initiative. For each case, the study investigator created a list of all potential relationships to the SL initiative that
drew upon the phase 1 interview(s) for the case and a review of the websites of the academic institution and the SL initiative. This list was also designed to include individuals with maximal knowledge about the SL initiative. The study investigator and the SL director at each participating institution collaborated to revise this list and the SL director identified individuals who met these criteria. The SL director invited these individuals to participate and the study investigator sent a follow-up email to schedule an interview.

Snowball sampling was used to include additional interview participants who were not on the initial list but who had unique perspectives to share on the SL initiative. This sampling occurred without solicitation. During data collection, interview participants responded to some interview questions by recommending that the study investigator interview other individuals who could discuss particular themes in detail. In some cases these individuals were already scheduled for interviews, and in other cases they were not. When these individuals were not already scheduled for interviews, the study investigator or SL director contacted them during the site visits, in person or by phone or email, to invite their participation.

Data Collection

Phase 2 data collection consisted of site visits, qualitative semi-structured in-depth interviews, and document review. Site visits and interviews were conducted from March through May 2009. For each case study, the study investigator conducted a five-day site visit that included visits to the academic institution and two of the three participating community agencies. During these site visits, she toured the facilities, conducted in-person interviews, and took field notes.
For each case study, one participating community agency did not host a site visit. This occurred for different reasons for each of these agencies. A strength of one of these SL initiatives was that it offered intensive SL immersion experiences. These were often in locations far from the university, including international settings. For this case study, a community partner agency for one of these immersions was selected to participate, in order to highlight this strength. For the other case study, a third community agency could not be identified to participate during the scheduled site visit. In both of these instances, it was not within the resources available to the study to visit the agency outside of the planned site visit. For each agency, therefore, interviews were conducted by telephone. For one of the case studies, one academic partner was unavailable for an interview during the site visit, and that individual’s interview took place over the phone as well. In addition, one community partner was unavailable to participate in an interview during the visit to that community agency, and that interview also took place over the phone.

Aside from the exceptions described above, all other interviews were conducted in person during the site visits. Most in-person interviews were conducted one-on-one, though a few occurred in small groups of individuals who shared the same role in relation to the SL initiative, for example, students who participated in SL. All telephone interviews were conducted one-on-one. Individual interviews ranged from 25 to 60 minutes and small group interviews ranged from 60 to 90 minutes.

A semi-structured interview guide was created for each interview. Interview questions were tailored to each participant or small group of participants according to their roles in the SL initiative. Questions were selected from comprehensive interview guides created for academic and community partners (Appendices F and G). Interviews
explored themes related to the quality and sustainability of SL that reflected the SL literature, as described in Chapter 2. All participants provided verbal informed consent to participate and agreed to have their interviews tape recorded.

Finally, the study investigator reviewed documents both before and after each site visit to orient her to the SL initiative at that institution and provide additional data to answer the research questions. These documents included: 1) the websites of the academic institution and the institutional home for SL in health professions education; 2) the websites of the SL initiative and other SL activities at the institution; 3) newsletter or newspaper articles about the SL initiative; 4) academic publications about the SL initiative; 5) lists and descriptions of community partner agencies; 6) the websites of community partner agencies; 7) syllabi of courses where SL is integrated; 8) SL handbooks, guidelines, and other learning and teaching tools for participating students and faculty members; 9) annual reports produced by the SL initiative; 10) evaluation forms used by the SL initiative to obtain feedback from participating students, faculty, and community partners; 11) results of student and community partner evaluations; 12) self-study reports of the institution and institutional home for SL; 13) strategic planning documents for the SL initiative; 14) documents describing community partner agencies and SL projects; and 15) products students created in their SL projects. Some of these documents were located using the same methods described for phase 1. Others were provided by interview participants during site visits, or were collected during site visits from publicly available information.
Analytic Approach

Following Miles and Huberman (1994) a pre-structured case outline was used to
guide data analysis and writing. In this method, “the processes of data collection,
analysis, and report writing are collapsed into one evolving procedure” (p. 85). Before
going into the field, a shell document was created to guide each case write-up. The
document outline reflected the research questions and the document already included
information gleaned from the review of documents conducted before the site visit. All of
the interviews were professionally transcribed, and the study investigator read all of the
transcripts, field notes, and collected documents. In most cases, carefully reading these
documents in combination with memo-writing was enough to elucidate the major themes
in the interviews that were relevant to the pre-structured case outline. Where new
themes emerged in the transcripts and documents, memo-writing was also used to
develop an understanding of the data and how they related to the research questions. For
some themes that were difficult to disentangle – for example, the goals versus impacts of
SL – coding was used to clarify the themes. Related text from each interview within a
case was coded using low-tech methods that involved cutting and pasting passages of text
into Microsoft Word documents created for each of the themes.

Analysis of these findings involved within-case and cross-case comparisons
(Miles & Huberman, 1994). Major themes were identified within each case and these
were compared across cases. In addition, within each case, respondents were stratified by
their role in the SL initiative: academic administrators, faculty, SL staff, students,
administrators of community agencies, and staff of community agencies. Similarities and
differences were explored between and among these groups, both within each case and
across the two cases. Matrices and memo-writing were the primary analytic tools used throughout this process (Miles & Huberman, 1994). The study investigator created matrices to compare the perspectives of different stakeholder groups within and across cases on each major theme. In order to inform this analysis, the investigator read extensively from the literature on quality of SL and sustainability of SL. Memo writing was used to apply these concepts to the analysis of the case studies. In addition, flow charts were created to identify relationships between themes. The results of the cross-case analysis were to identify overarching themes across the two cases, to clarify differences between the two cases, and to identify the factors underlying patterns within and between cases.

Once a first draft of each case was written, the investigator contacted each interview participant who had one or more quotes included in the case, to ask for his or her approval to use the quote or quotes. The investigator sent each individual his or her quote or quotes with the surrounding text. All participants approved of the use of their quotes in these contexts. This provided support for how these data were interpreted.

**Human Subjects Considerations**

**Benefits and Risks of Participating**

This phase of the research was approved by the JHSPH Institutional Review Board (JHSPH IRB-X Protocol #953). No direct personal benefits were expected to accrue to individuals for their participation in this study. However, for academic administrators, faculty members, and SL staff, as well as community partners, there were potential benefits to their professional activities as related to their involvement with the SL initiative. Specifically, the opportunity provided by this study to reflect on the SL
initiative in a structured manner might result in ideas for how to enhance the sustainability of SL and the benefits of SL for all stakeholder groups.

This research posed some risk to participants’ privacy. Because there were only 17 institutions in the HPSISN cohort, it was conceivable that the two institutions that participated in case studies might be identified, allowing individual participants also to be identified only by their job descriptions (Appendix H). A description of how this risk was mitigated is provided below.

Confidentiality Protections

In order to minimize the risk that readers might deduce the identity of participants, characteristics that could be used to identify each institution within the HPSISN cohort were not reported. Only where a group of characteristics could apply to multiple institutions in the cohort were these characteristics described. In addition, only individuals’ job descriptions, or their roles in the SL initiative were used to attribute quotes in the manuscript. In some cases, individuals’ job titles or the names that were used by the institution to describe their roles in the SL initiative might have identified the institution. In these cases, more generic job descriptions were used (in both the manuscript reporting these findings and in Appendix H), and different language with a similar meaning was used to describe their roles in the SL initiative.

All interviews were conducted in private rooms, and interviews were paused when other individuals entered the room. All audio recordings of interviews were stored in unlabeled audio files on a password-protected computer only accessible to the study investigator. All identifying information, such as the name of the interview participant(s) and the name of their institution, were edited out of interview transcripts, and electronic
copies of these transcripts were stored on the same computer. Printed copies of transcripts, field notes, interview notes, and documents about the participating academic institutions and community agencies were stored in locked file cabinets only accessible to the study investigator.

**Case Study of Student Leadership for SL in Health Professions Education – Manuscript 3**

As described in Chapter 2, this research consisted of a case study of the leadership of a student organization called SPARC to advance SL at JHSPH, a large research-focused school of public health.

**Goals and Research Questions**

The overarching goal of this case study was to examine how students can provide leadership to advance SL in health professions education. Research questions were:

1. How can students provide leadership in the organizational change processes involved in implementing SL in health professions education?

2. What are the results of student leadership for SL?

3. How do students’ contributions differ from those of administrators, faculty, and staff members, both in terms of the organizational change techniques that students use and the results of student leadership? and

4. How can administrators, faculty and staff members support and work together with students to enhance community engaged training at their institutions?

**Study Design**

This research was designed as a single case study. Yin (2003) writes that one rationale for a single case study is that the case is revelatory, meaning that it investigates
a phenomenon not yet studied by researchers. As mentioned in the introduction, a small body of literature describes the products of student leadership for SL in health professions education. But the investigator could identify no academic literature that explored in depth students’ contributions to the organizational change processes involved in fostering civic engagement and implementing SL in health professions education. The case study method was also suited to this research for the same reasons it was appropriate for the HPSISN study: this research aimed to explore longitudinal processes in a complex institutional setting.

**Data Collection and Analytic Approach**

Data collection for this case study consisted of participant observation, document review, and member validation. The primary method used was participant observation (Mason, 1996). The study investigator was a founding member of SPARC and a member of the group’s executive committee from 2005 to 2008. As the chair of SPARC’s curriculum committee, she led the group’s initiative to advance SL. In these roles, she participated in all major SPARC meetings related to strategic planning, chaired most curriculum committee meetings, and was the primary author of all of SPARC’s curriculum-related products.

The investigator moved from the role of participant to participant-observer about halfway through the events described in this manuscript, during SPARC’s partnership with faculty and staff to create a Certificate in Community-Based Public Health grounded in SL. At this time, she began observing SPARC’s activities through the lenses of the research questions for this study. She began reading articles, books, and gray literature about student leadership for SL in higher education in the U.S.; recent and ongoing
community engagement at JHSPH; and advocacy techniques for organizational change and public health advocacy. She then began writing analytic memos to synthesize these concepts with her past and ongoing experiences as a member of SPARC.

Participant observation is more likely than other qualitative methods to introduce bias because the investigator is, in fact, acting as the data collection instrument. In order to reduce the bias that is introduced through this method, data collection also included document review and member validation, both of which served the purpose of triangulation. The investigator reviewed all public documents produced by SPARC as well as key internal documents. Public documents included: 1) SPARC’s mission and vision statements, 2) the results of a student body survey conducted by SPARC, 3) a report the group wrote to the School’s administration summarizing survey findings and offering recommendations for action, 4) SPARC’s proposal for the Certificate in Community-Based Public Health, 5) an accompanying memo providing the rationale for the certificate, and 6) the certificate guidelines approved by the School. Internal documents included: 1) an early visioning statement, 2) internal emails and letters about key events, and 3) agendas and notes from important meetings about strategic planning and curriculum development. These internal documents were particularly helpful as a source for triangulation to reduce the risk of bias.

Member validation was also used as a form of data collection (Bloor, 1983; Miles & Huberman, 1994). Miles and Huberman (1994) write that, because “people often have widely varying perceptions of the same phenomenon,” (p. 276), researchers should look to member validation “as an occasion to learn more about the case” (p. 277) rather than corroboration of their analysis. Once a draft of the case study was created, the
investigator asked active and former SPARC executive committee members (n=9), staff (n=4), faculty members (n=2), and a national leader for SL who partnered with SPARC to review the case study and assess whether it corresponded with their understanding of events. Of the sixteen individuals who were invited to comment, eleven provided feedback. Following the approach recommended by Miles and Huberman, this feedback was used as additional data to clarify events in the case history and their interpretation. Where reviewers’ viewpoints differed from the case study, the investigator engaged these individuals in additional conversation about their perspectives and/or conducted additional document analysis to clarify events and interpretations. In some cases, interview participants pointed the investigator to internal documents that helped with this goal. In this way, member feedback served both as a source of triangulation and as an impetus to collect additional data for triangulation.

The following three chapters report findings from the inquiry described in this chapter. Chapter 4 reports findings from the first phase of the HPSISN ten year follow-up study, Chapter 5 reports findings from the second phase of the HPSISN study, and Chapter 6 reports findings from the case study of SPARC’s leadership for SL at JHSPH.
CHAPTER 4: MANUSCRIPT 1

Long-Term Sustainability and Impact of Service-Learning in Health Professions Education: Findings from a Ten Year Follow-up Study of the HPSISN Program

Abstract

Service-learning (SL) is becoming increasingly popular in health professions education. With this growing investment in SL, it is important to better understand how to sustain SL. It is also important to assess whether sustained SL can achieve many of its purported impacts, such as building capacity in community and academic partners for future partnerships, and improving “town-gown” relations. Yet little research has been done to assess the long-term sustainability of SL in health professions education, what factors influence sustainability, and the impacts of sustained SL initiatives. To address these gaps in our knowledge, we conducted a qualitative ten year follow-up study of the Health Professions Schools in Service to the Nation (HPSISN) program. From 1995 to 1998, HPSISN provided support to 17 health professions schools or programs to integrate SL into the curriculum.

We found that ten years after grant funding ended, 12 of the participating SL initiatives had routinized or institutionalized SL. The major influences on sustainability of SL – including facilitating factors and challenges – were located in the organizational setting. Facilitating factors in the organizational setting included: 1) an institutional culture that is favorable to SL, 2) support for SL among high-level administrators, 3) material support for SL in the forms of infrastructure to support SL and funding for faculty participation in SL, and 4) a “critical mass” of support for SL. A number of facilitating factors were also identified in the design and implementation of SL. These included: 1) a strong leader for SL, 2) the ability to adapt SL to changes in the academic
environment, and 3) stable, long-term community partnerships. Two final facilitating factors were the growing support for community engagement in higher education, including health professions education, and the ability of SL to contribute to achieving institutional priorities. Major challenges to sustaining SL were all in the organizational environment. They included: 1) turnover among faculty who teach using SL, 2) loss of champions for SL, and 3) competing educational priorities. Participants used two strategies to address these challenges: providing periodic professional development opportunities for faculty and marketing SL internally to opinion leaders and faculty members.

SL had long-term impacts for both academic and community partners. It fostered engaged scholarship among participating faculty members; increased capacity among both community and academic partners for future partnerships; led to the diffusion of SL and SL principles to other departments and universities; and improved “town-gown” relations, which also had related benefits for public relations and marketing. In a few cases there were also impacts on community agencies’ capacity to address community health. These findings provide guidance for how to maximize the sustainability of SL in health professions education and address common challenges. They also produce evidence that SL is achieving many of its goals for long-term impact, offering support for the expansion of SL in health professions education.
Introduction

Service-learning (SL) is becoming increasingly popular in health professions education. With this growing investment in SL, it is particularly important to better understand how to sustain SL. Many of the claims about the benefits of SL -- such as its ability to build capacity in community and academic partners for future partnerships, and its ability to improve “town-gown” relations -- assume a sustained investment. Yet little research has been done to assess the long-term sustainability of SL in health professions education and what factors influence sustainability. Due to the lack of research on sustained SL, we also know little about the long-term impact of SL in health professions education. To address these gaps in our knowledge, we conducted a ten year follow-up study of the Health Professions Schools in Service to the Nation (HPSISN) program. From 1995 to 1998, HPSISN provided support to 17 health professions schools or programs to integrate SL into the curriculum.

What is Service-Learning and What Are its Benefits?

Service-learning (SL) is a form of experiential learning that is built on community-academic partnerships. Through SL, academic institutions develop partnerships with community agencies, and together they identify community needs that can be met by students. Students engage in projects that simultaneously address these needs and achieve learning objectives. The types of activities that students engage in vary by their professional degree program, educational level, educational objectives and community needs. Structured preparation for the service experience and facilitated reflection during and after the experience are defining characteristics of SL that enable students to link the service experience to learning outcomes (Seifer, 1998b).
SL in health professions education has the potential to produce benefits for everyone involved, including students, faculty and SL staff, community agencies, and academic institutions (Seifer, 1998b). It has both short- and long-term impacts. In the short-term, SL can train students in competencies for community and population health. It may also foster an ethic of civic professionalism, and an interest in providing leadership to address community and population health concerns. The Pew Health Professions Commission endorsed SL as a strategy to teach the competencies in its “Twenty-One Competencies for the Twenty-First Century,” which it believed all future health professionals would need (O’Neil and Pew Health Professions Commission, 1998; Appendix A). Also in the short term, SL provides direct services to community partner agencies, and often to their clients, that respond to community-identified needs. These services may help community health agencies achieve their missions, particularly when they fill workforce shortages (Cashman, Hale, Candib, Nimiroski, & Brookings, 2004; Kushto-Reese, Maguire, Silbert-Flagg, Immelt, & Shaefer, 2007).

In the long-term, SL may increase capacity for community-academic partnerships in both academic institutions and community agencies by establishing infrastructure and policies to support future partnerships and develop partnership skills among faculty members and the staff of community partner agencies (Cashman & Seifer, 2008; Seifer, 1998b). SL partnerships may also develop the capacity of community agencies to address community health priorities independent of academic partners (O’Toole & Freyder, 2000). Additionally, SL may foster better mutual understanding between health professions schools and programs and their communities, which can, in turn, improve the ways they interact (Cashman & Seifer, 2008). SL may also shift the culture of academic
institutions toward greater community engagement (Cashman & Seifer, 2008; Seifer, 1998b). For these reasons, the Institute of Medicine (IOM) identified SL as a way that health professions schools and programs can use their resources to provide service to their local communities (2003a).

**What is Known About the Sustainability and Long-term Impact of SL in Health Professions Education?**

These long-term impacts require, of course, that SL be sustained for a significant enough period of time. Sustainability is also important to the efficiency and quality of SL. Lapses in SL may lead academic institutions to unnecessarily replicate initial investments in SL planning and infrastructure development. They may undermine community partners’ trust and willingness to collaborate for SL or other partnerships (Shediac-Rizkallah & Bone, 1998). Yet little is known about the sustainability of SL in health professions education.

While there is a growing literature on SL in health professions education, most publications describe initial start-up experiences, program design and implementation, and short-term impacts such as student learning outcomes and services delivered to community agencies (Baumberger-Henry, Krouse, & Borucki, 2006; Brown, Heaton & Wall, 2007; Elam, et al., 2003; Gregorio, DeChello and Segal, 2008; Hamner, Wilder, Byrd, 2007; Hayward & Weber, 2003; Young, Bates, Wolff, & Maurana, 2002). This literature provides evidence that SL is achieving its intended educational outcomes, including cultural competency (Brown, Heaton & Wall, 2007; Sauer, 2006), an understanding of the social determinants of health (O’Toole, Kathuria, Mishra, & Schukart, 2005); skills for working in community-based settings (Brown, Heaton & Wall,
2007; Reising, Shea, Allen, Laux, Hensel, & Watts, 2008); and civic professionalism, and is doing so in training programs from across the health professions (Aston-Brown, Branson, Gadbury-Amyot, & Bray, 2009; Brown, Heaton & Wall, 2007; Carufel-Wert, Younkin, Foertsch, Eisenberg, Haq, Crouse, & Frey, 2007; Reising, Shea, Allen, Laux, Hensel, & Watts, 2008). This literature also documents how student participants in SL are delivering important health services to communities, such as influenza immunizations (Kemsley & Riegle, 2004), depression screening (Cashman, Hale, Candib, Nimiroski, & Brookings, 2004), pediatric screenings for obesity, hypertension, and hearing and vision impairments (Kushto-Reese, Maguire, Silbert-Flagg, Immelt, & Shaefer, 2007), blood pressure monitoring and medication counseling for older adults (Sauer, 2006), and heart disease and diabetes education (Reising, Shea, Allen, Laux, Hensel, & Watts, 2008).

But empirical studies have not yet been done to assess the long-term sustainability of SL in health professions education, what factors contribute to sustainability, or the long-term impacts of SL in health professions education. We could identify only a few articles, all descriptive in nature, that describe the strategies that long-term sustained SL initiatives in health professions education have used to work toward sustainability, and the long-term impacts of these sustained SL initiatives (Andrus & Bennett, 2006; Davidson & Waddell, 2005; Greenberg, Howard & Desmond, 2003; Meyer, Armstrong-Coben, & Batista, 2005). These articles, however, provide evidence for the claims that SL may create more engaged institutions (Davidson & Waddell, 2005), increase engaged scholarship among faculty (Andrus & Bennett, 2006), enhance “town-gown” relations (Meyer, Armstrong-Coben & Batista, 2005), and develop institutional capacity for community partnerships (Meyer, Armstrong-Coben & Batista, 2005). They also suggest
that two keys to sustainability are to constantly update SL courses to match changing educational goals (Davidson & Waddell, 2005), and to create longitudinal partnerships between faculty members and community agencies to undergird SL (Andrus & Bennett, 2006).

**What is Known About the Sustainability of SL in Higher Education More Broadly?**

There is a more developed body of literature on sustaining SL in higher education more broadly. It focuses on identifying what factors are important to institutionalize SL in an academic institution. This literature includes a small number of empirical studies that provide a great deal of guidance for sustaining SL (Bell, et al., 2000, as cited in Furco, 2002; Bringle & Hatcher, 2000; Furco, 2002; Gray, et al., 1998, as cited in Furco, 2002; Holland, 1997). These studies identify the following factors as important to institutionalize SL: support for service in an institution’s mission and vision (Holland, 1997); support for SL in faculty promotion, tenure, and hiring policies (Holland, 1997); a formal strategic plan for the institutionalization of SL (Bell, et al., 2000, as cited in Furco, 2002); support for SL among top administrators and faculty (Furco, 2002); internal funding for SL (Bringle & Hatcher, 2000); the presence of a SL or civic engagement center, and the central location of the center in the organizational structure (Bringle & Hatcher, 2000; Gray, et al., 1998, as cited in Furco, 2002). Other publications that draw on the experiences of practitioners assert the need for the active support of the university president, including both “rhetoric and action” (Furco & Holland, 2004; p. 33); funding for faculty participation; the hiring of SL staff; and the integration of SL into the curriculum (Eyler & Giles 1997; Furco and Holland, 2004; Jacoby, 1996b; Jacoby & Hollander, 2009).
The literature on sustaining SL in higher education also highlights the importance of the buy-in of faculty, students, and community partners to institutionalize SL (Furco, 2002; Hutchison, 2005; Rubin, 1996; Zlotkowski, et al., 2006). It recommends a number of strategies to foster this buy-in, including: identifying a model for SL that is consistent with the organizational culture and mission of both academic and community partners (Rubin, 1996; Torres, 2000); linking SL to other organizational priorities, something Furco calls “institutional hooks” or “leverage points,” (Furco, 2002); integrating SL into preexisting programs that connect SL to other institutional activities (Furco & Holland, 2004; Rubin, 1996); publicizing SL internally and externally (Hutchison, 2005); creating a “partnership process” for communication and decision making (Torres, 2000); and engaging in regular evaluation involving all stakeholders, including community members and students (Torres, 2000; Gelmon, 2003).

There is a need for empirical research on the sustainability of SL in health professions education, specifically. This research would help to identify to what extent factors in the literature on institutionalizing SL in higher education more broadly are relevant to SL in health professions education, specifically. It might also identify additional influences on sustainability that are unique to health professions education. Research is also needed to assess the long-term impact of SL in health professions education. Opportunities for such research are rare, however, due to the nature of funding for SL, which typically supports initial implementation and assessment of short-term impact (Furco, 2002). We had a unique opportunity to conduct a study that explored these questions. We assessed the ten-year sustainability and impact of the HPSISN program. From 1995 to 1998, HPSISN provided support to 17 health
professions schools or programs to integrate SL in the curriculum. In 2007 to 2008, we assessed the sustainability of the HPSISN-supported SL initiatives, influences on sustainability, and the long-term impact of these SL initiatives.

**Methods**

This was a qualitative study with data from two sources: interviews with individuals who had been involved with the HPSISN-supported SL initiatives, and documents that shed light on these SL initiatives. This section provides background on the HPSISN program, describes the conceptual and theoretical basis of our inquiry, our sampling strategy, data collection methods, and analytic approach.

**Research Questions**

Our research questions were: 1) To what extent have the HPSISN-supported SL initiatives been sustained since the HPSISN program ended in 1998? 2) What factors have influenced the sustainability of the HPSISN-supported SL initiatives, as facilitating factors, challenges, or beneficial strategies? And 3) What have been the long-term impacts of the HPSISN-supported SL initiatives for the various stakeholder groups involved in SL?

**Study Population: The HPSISN Cohort**

The HPSISN program was a national demonstration program created to implement on a broad scale the Pew Health Professions Commission’s recommendation that all health professions schools implement SL to train students in community and population health competencies, particularly an ethic of public service (O’Neil, 1993). From 1995 to 1998, HPSISN provided support to 17 health professions schools and programs across the United States to develop community-academic partnerships for SL.
and integrate SL into the curriculum. Faculty members, community partners and students who participated in the HPSISN program received technical assistance and professional development opportunities in SL. Each institution also provided matching support, in cash or in kind, over the three-year grant period.

The HPSISN institutions represented the breadth of characteristics of U.S. health professions education. They included AHCs, large research institutions, and small teaching institutions. Eleven were public institutions and six were private. Four were faith-based and 13 were secular. The HPSISN institutions were geographically dispersed, with five in the South, five in the West, four in the Mid-Atlantic, two in the Northeast, and one in the Midwest. Of the 17 SL initiatives, 13 had an urban focus, three had a rural focus and one addressed both rural and urban health. The SL initiatives included programs in allopathic and osteopathic medicine, nursing and nurse practitioner, physician assistant, pharmacy, public health, health administration, and dentistry, as well as fitness and nutrition. Some initiatives were multi- or interdisciplinary.

Table 2: HPSISN Grantees, 1995-1998

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<tr>
<th>1. Georgetown University</th>
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<td>2. George Washington University &amp; George Mason University</td>
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<tr>
<td>3. Northeastern University</td>
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<td>4. Ohio University</td>
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<td>5. Regis University</td>
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<td>6. San Francisco State University</td>
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<td>7. University of Connecticut</td>
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<td>8. University of Florida</td>
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<td>9. University of Kentucky</td>
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<td>10. University of North Carolina</td>
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<tr>
<td>11. University of Pittsburgh</td>
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<tr>
<td>12. University of Scranton</td>
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<tr>
<td>13. University of Southern California</td>
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<tr>
<td>14. University of Utah</td>
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<tr>
<td>15. University of Utah &amp; Purdue University</td>
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<tr>
<td>16. Virginia Commonwealth University</td>
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<td>17. West Virginia Wesleyan College</td>
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Community partners were selected by the participating institutions, and were
diverse in their organizational missions, the populations they served, and the health issues
they addressed with SL. Community partners included the American Red Cross, Boys
and Girls Clubs, churches, public schools, community health clinics, Head Start
programs, hospices, local public housing authorities, Planned Parenthood offices, senior
centers, youth centers, the Salvation Army, and many other local agencies.

HPSISN is the only national demonstration program for SL in health professions
education in the U.S. It therefore provided a unique opportunity to explore the
longitudinal experiences of a cohort of SL initiatives implemented over a decade ago.
HPSISN was a program of the Pew Health Professions Commission and the National
Fund for Medical Education, and was supported by The Pew Charitable Trusts, the
Corporation for National and Community Service (CNCS), and the Health Resources and
Services Administration (HRSA). It was administered by the Center for the Health
Professions at the University of California-San Francisco. In 1998, the Center for the
Health Professions created Community-Campus Partnerships for Health (CCPH) a not-
for-profit organization that fosters community-academic collaborations. It was charged
with all future evaluation of the HPSISN program. This research was conducted with the
support of CCPH.

**Conceptual Framework**

The research on SL has been criticized for lacking a conceptual or theoretical
basis (Aronson, 2006; Serow, 1997). Rather, the design of much of the inquiry on
sustaining SL has been informed by the accumulated wisdom of SL practitioners. While
this is without question a valid starting point for empirical research, it may nonetheless
restrict inquiry into SL to areas that are already known. Aronson (2006) recommends that to enhance the rigor of research on SL, we apply concepts from related fields. This research applied a conceptual framework from the literature on community-based public health programs. It also adopted theoretical approaches from the literatures on sustaining organizational change and assessing the broad impact of SL.

We structured our inquiry using a conceptual framework for sustainability of community-based public health programs that is helpful to guide a holistic exploration of influences on the sustainability of SL. This sort of exploration has the potential to expand our understanding of the influences on sustainability. Proposed by Shediac-Rizkallah and Bone (1998), this framework identifies three categories of influences on program sustainability: 1) program design and implementation factors; 2) factors within the organizational setting, and 3) factors in the broader community environment. It also identifies the interactions among these categories of influences (Figure 3).

**Theoretical Approaches**

**Defining Sustainability**

While the literature on sustaining SL focuses on the outcome of institutionalization, we used concepts from the literatures on organizational change and community-based public health programs to assess a broader range of indicators of sustainability. These literatures provide three main definitions for sustainability: durability, routinization, and institutionalization. Durability is the simplest and most widespread definition of sustainability. It refers, simply, to program continuation...
(Shediac-Rizkallah & Bone, 1998). As cited in Pluye and colleagues (2004), Scheirer writes that a sustained program is a set of durable activities and resources aimed at program-related objectives (Pluye, Potvin, & Denis, 2004). This definition suggests that innovations can be sustained at the programmatic level, without additional sources of support at the organizational level that would qualify the innovation as institutionalized.

Another popular way the literature on organizational change defines sustainability is the extent to which an innovation has been integrated into, and supported by, the workings of an organization. This concept is described as two degrees of the same process: routinization and institutionalization. According to Yin, routinization refers to the point at which an innovation “has become a stable and regular part of an organization’s routinized activities” (Yin, 1979, p. 55). These are the organizational procedures and behaviors for which sustainable resources are mobilized, including: program planning, creation of objectives, developing rules for operation, allocation of resources, and program monitoring/evaluation (Pluye, Potvin, & Denis, 2004; Pluye, Potvin, Denis, & Pelletier, 2004). For SL these resources would include: assigning faculty and staff to participate in SL, training these faculty and staff, funding faculty participation, identifying educational objectives for SL, integrating SL into the curriculum, and evaluating SL.

Goodman and Steckler (1989) use the term institutionalization to include the same indicators of sustainability, and add the existence of policies, infrastructure, and institutional priorities that support the innovation (Goodman and Steckler, 1989). In the case of SL, these would include hiring, promotion, and tenure policies that recognize SL and infrastructure to support SL, such as a SL coordinating center. Goodman and
Steckler (1989) describe institutionalization as a process of “mutual accommodation” between the innovation and the organization. Other authors highlight how an innovation is institutionalized when it has been imbued with institutional value: “It is when the structures surrounding a change also change to support it that we say that a process is ‘institutionalized’ – that it is now part of legitimate and ongoing practice, infused with a value and supported by other aspects of the system” (Kanter, 1983, as cited in Goodman & Steckler, 1989). These three definitions of sustainability – durability, routinization and institutionalization – reflects the understanding that sustainability is not an endpoint, as may be suggested by the term “institutionalized,” but is, in fact, a matter of degree.

**Defining Impact**

We structured our inquiry into the impact of SL following an assessment method proposed by Gelmon and colleagues (Gelmon, Holland, Driscoll, Spring, & Kerrigan, 2001). They define the impact of SL in terms of the stakeholder groups that may benefit from, or be affected by, SL, including: students, faculty, SL staff, the staff members of partnering community agencies who are directly involved with SL, and more broadly, the participating academic institution and community agencies and the communities served by these agencies. We followed this definition of impact.

**Sampling Strategy**

The interview sample was designed to provide information on the experiences of each of the HPSISN-supported SL initiatives for the entire time period from 1998 until these data were collected in 2007-2008. It was also designed to capture information on each of the categories of interest in this research: sustainability, program design and implementation, organizational traits, influences in the broader environment, and impact.
To create this sample, we used a combination of purposeful and snowball sampling. Each of the 17 original principal investigators from the HPSISN program was invited to participate in an interview. When an interview participant could not answer all of the interview questions – for example, if he or she had left the institution or was no longer directly involved in the SL initiative – snowball sampling was used. The participant was asked to recommend one or more individuals at the institution who could answer the remaining questions and might like to participate in an interview. In each of these cases, one individual who could provide the needed data was invited to participate in an interview.

**Data Collection**

A semi-structured in-depth interview guide was developed for use in all interviews (Appendix D). Interview questions reflected the review of the literatures on the sustainability of SL, impact of SL, and related literatures on organizational change, community partnerships for health, and CBPR, as described in Chapter 2. All interviews were conducted over the telephone and most lasted between 60 and 90 minutes.

This research was exempted by the JHSPH Institutional Review Board as Not Human Subjects, because participants were speaking about their regular professional activities (JHSPH IRB-1 Protocol #211). However, each participant received a disclosure statement describing the study purpose, design and procedures; risks, benefits and protections; anticipated products; and the voluntary nature of his or her participation. All participants agreed to have their interviews tape recorded.

Key documents were also collected and reviewed to shed light on these 17 SL initiatives. To begin, the investigator reviewed documents about the HPSISN program,
including a published evaluation of the implementation and early outcomes of HPSISN (Gelmon, Holland, & Shinnammon, 1998) and peer-review articles describing the implementation of HPSISN and 1998 evaluation findings (Gelmon, Holland, Seifer, Shinnammon, & Connors, 1998; Gelmon, Holland, Shinnammon, & Morris, 1998; Seifer, 1998b).

The investigator also reviewed documents about the 17 HPSISN-supported SL initiatives. HPSISN principal investigators from nine of the HPSISN-supported SL initiatives had authored case studies of their initiatives for an edited collection, and these case studies were reviewed (Seifer, Connors, & Seifer, 2002). Additional documents that were reviewed included: 1) the biographies or curricula vitae of the interview participants; 2) the websites of the institutions, their SL initiatives in health professions education, and the department(s), school(s), or college where SL in health professions education was located; 3) newsletter or newspaper articles about the SL initiative, and 4) academic publications that featured the SL initiative. Newsletter and newspaper articles and academic publications were located via the institutions’ websites and electronic searches using Google, Google Scholar, and PubMed. Interview participants were also asked to recommend other publications about SL at their institutions, and to send copies or identify where these could be located. Whenever possible, these documents were reviewed before the related interview or interviews in order to inform the interview questions.

**Analytic Approach**

Transcripts were analyzed using thematic coding and memo-writing (Morse & Richards, 2002). With one exception, interviews were professionally transcribed and
codes were developed to identify the major themes that emerged. One interview was not transcribed at the request of the interview participant. To analyze this interview, the study investigator listened to the audio recording and took notes on the major themes that emerged.

Coding followed a combined deductive and inductive approach (Miles & Huberman, 1994). A “start-list” of deductive codes reflected expected findings based on the literatures on the sustainability and impact of SL and other forms of community-academic partnerships, as described in Chapter 2 (Miles & Huberman, 1994). The study investigator read all of the transcripts, and applied this original set of codes. During this process, she revised some of these codes to reflect an emerging understanding of the data, and created new codes to reflect themes that emerged from the data. Some interviews were coded by hand, while others were coded using NVIVO qualitative data management software (version 7, QSR International, Cambridge, MA). As a result of this process, a final codebook was developed that included 42 codes and sub-codes (Appendix E). These codes were then re-applied to the entire set of 22 transcripts using “low-tech” methods that involved cutting and pasting passages of text into Microsoft Word documents for each of the 42 codes and sub-codes.

Other methods were also used to develop this analysis. Memo-writing was used to develop an understanding of emerging themes and to help identify the relationships among themes. Documents, including notes on the one interview that was not transcribed, were reviewed to clarify or supplement the content of study interviews. Finally, the investigator read extensively from the literature on sustaining SL in higher education to inform the emerging analysis.
Findings

Sample Characteristics

Our sample included 23 participants, including 16 of the 17 original HPSISN principal investigators and seven individuals identified through snowball sampling. Of the 16 principal investigators who participated in interviews, eleven were still affiliated with the HPSISN institutions; of these, nine were able to complete all interview questions about SL at these institutions. For the other seven institutions, a second individual was recruited to participate through snowball sampling. These seven individuals included 5 faculty members and 2 SL directors. One institution declined to participate in interviews.

Sustainability of SL and Correlations in the Organizational Setting

As summarized in Table 3, of the 16 SL initiatives that were described by interview participants, only one was not sustained. Of the other 15, three had reached a level of sustainability that could only be classified as durability, five had been routinized, and seven had been institutionalized. The one institution that did not sustain SL continued to recommend extracurricular service, and it had extensive resources to support student involvement in service. It also incentivized service by recognizing service in dean’s letters, which were issued to students on graduation as recommendation letters. However, no curricular or extracurricular SL existed.

At the three institutions where SL fell into the category of “durability,” SL continued to be offered through elective courses or required co-curricular service experiences, but it was maintained only through the efforts of individual faculty members. If these faculty members were to leave these institutions, SL might not continue. At these institutions, there were also no resources to support faculty
participation in SL. Nevertheless, at each of these institutions SL had been sustained continuously since HPSISN ended in 1998 through the efforts of individual faculty members.

These three institutions had a number of traits in common. At all three institutions, there was no leadership for SL among high level administrators in health professions education. In addition, at two of these institutions, there was no support for SL in the university’s mission statement. At all three institutions there was also a strong institutional focus on other teaching methods or goals. For example, one of these institutions was very traditional in its teaching methods, and retained a strong emphasis on didactic learning. Another institution in this group adopted an institution-wide model of problem-based learning, and in that transition, the core course that housed SL was eliminated. The necessity for administrative leadership for SL and the challenge of competing institutional priorities are described in further depth below.

At all five HPSISN institutions where SL was routinized, SL was integrated into required courses. However, there was a wide range of characteristics within this group of institutions, in terms of the scale of SL. They ranged from having one to eight required courses that integrated SL, and these courses served a wide ranging number of students. For example, at three institutions that each had one course that integrated SL, these courses served over 100 students each, while at another institution with eight such courses, there were only about ten students in each course. This variability correlated with organizational characteristics such as what health professions were involved in SL and whether the institution’s main focus was on research on teaching.
Table 3: Indicators of Sustainability and Related Factors in the Organizational Setting, 16 SL Initiatives

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<th>Routinization</th>
<th>Institutionalization</th>
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<td>1 2 3 4</td>
<td>5 6 7 8 9</td>
<td>10 11 12 13 14 15 16</td>
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**Indicators of Sustainability**

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<th>Indicator</th>
<th>Durability</th>
<th>Routinization</th>
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<tr>
<td>SL not sustained</td>
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<td>SL offered in elective course/co-curricular experience</td>
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<td>SL integrated into required course</td>
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<td>SL coordinated at level of the school/college</td>
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<td>SL coordinated at level of the university</td>
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<tr>
<td>Internal funding for SL director or faculty release time</td>
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<tr>
<td>Steering committee for SL in health professions education</td>
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**Organizational Setting**

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<th>Indicator</th>
<th>Durability</th>
<th>Routinization</th>
<th>Institutionalization</th>
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<tbody>
<tr>
<td>University mission supports SL</td>
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<tr>
<td>High-level administrators at university level support SL</td>
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<tr>
<td>High level administrators in health professions education support SL</td>
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<td>Hiring, promotion, and tenure policies support SL</td>
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*NS = Not sustained
Whatever the number of required courses that integrated SL, however, these institutions invested related resources in SL, including faculty time and development of learning objectives for SL. At the three institutions in this group where SL was coordinated at the departmental level, investments included departmental planning processes and, in one case, funding for a full-time SL director. There was a correlation between level of routinization, as indicated by coordination of SL at the level of the course versus department, and factors in the organizational setting. Institutions where SL was coordinated at the level of the department were more likely to have support for SL in the university mission and among high-level administrators than institutions where SL was coordinated at the level of the course (institutions 7-9). At one institution in this group (#5), there was a university-level SL center, which was an indicator of institutionalization in other institutions (#12-16). But faculty members at that institution were not taking advantage of the resources of the center in any coordinated way.

At the seven HPSISN institutions that had fully institutionalized SL, SL was integrated into required courses and received the same related support as it did at institutions where SL was routinized. But at these institutions, SL was centrally coordinated through an office at the level of the school/college. At most of these institutions, there was also a coordinating center for SL at the level of the university. Coordinating offices and centers for SL had full-time, internally-funded staff members who provided technical assistance to faculty who taught courses that integrated SL and who created and maintained community partnerships for SL. At institutions where there was also a coordinating center for SL at the level of the university, the university center provided additional support to the school/college SL office to set quality standards for
SL, provide faculty development in SL, and maintain community partnerships for SL. These institutions also allocated internal funding for a high-level SL director and for faculty participation in SL.

A common trait among institutions that had either routinized or institutionalized SL was that there was almost uniform support for SL in the university mission. But in contrast to those that had only routinized SL, at HPSISN sites where SL was institutionalized, there was also almost uniform support for SL among high-level administrators at the level of the university (6 out of 7) and there was a high level of support among administrators in health professions education (5 out of 7). In addition, at about half of these institutions (3 out of 7), promotion and tenure policies recognized faculty for teaching, community service, or both, and about half of these institutions (4 out of 7) convened steering committees for SL that included administrators, faculty members, students, and in some cases, community partners.

Within the group of HPSISN sites where SL was institutionalized, there was a correlation between level of institutionalization – as indicated by the presence of a coordinating office only at the level of the school/college versus the presence of coordinating entities for SL at both the school/college and university levels – and factors in the organizational setting. Institutions where SL also was coordinated at the level of the university (#12-16) were more likely than others (#10-11) to have support for SL in the university mission, promotion and tenure policies, and among high-level administrators at both the level of the university and in health professions education. This correlation continued the same pattern that was evident among institutions that had routinized SL, which was that increasing levels of sustainability were correlated with
greater numbers of supportive factors in the organizational setting. These and other key factors that supported the sustainability of SL are described in further depth, below.

**What Facilitates Sustainability?**

Participants from the 12 institutions that had routinized or institutionalized SL described many factors that had helped sustain SL over the last ten years, while participants from all 16 institutions described challenges to sustainability. Often, these challenges were the mirror images of the facilitating factors. For example, many participants described how leadership for SL among high-level administrators in health professions education was a key facilitating factor, while others described how the absence of leadership at this level was a major challenge. What emerged from the entire group of interviews were nine main factors that were important facilitators of sustainability.

Almost half of these facilitating factors – four out of nine – were characteristics of the organizational setting. These were: 1) an organizational culture that provided support for SL, particularly as reflected in the institutional mission; 2) leadership for SL among high-level administrators both at the level of the university and in health professions education; 3) material support for SL, including infrastructure to support SL and funding for faculty participation; and 4) the presence of a critical mass of support for SL. Three additional facilitating factors were identified in the design and implementation of SL. These were: 1) the presence of a strong leader for SL who acted as a champion for SL within the institution; 2) the ability to adapt SL to changes in the academic environment – something one participant called “being relevant;” and 3) investing in stable, long-term community-academic partnerships. Finally, two additional facilitating factors were
growing support for community engagement in higher education, including health professions education, and the ability of SL to contribute to achieving institutional priorities. These nine facilitating factors are described in depth in this section.

**Facilitating Factors in the Organizational Setting**

**Institutional Culture**

As described in the summary of the HPSISN program, these institutions varied dramatically in terms of institutional characteristics. Yet across this breadth of characteristics, many interview participants from institutions where SL was routinized or institutionalized described how there was support for SL in the institutional culture. At most of these institutions, the culture was reflected in the institutional mission.

Participants described three institutional cultures that provided support for SL.

Participants from public universities described how their universities had a mission to serve the people of their region, and that this provided support for SL:

“There are a lot of expectations on the part of this campus to serve the people of [the state] that come out of the governor’s office, the legislature and elsewhere. … It’s a factor that influences our behavior as a campus.”

Three Jesuit institutions participated in this research, and interview participants from all three described how their institutions had a mission to provide service to society, and to develop students into citizens who would also provide service as individuals. Both of these institutional priorities provided support for SL:

“I think there was institutional support [for SL from the very start]. And again, I think that may have something to do with the Jesuit nature of the institution. … I think it was part of the overall university’s philosophy that made it something that they were interested in pursuing and supporting.”

“The mission of [the University], and any Jesuit university, actually, is to develop leaders in the service of others. … And I would say that the university has been
committed to finding ways to develop that sense of social responsibility in the students.”

Finally, a third group of participants described how their institutions were located in urban areas where the institutions strongly identified with the local community – “the campus has a reputation of being the city’s university,” said one. They described how their institutions felt a related responsibility to address urban health concerns, particularly health disparities. These participants described how SL was supported by the institutional culture because it solidified the institution’s role in the community and addressed the health of the underserved.

Leadership for SL Among High-level Administrators

Many interview participants from institutions across the spectrum of sustainability described how another important facilitator of sustainability was leadership for SL among high-level administrators both at the level of the university and in health professions education. Participants described how these leaders helped to promote SL with supportive rhetoric and concrete expectations for engagement in SL, and helped sustain SL with instrumental support.

Participants described how the vocal support for SL from the university president and deans contributed to an institutional culture that helped to sustain SL in health professions education:

“When [the university president] is speaking about his priorities and strategies, service-learning, service to the community, [and] working closely with the community have been in just about every speech and every strategic plan. And so… it behooves the colleges to also have that be a priority.”

Other participants described how the university president had provided support or incentives for the schools and colleges within the university to engage in SL. One
participant described how it was the university president who encouraged the dean of her college to institute a service-learning requirement for the whole college. Another participant described how the university had created expectations for community engagement for each college:

“Each school is responsible to identify, and report on, the ways in which the faculty and students are involved with the community. … I think the fact that it is something that is valued at the university level -- the university puts scarce resources there and calls for reports, which is, ultimately, the reminder that people are focused on it – has really helped keep service-learning in the forefront for schools.”

Many participants also described how high-level administrators provided instrumental support that was essential to sustain SL. They described how provosts, deans, and department chairs who were supporters of SL had provided matching funds for SL grants, used discretionary funds to establish interdisciplinary SL courses, ensured that faculty who were providing leadership for SL had release time to do this work, and created infrastructure for SL at the school/college level, creating staff positions to support SL, or SL centers. Many described how these financial commitments were critical to sustain faculty participation in SL.

Many participants described how deans and department chairs had helped to sustain SL by cultivating support for SL among other decision-makers. One assistant dean described how she provided this leadership:

“I was able to evaluate the program and look for ways to get it integrated into the academic health center in more meaningful ways that could promote its identity and visibility within the school.”

Some participants who were mid-level champions for SL at their institutions described how the support of their deans also was essential to sustain SL because it “gave [them] permission” to devote themselves to this work. One described how the support of
a number of deans at his medical school created an “environment that allowed people
[like me] to be professionally successful doing this type of work.”

The importance of leadership for SL among high-level administrators was also
evident in the stories of interview participants from institutions where SL had not been
routinized or sustained. All of these participants described a leadership vacuum for SL in
health professions education:

“I think there is no one or no one organization on campus that is focusing its
efforts on promoting service-learning in health affairs. … It’s a little bit
disappointing that it’s perfectly well accepted, and our dean talks about service,
and talks about service-learning, but the money isn’t where the mouth is, so to
speak.”

Institutional Investments in SL: Funding and Infrastructure

Interview participants from institutions that had institutionalized SL described
how material support had been important to sustain SL, and described how two sorts of
material support were particularly important: an internally-funded SL center with staff
who could provide technical assistance and faculty development for SL, and the
availability of funding for faculty participation in SL. Some participants described how
this financial support for SL demonstrated their institutions’ true commitment to SL:

“[The university and the college] cover all of the salaries for all of the service-
learning coordinators in the university. And all of their offices and assistants and
all of that is provided for by the university. … We don’t have any private
funding for this or outside grants or anything. … It’s the number one mission of
the university and … they walk the talk.”

At all of these institutions, SL was coordinated out of the office of the dean of the
school or college. Participants described how a coordinating center for SL at this level
supported participation in SL by faculty members, students, and community agencies.
Many described how these centers enabled faculty members to stay involved with SL,
because they could focus on teaching, and not become “overwhelmed” or “burned out” from having to also maintain community partnerships. Of equal importance, the center could maintain these partnerships regardless of faculty turnover. One participant described how the SL center at his college maintained community partnerships for SL:

“Ultimately what they’re responsible for is to keep those connections. So they do a lot of the communication. So if we need to have a meeting with the community partners they coordinate that, and they communicate … to the partners to let them know what’s happening at the college, who the students are [that] they’re going to have. They help work with the students to make sure that they get a community partner that they want to work with. … But they’re there as supportive staff to take some of that burden off for the community partners. And the partners like it because they’ve got somebody they can call. … And I think that for sure helps with the sustainability of the [service-learning] courses.”

Many participants also described how SL centers either at the level of the school-college or the university also supported faculty participation in SL by providing training in SL for new faculty, technical assistance for faculty teaching SL courses, and ongoing opportunities for professional development. A number of interview participants described how this support was critical to sustain SL, because it was not easy for faculty to implement SL for the first time:

“It’s not easy. It’s very difficult for some faculty to think about how to do that; … and that they do need support and training and kind of mentorship in that particular role. You just can’t say, “Oh, make a part of your class service-learning.”

University-level centers also provided important instrumental and financial support to sustain SL. Participants described how these centers created quality standards for SL courses, and provided turnkey resources for SL, including pre-existing community-academic partnerships that could be used for SL in health professions education, and resources to support SL teaching methods, such as reflective practice. One participant described how the university-level SL center made a small grant to her
college to help it establish a college-level SL center, which still exists. Other participants described how their university-level SL centers provided stipends or fellowships to faculty members to engage in SL:

“[The university SL center] also had the opportunity for community fellowships, so that if a faculty member wanted to use the vehicle of service-learning and add additional work, then they had the opportunity for a faculty grant to do that. That gave an extra bonus, as it were, to service-learning. … You could become a service-learning fellow and have the opportunity for some support of your work where you could have a course release, and spend some time with a community agency developing a more robust community service-learning experience. And [you could] then carry it back into your course after the fellowship ended.”

Availability of funding for faculty participation in SL was mentioned by a number of participants as important to sustain SL. They described how SL took more time than traditional teaching methods, and it was important to acknowledge this with financial support, rather than implicitly requiring that faculty members add SL to their current workload without compensation:

“One of the recommendations we made was that faculty teaching the service-learning courses needed to have recognition for this because these five courses took on an additional task. … So now when they are assigning coursework, someone teaching the service-learning course has an additional ten percent of their time acknowledged because of it being service-learning.”

A Critical Mass of Support for SL

Organizational culture is also shaped by the members of an academic institution, including faculty and students. Many interview participants from institutions across the spectrum of sustainability described how another critical factor in sustaining SL was the buy-in of these members of the academic institutions. Many participants said that faculty buy-in was vital to sustain SL because faculty members were ultimately responsible for incorporating SL into the courses they taught. Even at institutions where faculty were
assigned to teach core courses that included SL, buy-in was important to ensure the quality of SL, which ultimately contributed to its sustainability.

Other participants said that faculty members’ buy-in was important because they could act as program champions who could convince other members of the institution of the value of SL:

Q: “What do you think have been the most important factors to facilitate sustainability of the [SL] program, in particular?”
A: “The most important [is]… the quality and doggedness of… many of the faculty who got engaged in service-learning a decade or so ago. These are people for the most part who are highly respected faculty members, junior faculty all the way up to some very, very senior people…. You get that core of people who just believe in the value of service-learning and they tend to influence others, particularly when they are not seen as outliers. They’re seen as really solid, top-notch faculty types.”

Participants described how these champions in the middle of the organizational structure could create a climate of support for SL both among the administration and among students.

A number of participants also identified an important role for students as champions for SL who could convince faculty members, community partners, and other students of its value:

“I think the best, the most telling advocates are the students themselves, because I think they find this incredibly valuable. … So I think certainly having them as promotional agents is probably a valuable thing to get [service-learning] sustained. And they might be the best advocates of demanding that this happen.”

Q: “You said that students’ moving comments [about SL] were influential. Influential on whom and with what effect?”
A: “Well, I think influential on whoever heard the comments. So if those were shared with other faculty, faculty would say, ‘Gee, they really had a great insight when they visited that resident in that home, and now they’re thinking about aspects of death and dying and things that maybe they wouldn’t have thought on their own.’ So it showed faculty the positive things that were happening to students. And when other students heard students talk about what they experienced, they were also impressed with, ‘Gee, I never thought of life that
way,’ or, ‘I never thought of healthcare in that fashion, or death and dying.’ And also sharing that with the community partners, the community partners then realized that students [were] gaining a lot in their agency [and] could share that [perspective], maybe, with some of their employees who were working there.”

Participants from three institutions described how students had provided leadership for SL. At one institution, students created the university-wide SL center. At the other two institutions, students created new alternative spring break SL opportunities. Participants from two other institutions described how, in their experiences, community partners were also effective advocates for SL.

Still other interview participants stated that what was important to sustain SL was not the presence of champions in any one stakeholder group, but instead, a “critical mass” of support for SL. One participant described a “triangle” of support for SL involving administrators, faculty, and community partners. Others described this critical mass as including administrators, faculty and students. What became clear from the group of interviews was that buy-in from all four of these stakeholder groups was important to sustain SL.

Facilitating Factors in the Design and Implementation of SL

A Strong Leader for SL

Participants from the institutions that had institutionalized SL, and at the one institution where SL was routinized but had a SL director, described how having a strong leader for SL was important to sustain SL because this individual could cultivate support among high-level administrators and faculty members, and provide leadership to maximize the quality of SL:

“I think that one of our reasons for our level of success would be that there’s a warm body hovering over this, and showing up at meetings of preclinical course directors, and sending emails to all the faculty, and going to department meetings...
to show the dog and pony show and recruit people. One person, I think, needs to be responsible for that, not even a team, because the buck has to stop at somebody’s desk to be successful.”

A number of interview participants described how they, personally, filled this role. Some interview participants organized symposia to share information about SL with other faculty members and provided technical assistance to faculty members in health professions education and other unrelated disciplines to support them in implementing SL. Others described how their goal was to cultivate support for SL among high-level administrators:

“Being on their radar screen, so to speak, and not being afraid to say, ‘hey, look at what we did, and what we’re doing,’ and always keep[ing] it on their screen. … You’re always letting them know projects that you’ve undertaken and the success of those.”

A number of participants described how they went to the top administrators at their institutions and successfully advocated for internal funding for SL when the HPSISN grant ended:

“I actually met with the deans of the school of medicine and the school of public health, and with the dean of the nurse practitioner program, and we got them to commit real dollars so that the [service-learning] program could continue after the grant funding ended. I remember, specifically, the meeting where we had all three deans in a room. We got them to agree to financially support the program.”

Still other participants spoke about how, as the directors of SL, they advanced SL by “pushing the limits” in terms of identifying creative ways to integrate high-quality SL into the curriculum.

Adaptability

Among interview participants from institutions that had routinized or institutionalized SL, a common statement was that SL had to be able to adapt to change in order to be sustained. Participants described how changes in leadership and turnover
among faculty could put SL in jeopardy, and changes in educational goals could shift
attention and financial support to other forms of learning, and away from SL. The key to
addressing these threats, they believed, was to be able to adapt SL to changes in both the
academic institution and the community, so that SL retained its value for everyone
involved:

“You know, being relevant is the most important thing you could do. … I mean
being relevant in the community, and being relevant with what’s going on in the
institution in terms of education. … Everything is changing all the time. So you
can’t just sit on your laurels. You’ve got to continue to grow and change if you’re
going to have a meaningful part in education and in community. … I mean, it’s
an organic process. And I think too many times, we think you develop a
curriculum and you get it to work, and then you just sit back and let it continue.
And you can never do that with anything if you want it to work.”

Participants described how one important responsibility of the SL director was to adapt
SL to teach to changing educational objectives:

“We’re always assessing what the students’ [experiences] are. We get feedback
from the student experiences, we get feedback from the faculty about the student
experiences, we get feedback from the community about the student experiences.
That information all goes into deciding what we need to change. And to go with
it, the major emphasis over the last few years has been on improving cross-
cultural skills and addressing some of the health disparities. … We did focus
groups in the community to find out what community residents and partners
wanted our students to be learning as well as talking to our students and faculty
about what they should be learning.”

Along with the interview participant quoted above, a number of other participants
described how they had adapted the content of students’ SL projects to teach students
about “hot topics” in health professions education:

A: “We’re trying to educate the students about the concept of a medical home and
an electronic medical record. And so for the students that work in community
sites where there are patients – for example, the clinic where the homeless men
are seen – we will instruct the medical students about how to help homeless
patients, in this case, keep track of their medical records. One of the other things
… is to teach medical students to teach end users how to be a good patient: … the
questions you should ask, how do you find a surgeon. You know, questions that
people have but they may not ask their own doctor and they may not have somebody in their social circle to ask. So that would be one of the things that we plan to do.”

Q: “It sounds like you’re using service-learning to teach to ‘hot topics’ in the field.”

A: “Well, it’s growing into that. … But ‘hot topics’ are starting to be the request of our community partners, and that’s … what’s driving what the students get.”

Both of the two quotes above describe how SL projects could be successfully adapted to appeal to both academic and community priorities.

Other SL initiatives developed a focus on an important community health issue, which also solidified the value of SL at the institution. For example, one SL initiative focused on the health of the growing local Latino immigrant population, and allied itself with a high-profile health disparities center on campus that focused on Latino health. A second SL initiative “carved out an identified niche” as a specialty program on underserved populations in its urban area. The local health department looked to the SL director as a resource for policymaking on care for the homeless, and this created added value for SL at the institution.

Stable, Long-Term Community-Academic Partnerships

The third and final aspect of the design and implementation of SL that participants cited as important to sustainability was the creation of stable, long-term community-academic partnerships. Interview participants from almost every institution that routinized or institutionalized SL cited this as a contributor to sustainability. They also identified a few factors that contributed to the creation of these stable-long-term community-academic partnerships. Many participants stressed the importance of having a SL director who had the time and skills to develop and maintain “personal
relationships” with staff at community agencies. They described how these interpersonal relationships could foster long-term commitments from community agencies.

Interview participants also described aspects of the partnership process that were critical to good community-academic relationships, including ongoing communication, reciprocal benefits, and equity. All of these principles were demonstrated in a comment made by a number of participants who were HPSISN principal investigators or SL directors that they asked community partners how SL could be more meaningful for them. Other participants described how they had implemented principles of reciprocity and equity by using HPSISN grant funds to support community partners’ capacity to fulfill their organizational missions and provide leadership in the SL partnership:

“I think initially, with the grant, it was a wonderful opportunity to offer services to the community agency, and to have them be part of this partnership. I think somebody from hospice went to one of the [HPSISN] conferences with [the principal investigator]. I know we were able to purchase a computer for the teenage moms programs. The initial grant funds were very helpful in solidifying that [partnership].”

A: “I used a lot of our [HPSISN grant] resources to support community partners to attend [HPSISN] meetings.” …

Q: “What do you think was the result of your involving community partners as much as possible in those meetings?”

A: “I think that also probably contributed to agency buy-in. Because … not-for-profit organizations are shorter on resources than universities are. … And even for me to cover airfare … showed that there was a commitment on this end to try and continue that partnership.”

Interview participants also described how a crucial element to sustain community partnerships for SL was the reliability of the academic institution. Participants described how academic partners for SL had to demonstrate their commitment and reliability over the long-term in order to develop trust:
“The important thing with partners is showing them our commitment and our stability. … That we’re not going to be there with one group of students and then we’re out of there. You know, we’ll have another group come, and then another group, and that group builds on what that group before them did, etcetera. And I think that our reputation in [the city’s] communities is based on that kind of commitment and stability. So other agencies see what we’ve done and what we’re doing with agencies and the word’s out. … [Our SL director] probably gets called every day from agencies saying, ‘we heard that your students are doing this, this and this for this agency. Is there any possibility of your doing that for us?’ … The community partners know and trust that we’re going to follow through on things.”

Participants also described how they put in place a number of measures to enhance the stability of these community partnerships:

“We were very, very purposeful in making sure that whoever we were bringing on and partnering with, they were committed to the long haul as much as we were. Sometimes those staff people in the community partner will change, but there’s the history of the relationship that’s very important. We have memorandums of understanding that solidify the relationship, we have multiple workshops, professional development opportunities. … We have regular site visits by the [service-learning] director. The community partner will come to the monthly [service-learning program] meeting on campus, or they have it out in the community.”

Finally, a number of participants also described how a champion for SL at a community partner agency could maintain the SL relationship, even if there was turnover in the job position that was responsible for the day-to-day maintenance of the partnership. By developing interpersonal relationships, SL directors were more likely to cultivate these champions for SL at community agencies.

Factors in the Broader Academic Environment

In addition to factors in the organizational setting and the design and implementation of the SL initiative, participants described how the climate in academia was also evolving in such a way that it was helping to sustain SL. Participants cited two main sources of support for SL in the broader academic environment. The first was
growing support for community engagement in higher education, in general, which translated into greater support for SL on their campuses:

“There’s been a sea change – and that’s the right word – in attitude about service-learning since the beginning of the HPSISN grant and now. So that what I am happy with is, the barriers to creating service-learning courses that we faced so dramatically ten years ago, we don’t see that anymore. And chairs and deans – all of our deans, as far as I know – are very supportive of service-learning, and that was absolutely not the case a decade ago. So that has changed. So I’m optimistic over time that we’re going to see ever-increasing numbers of service-learning courses on the health side again. … You just don’t hear the way you did a decade ago of department chairs actively discouraging faculty from creating service-learning courses. As I said, it’s been this sort of attitudinal change and with it, disincentives [to engage in service-learning] have decreased enormously around here.”

Participants from a number of institutions also described how accreditation guidelines had helped to sustain SL. One participant described how his institution had written SL into its approach to fulfilling new pharmacy accreditation guidelines:

“The college had to increase their early professional experience and their advanced professional experience and they’re still trying to add to both of those to remain in compliance with being accredited. … But the service-learning, I think, lends itself very well to that. … It’s not to say that a college of pharmacy couldn’t still provide early professional experience and not do service-learning, but we’ve chosen to use that as a method to train our students, and we’ve made it work for us, and told the powers that be that that’s how we do it. So that’s how we do it.”

Interview participants in nursing described how the National League for Nursing Accrediting Commission (NLNAC) accreditation guidelines established in the late-1990s introduced optional outcomes that nursing programs could address, and service was one of these. As a result, these programs also wrote SL into their curricula:
“In 1999, part of the criteria for accreditation included some things that you had to address, such as your pass rate, and program satisfaction, and critical thinking – that kind of thing. But there were some optional outcomes that a program could elect to address, and service was one of those. Because we had the HPSISN grant, we elected service as an optional outcome for part of the accreditation process. As a result of that, we wrote a service outcome within our formalized curriculum. That’s a core component of our curriculum.”

Finally, two interview participants described how their institutions were in the process of applying for the Carnegie Endowment for the Advancement of Teaching elective classification for Community Engagement. (Two other institutions in the HPSISN cohort already successfully earned this classification.) These participants described how their institutions had increased their investments in SL in order to meet the classification standards, because they saw it as a “vehicle” for community engagement.

**Proven Impact: SL Advances Organizational Priorities**

Finally, interview participants from institutions that had institutionalized SL and two of the institutions that had sustained SL described how a factor in sustaining SL was the proven ability of SL to advance organizational priorities. They described how SL helped to achieve three specific priorities. It helped to achieve educational objectives, recruit students, and improve “town-gown” relations and, as a result, the reputation of the institution.

As described above, a key to the sustainability was that SL was used as a teaching method for valued educational objectives. In addition, a number of interview participants described how students told them that they chose to attend their institutions because of the opportunity to participate in SL. In addition, a number of participants reported that
their institutions had understood the value of SL to recruit students, and had even developed marketing campaigns that highlighted SL:

“Other interesting things come up [for the service-learning center, like], how can we work with the marketing department? I think for two years that was our goal, to inform them about service-learning and for them to be able to use that as a marketing tool … because not all schools offer that.”

A number of participants described how their institutions valued SL because it contributed to improved “town-gown” relations. One participant described a wide-ranging community-academic partnership to support economic development in the local neighborhood around the campus and improve the relationship between the academic institution and the local community. SL was incorporated into this initiative as a way to provide direct service to the community:

“As universities grow they sometimes take over their neighborhoods. And that’s what was happening in the [local] neighborhood, was that the university was taking over a space. And the neighbors were not actually excited about that. So the [broader] partnership there was so that the neighborhood had some opportunity for input into the ways the university would grow, and also to provide some opportunity for the neighbors to have access to university services [which service-learning contributed to].”

Finally, a number of participants described how their universities also valued SL because it contributed to good press for the institution, which could, in turn, improve the reputation of the institution and help to raise funds from a number of sources:

“We got a lot of recognition for the types of things that our students do [through service-learning]. And we get a lot of publicity in not just the university community, but we’ve had a lot of really good write-ups about nursing students and our health care students doing projects out in the community in the [city] papers.”

A: “I think the institution has realized … the PR value or the social marketing value of the institution is enhanced because of these [service-learning] activities.”
Q: “When you say the PR value, who’s the audience for that PR?”
A: “Alumni, primarily. Also the local government. There’s a tremendous need on the part of institutions to eradicate the town-gown conflict. This is one strategy from an institutional level that says, ‘We’re doing our part.’” It had added
value because there’s a possibility that by promoting the institution as a good community partner, then there could be contracts and different city funding opportunities that come down the pike.”

**What Are the Challenges to Sustainability, and What Are Effective Responses?**

Institutions across the spectrum of sustainability also identified challenges to sustainability. Three major challenges emerged, all of which fell in the category of the organizational setting. They were: 1) turnover among faculty members who teach using SL, 2) turnover among champions for SL among the administration and faculty members, and 3) competing educational priorities. Participants also identified two effective responses to these challenges: providing periodic professional development opportunities for faculty and marketing SL internally to opinion leaders and faculty members. These challenges and responses are described in depth in this section.

**Turnover among Faculty Members**

An important challenge described by interview participants from SL initiatives that ranged across the whole spectrum of sustainability was the loss of faculty members who taught using SL, due to turnover. Participants at institutions where faculty were assigned to teach core courses that integrated SL described how new faculty who did not have skills for SL produced lower quality SL experiences, which in turn, affected the sustainability of SL:

“When we started [service-learning], we had a cohort of faculty who were absolutely committed to community engagement in service-learning. And over time you have turnover. … Since [service-learning experiences are] integrated into the courses, people engage in service-learning. But because it’s an assigned part of the course doesn’t mean that the faculty member understands [its] philosophy or the community partnership aspect. So perhaps the biggest struggle is working with faculty to make sure that service-learning is implemented not just as a course assignment where students are in the community, but in full partnership.”
Interview participants from institutions where SL was integrated into courses at the discretion of faculty members described how turnover among faculty could lead to the decline of SL in a department or school, particularly because new faculty members typically had many other responsibilities to worry about, and “augmenting” their courses with SL was not a priority. Another concern was that some new faculty simply would not “buy-in” to SL, because the pedagogy was too unfamiliar to them:

“… because you’re asking physicians who were trained twenty years ago to work with students either in terms of doing community-level health education, which they have no experience with, or even home visiting, which the … preceptors are uncomfortable doing.”

**Responses to Faculty Turnover**

Some interview participants described how faculty turnover at their institutions was an insurmountable challenge to SL, and at their institutions SL was in decline. But other interview participants described how their institutions encountered this challenge and responded successfully by creating multiple opportunities for faculty development in SL. Participants described various ways their institutions provided this training. At a nursing school where faculty were assigned to teach courses that include SL, the SL director for nursing described how, “I have materials that I give to all of the new faculty, and meet with them, and help them to get their course up and running.” She also relied on her university-level SL center to train new faculty members. It provided a day-long faculty training in SL each semester.

Another participant described how, as SL director, she participated in faculty retreats where she gave workshops on SL, and sometimes included community partners as co-teachers.
She also described how she had increased the success of these trainings by involving faculty members as co-trainers. She described how peer-to-peer outreach among faculty members helped new faculty to more readily understand how SL was relevant to their course content and educational objectives.

A third interview participant described how her school implemented a one-year initiative to train new faculty in SL, after realizing that there had been dramatic faculty turnover:

Q: “How have you addressed that challenge of training new faculty?”
A: “We do it as a part of faculty orientation to new courses. But we also do it as a part of a … specialized training program that went across a year. That was about four years ago. Because we realized that probably about 60 percent of original faculty had left, and we had only 40 percent remaining. Sixty percent new people might not have the full understanding [of service-learning]. So there was a year-long dialogue about service-learning [among] the faculty and [we] updated [service-learning] resources. That was very useful in terms of recommitting to service-learning. … It was a one-time thing. I think it will be regular, but it’s prompted by changes in faculty, and it hasn’t been needed [again] at this point.”

This ability to provide faculty development was not available to all participating institutions. It stemmed from the presence of a coordinating center for SL, which was only present in institutions where SL was already institutionalized.

Loss of Champions among Administrators and Faculty

Another challenge to sustaining SL mentioned by interview participants from SL programs that ranged across the whole spectrum of sustainability was the loss of champions among high-level administrators and faculty members. One participant described how this led to the cancellation of SL activities in a core course at her school:

“In an institution like a medical school, course directors have a lot of power. … If you get a new course director who doesn’t understand, and who isn’t willing to listen, a lot of damage can be done. And that’s how some things disappeared.”
Another described how the loss of a champion who was an assistant dean led to significant drop-off in faculty and student participation in SL:

“I can tell you that you can draw a direct correlation between when that physician champion … resigned and left the institution [and] the drop-off of not only physician participation, but medical student participation.”

At another institution where the SL initiative only fell into the category of durability, the interview participant described how new leadership at the top redirected the focus of the institution from teaching to research, and resulted in the departure of a whole cohort of faculty members who were involved in SL: “There's a new dean. And a lot of the faculty that were involved in this have moved on. It was a new day at the school.”

*Competing Educational Priorities*

Another major challenge that was experienced by SL initiatives from across the spectrum of sustainability was competing educational priorities. As described above under the section called “Adaptability,” some institutions were able to adapt SL to teach to new educational priorities. But in other cases, these priorities were perceived as too different from SL to make this possible. A number of interview participants described how SL initiatives that were once strong were marginalized because, although decision-makers at their institutions “do recognize the value of service-learning,” SL was not seen as central to teaching two core skill sets at the center of most health professions education: clinical care and research. High level administrators were interested in investing in educational innovations that they believed were more closely related to these learning outcomes. For example, a participant at a school where SL was routinized but only existed in one required course without any departmental support, described how the school’s major educational priority was to renovate its nursing skills labs to create a high-
technology patient simulation center, and that SL was extremely peripheral in comparison.

Many interview participants from institutions where SL was durable or routinized described how a growing emphasis on teaching research skills was a major challenge to sustaining SL. Interview participants at two of the institutions where SL fell only into the category of durability said that the main reason for the absence of leadership for SL was that high-level administrators prioritized teaching hard science and research skills. One participant from a school where SL had been routinized but was now in decline – as measured by student and community participation and the hours of SL included in students’ schedules – described the challenge of protecting SL in the face of a growing focus on teaching bench research skills:

“The school started research requirements for medical students and I think what [the school] was talking about … [was] probably a lot of biomedical type frontline research that gets you a lot of money and publicity and so on. … [T]o get students to get involved with various scholarly projects [the school] gave a lot of incentives for students to do different kinds of research with their faculty. So students are given summer research money. They are given different types of incentives, a stipend to do research in who’s-and-who’s lab. And most of it is very biomedical, very science-based, very bench type research. And we don’t have any stipend to entice students to do more community-based projects. So the number of students dried up. … And then couple that with not having enough faculty with a lot of [community-based] research [experience]. If I’m at an institution where there’s a lot of faculty doing community-based participatory research that’s exciting and well funded and all that, then I think students will be interested in coming to those faculty, will seek them out and get involved. But we don’t have that here. … I feel that the whole idea of service-learning in terms of institutionalizing it and exposing more students to it, I think that has been lost, has gone.”

A related challenge was that in some health professions, such as nursing and medicine, curricula were so prescribed, and schedules so full, that there was little time for SL. One participant described her own school, where SL was only integrated into one
required course, as follows: “within a nursing program, in particular, it’s so lockstep that it is difficult for students to have the time to do [service-learning].” Another described how SL was changed from a required to an elective experience because of students’ tight course schedules:

“We went from a five semester to a four semester curriculum to expedite meeting the shortage of nursing supply. And so, when we went to a four semester curriculum, it really condensed things and intensified. And so the administration was getting a lot of rumbles from students that service-learning just was one more additional thing that they didn’t need. And so the task force studied for two years. And the task force was very supportive of service-learning. Everything they learned about it they liked. [But] ultimately, they recommended that it be voluntary, that there not be courses that require it, so that the students didn’t feel like they were just being asked to do more than they could feasibly do.”

The same compression of schedules was a challenge in a participating medical school, and also resulted in a reduction in the time allocated to SL.

Responses to Loss of Champions and Competing Educational Priorities

Some interview participants reported that a loss of champions for SL among the administration and faculty at their institutions was devastating in terms of its impact on funding for SL, the integration of SL into core courses, and the presence of a critical mass of support for SL. Others reported the same impacts resulting from competing educational priorities. At institutions that were unable to respond to these challenges, SL had declined in terms of hours of SL in the curriculum and participation among faculty, students and community partners.

But at other institutions, SL initiatives found a way to address these challenges. Interview participants described how their SL initiatives had engaged in vigorous internal marketing to decision-makers and faculty members to convince them of the value of SL. These efforts had two specific goals: 1) to cultivate new champions for SL among high-
level administrators and faculty members, and 2) to establish SL as a means to achieve the institutional priorities described earlier: educational goals, student recruitment, improvements in “town-gown” relations, and improved public relations, with related benefits for fundraising.

Rather than attempt to compete directly with priorities such as research and simulation labs, champions for SL described how this internal marketing was designed to demonstrate how SL could achieve other educational objectives that were equally important, such as developing students’ skills for interdisciplinary teamwork, cultural competency, civic professionalism, community-oriented primary care, community-based research skills, and communication skills for patient interactions. For example, one participant described how an interdisciplinary SL initiative successfully created a valued niche at its institution by demonstrating how it trained students in skills for interdisciplinary teamwork. It used student evaluation data to provide evidence that SL was training students in this skill set – something no other training experience at the institution offered. In doing so, it both created a new educational priority for the institution and secured the value of SL at the institution:

“I think that the unique nature of the interdisciplinary work [students did through service-learning] was fairly groundbreaking for the school of medicine. It helped the senior leadership start to appreciate what interdisciplinary experiences can do for medical students. ... The medical school dean said, ‘This [service-learning] is great, because it really helps our students have experiences around interdisciplinary work.’ That recognition on the part of the senior leadership of the medical school was a key factor [to sustain SL].”

This SL initiative also attempted to solidify its foothold at the school by marketing SL to the directors of elective tracks. These tracks were highly valued at the school as a draw for prospective students. A high-level champion for SL spoke with the track directors
about how incorporating SL as a required component of their tracks could better achieve their educational goals. While this effort has not yet been successful, it is another example of how internal marketing can work to create new champions for SL.

Interview participants described a number of strategies for internally marketing SL. One was to use internal media, such as institutional newsletters and newspapers, as well as external media, to highlight the benefits of SL to students and community partners and spotlight the work of the institution in the community, through SL. Another was to identify high-level administrators who already had some favorable inclination toward community engagement, and focus energy on educating them about the benefits of SL, essentially cultivating them as champions who could influence other decision-makers.

Two interview participants who were champions for SL at research-oriented institutions described how, recognizing the power of data at their institutions, they rigorously evaluated the outcomes of SL in order to demonstrate its value:

“When we started with this program, we knew we had to evaluate the heck out of it at the individual level, at the group level, at the team level. We evaluate the student experience. Was it valuable for their learning and their professional goals? We evaluate the faculty member experience, the community member experience. We have a curriculum … so we evaluate whether or not the curriculum met the needs of the students, whether it met their … learning objectives. … We try to evaluate the students’ knowledge and skills. … We can now demonstrate to the different constituencies from the academic perspective that there are other added educational outcomes [from SL that are not derived from other courses].”

Q: “What led you to conduct evaluation?”
A: “Development people. We wanted to tap into the alumni to help with expenses for the service-learning teams. But when alumni got involved they said, ‘Well, what are some of your outcomes? Because we want to tell a good story, and the anecdotes are fine, but we would like a little more hard data, more substantive data.’ … So I started thinking about that, and developing instruments, and asking for help from the assessment and evaluation people. So
that's how it started. Now mind you, we have course evaluations from students for every year, but I wanted to hear from [community] partners and faculty, as well.”

One of these participants described how publishing these data was another strategy to maximize the perceived value of SL in a research-focused institution:

“You have to think about how you sustain a program like [service-learning]. How does it communicate its value to the senior leadership of the school? One of the things that we’ve strategically and intentionally done is look at research opportunities to publish some of our work to highlight the impact of the [service-learning] program on … students’ professional development.”

An interview participant who had been a champion for SL at a school where SL now only exists through a single elective course offered retrospective advice about the importance of internal marketing to sustain SL:

Q: “What advice would you give to other schools about how to sustain service-learning?”
A: “I think working with the upper management, the president, the provost. And there needs to be more publicity about [service-learning] and what a wonderful thing it is. And I was so busy setting up the program and dealing with all of the daily hurdles that the larger publicity issues, I didn't do. I just didn't have enough time or staff or energy.”

What are the Long-term Impacts of SL?

SL had long-term impacts for both academic and community partners. The most commonly described impacts were: 1) engaged scholarship among participating faculty members; 2) increased capacity among both community and academic partners for future partnerships; 3) diffusion of SL and principles of SL to other departments or schools at their institutions; and 4) improvements in “town-gown” relations, and related benefits for public relations and marketing. In only a few cases were there improvements in community agencies’ capacity to address community health. These impacts are described in depth in this section.
**Engaged Scholarship Among Participating Faculty Members**

The most commonly cited impact of SL was its effect on interview participants’ careers. This impact occurred across the spectrum of sustainability, but was most often the result of SL that was routinized or sustained. About half of the interview participants described how their involvement in SL had contributed to their developing careers as engaged scholars. Many others said that this was the career path they were already on, so it was hard to distinguish the impact of SL. Of those who attributed their career focus to SL, four described writing books or book chapters, or editing books, about SL in their professions. A number of participants also related how they had consulted with other institutions in the U.S. and abroad to help them implement SL. Some of these participants received add-on mentor-mentee grants from CCPH that created partnerships between those already implementing SL in health professions education and those wishing to do so. One participant described how she and a group of colleagues developed a summer community-based education and SL institute at their university to train faculty from other health professions institutions in SL.

In addition, a few participants described how SL linked them to governmental and community agencies where they took on leadership roles as engaged professionals, or conducted engaged research:

Q: “Do you think there has been any impact for your career, personally, of being involved in the HIPSISN cohort?”
A: “Well, [yes,] within the [city]. I was [also] appointed by the governor to the state board of nursing to represent professional nursing education. I think I’m recognized in the community as being involved with different kinds of social issues. I’m on the board of directors of [a] hospital. … So I would say yes, it’s helped me develop in my profession.”

“I did a study at [the hospital that was a SL partner,] looking at implementing protocols in the urgent care department to screen for victims of violence. Because
there was a protocol in primary care that everybody should be screened when they come into urgent care, so we did a study to see if that was true.”

Other participants described how SL gave them a different perspective on what their roles in the world could be, as engaged health professionals and as citizens, and this influenced their future professional activities:

“[Service-learning] provided a home for me … to this day, that allows me to understand how I can give back. And I got hooked. And then [I] started thinking more broadly about what the role of the universities was in educating students to think more broadly about civic responsibility. Marion Wright Edelman says service is the rent we pay for living. … I was introduced to Thomas Ehrlich’s work. That really made me cross multiple boundaries as a faculty member, as a citizen in my own local community.”

“It clearly has influenced my career, and I think influenced it in a positive way. … It helped provide a more academic, or intellectual, or grounded base in some of the issues of community-based participatory research, community-based service-learning. … I think it clearly helped form a lot of the work that I did while at [the university], it clearly helped inform a lot of the work that I did with the [foundation], and [it] definitely helped a lot in terms of my work as dean of curriculum at [another university]. So I would say that it’s definitely had a profound impact on the work that I do. … It’s a sensitivity. It’s a lens to look at problems. And I think it’s [provided] a perspective that’s been greatly informed by those initial experiences.”

**Increased Capacity for Community-Academic Partnerships**

The second most commonly cited impact of sustained SL initiatives was that they built capacity among both community agencies and academic institutions for future partnerships for research, education and service. A number of interview participants at institutions where SL was routinized or institutionalized described how the SL center or faculty members who were involved with SL were able to reach out to community partners for SL to write grant proposals for future research and community-based education:

“We have been able to leverage some of the [service-learning] projects. … There’s one [service-learning] team I can think of that the faculty member has actually written a grant that speaks to the need that was identified by the
community partner. The outcome of that has been: now the faculty member has a grant to study obesity in this population. The community agency benefits because they didn’t have to write the grant. It’s the research for the faculty member’s portfolio at the institution. But there are programs and interventions developed through that grant that benefit the community.”

In particular, SL built capacity in academic partners to successfully apply for other grants to support community engaged education:

“We applied for one of the regional medical education and public health grants. And then [at those times] everybody [academic and community partners] comes together. And we have credibility with our [service-learning] partners, and so we can usually come up with something pretty good. … So people [in the community agencies] will mobilize when there’s a need to mobilize. And we, equally, will mobilize for them when they need our input on grant funding they’re trying to get.”

Just as often, participants described how SL had created capacity among community partners to initiate collaborations with the university to address their health priorities:

“The community partners now seek us out because they have an issue that they think would be relevant for a course group or for students and faculty. … [And] they’re able to more effectively deal with the problems that they bring to us because they have the extra support of the bodies, as it were – students and faculty – and they have the intellectual capital of a university to help them see and deal with their problems differently. They feel, very often, empowered by the process and not overwhelmed by having to address the issues, because now they have help.”

“Usually the [grant] applications are initiated by the community partner, and we provide technical assistance. … Our faculty members, to my knowledge, don’t receive any money from those. But the [service-learning] students then can be part of that. They write the students in as the people who are going to deliver the [services].”

**Diffusion of SL and SL Principles**

Another commonly-cited impact of routinized and institutionalized SL initiatives was that they helped to support the diffusion of SL to other departments or schools at
their institutions. Interview participants described how they provided leadership to encourage other departments to adopt SL:

“We were able, after the [HPSISN] grant was finished, to continue to encourage [other] departments to come on board. … So right now, the college does have service-learning requirements for [all of] their students in some fashion. … It is a requirement for that whole college.”

One interview participant hosted a series of colloquia on her campus about SL that led to the diffusion of SL to other disciplines:

“Faculty would say, ‘Well, we can’t do service in our course. This is a humanities course. We can’t have service-learning.’ Or, ‘I teach English,’ or ‘I teach a 70-student section of general biology. How would I get service into my course?’ … But part of what I did at that time was to help people try to get an understanding of what service[-learning] was all about. … And then the students did campus-wide colloquia and presentations about the service that they were involved in. … Part of it was trying to just introduce the idea that service-learning is something that nearly everybody can do. … Faculty who participated in some of those discussions went back, and there are activities that are occurring within some disciplines now that … were [not] there before that. … There were some things, especially in music, that were being done with students in after-school programs and events like that. I think the art faculty and students did some things in the low-income housing community. … Business does a lot of things in the community. … Department faculty and students, especially during income tax preparation time, work with the senior centers and work with seniors to help them with what they need to do in relation to preparing for tax season.”

Other participants described how, while SL did not spread to other disciplines, the underlying principles of collaborative community-academic partnerships with reciprocal benefits had an influence on activities at their institutions:

“I will say that this program has had an influence on the MPH program: where it’s going as a program and the recognition that, for example, the MPH practicum needs to be more of value [to the community partners] and more collaborative. [Also] the creation of a community advisory group for the MPH program, which was modeled directly on what we were doing. So, I mean, a lot more attention to getting people involved in a collaborative way, much as we have with the medical school [service-learning] curriculum, [which] didn’t exist before. And that’s happened probably in the last five years with the new MPH program director … because he’s recognized the value, so he’s actually come to us to learn from us how to do it better.”
“I think the service-learning effort really promoted the mandate, the philosophy, the passion for community-based participatory research. … Service-learning enhanced people’s attitudes about doing research in that way, really in the community, with the community, and with applications back to the community that we’re going to improve the quality of life.”

**Improvements in “Town-Gown” Relations and Related Benefits for Public Relations and Marketing**

A number of interview participants from institutions where SL was institutionalized described how SL helped to change the way that the academic institution and community related to each other, leading to a sense that the university could be trusted, and that it would address the needs of community partners:

Q: “What’s been the impact of the service-learning program from 1998 to the present on community partners?”
A: “One of the major ones is a sense of trust in the university. Sometimes people approach projects with universities with a sort of skepticism because they feel like they’re going to be the subjects or guinea pigs of some project, and that their needs are not going to be considered, just the student needs or the faculty needs. That’s certainly not true in service-learning. And that’s been our experience, that the community partners now seek us out.” …
Q: “Did community partners not seek you out before the service-learning program?”
A: “Not to the extent that they do now.”

“I think that for the most part [the university] has, at least in our local community here, made a name for itself [through service-learning] in terms of there’s a certain level of integrity when it comes to working with community. So you know, ‘it’s a good partner to have. They will deliver when they say you’re going to do X, Y, Z.’”

However, some participants from institutions where SL was only routinized at the level of the department described how the improvements that SL created in “town-gown” relations could be limited to the departments that were engaged in SL:

A: “Some communities have a terrific town-and-gown relationship, and some communities have a strained town-and-gown relationship. And our town-and-gown relationship between our department and the community has been terrific. I
think people in the community where the college is located would say the town-and-gown relationship [with the college] has been strained over the last decade.”

Q: “So the town/gown for the whole college has been strained, but for your department it’s been terrific?”
A: “I would call it terrific, absolutely. And I think other departments would say the same thing—like education and business, and some of the disciplines that are most always visible in the community.”

A few interview participants described how improvements in town-gown relations contributed to more effective public relations campaigns, and as a result, more effective fundraising:

“I think that this is good PR for the school, and development people are looking for good press. And so our students are out there in the community and they’re teaching, and they’re providing outreach activities. … It’s impacting the development and then eventually, our bottom line. Because as development people get involved, then alumni get involved, and then alumni spend their dollars.”

Finally, as described earlier in this paper, a number of interview participants described how SL had been used effectively in marketing campaigns to prospective students.

**Capacity Building in Partnering Community Agencies**

Only a few interview participants described how SL had impacts for the independent capacity of community partner agencies to address community health needs. However, because this is an important long-term goal of SL, this finding warrants discussion (Seifer, 1998a). As described earlier, one way that SL built capacity in community partner agencies to address health concerns was by creating capacity for future community-academic collaborations. While this is an important impact that can have long-term benefits for community agencies, an additional goal of SL is to build independent capacity in community agencies to address community health needs.

Interview participants from only two institutions described this impact in partnering community agencies. Surprisingly, one of these institutions only routinized
SL, while the other neither routinized nor institutionalized SL. One of these institutions partnered with a single community agency and invested heavily in developing its capacity to address health. Before the SL partnership began, this community agency was mainly an addiction treatment provider and offered some basic health services for participants in its treatment programs. With the support of the SL partnership, the agency expanded its mission, opening a number of health clinics serving all underserved members of the local community. The agency now no longer sees itself as an addiction treatment provider, but instead as a safety net healthcare provider for the underserved that provides addiction treatment as part of its range of services.

The interview participant from the other institution where SL had an impact on the capacity of a community agency described how her SL initiative partnered with a local hospital to teach students about domestic violence, but first instituted confidentiality procedures related to patients’ medical records, to enable students’ participation. Although the SL partnership (and SL initiative) ended, the hospital maintained these protections because they also shielded the confidentiality of patients’ records from perpetrators of domestic violence.

Finally, a number of interview participants from institutions that had routinized or institutionalized SL reported that community partners were able to write about their academic partnerships for SL in their own grant proposals, annual reports and other public relations materials. These interview participants believed that this may have increased community agencies’ status in the community or produced financial benefits, which may have led to capacity building. But they did not report specific examples of this occurring.
Discussion

This is the first study we are aware of to assess the sustainability and long-term impact of SL in health professions education. Our findings suggest that SL is highly sustainable in health professions schools and programs. Our findings also provide evidence for the importance of the organizational setting to sustain SL in health professions education. Table 3 shows how the presence of a greater number of facilitating factors in the organizational setting was correlated with increasing sustainability. In addition, almost half of the reported facilitating factors were in the organizational setting, and all of the major challenges to sustainability were in the organizational setting.

These findings echo the strong focus on the influence of the organizational setting in the literature on sustaining SL in higher educational more broadly (Bringle & Hatcher, 2000; Furco, 2001; Furco and Holland, 2004; Gray, et al., 1998, as cited in Furco, 2002; Holland, 1997; Jacoby & Hollander, 2009). Of the many factors in the organizational setting identified as important to sustain SL in the literature on SL in higher education, nearly all were also identified by this research as important to sustain SL in health professions education. In particular, our findings on the importance of organizational mission, leadership for SL among high-level administrators, infrastructure and funding to support SL, and a critical mass of support for SL echo Holland’s (1997) findings on the importance of institutional commitment to sustain SL. Our findings also reflect the importance of the organizational setting to introduce challenges to the sustainability of SL, namely through turnover among faculty, loss of champions for SL, and competing educational priorities.
In addition, our findings identify aspects of program design and implementation as important to sustain SL, both as facilitating factors and as responses to challenges in the organizational setting. Our findings confirm nearly all of the recommendations from the literature on strategies to foster the sustainability of SL summarized in the Introduction, including linking SL to the achievement of institutional priorities and publicizing the value of SL to contribute to these priorities, connecting SL to high-value institutional initiatives, and engaging all stakeholders in evaluations of SL (Furco, 2002; Gelmon, 2003; Hutchison 2005; Rubin, 1996; Torres, 2000).

This research adds to the literature on the sustainability of SL by identifying how attitudes about SL in academia more broadly, as well as accreditation guidelines for specific health professions, can have an important influence on the sustainability of SL in health professions education. To our knowledge, these findings have not yet been reported in the empirical literature on sustaining SL. Our findings on the influence of accreditation standards reflect the focus of this study on health professions education, in particular. These findings also have implications for policy development, as they suggest that accreditation standards in health professions education can play a role in sustaining SL. Our finding also highlight the challenge of competing educational priorities, particularly as related to introducing high-technology training methods such as patient simulation labs, and emphasizing training in research skills. These competing priorities may also be specific to SL in health professions education.

As a whole, our results suggest that while some facilitating factors and challenges to sustainability are immalleable traits of the organizational setting, such as culture and mission, many others are traits that can be influenced by the leadership of SL champions.
– with strategies such as appealing to “institutional hooks,” adapting to changes in the academic and community environments, and internally marketing SL – and by factors in the broader academic environment. Together, these findings suggest that no one set of influencing factors determines the sustainability of SL, but instead, that sustainability is the result of the interaction between the organizational setting, the activities of SL champions, and the broader academic environment.

A Conceptual Framework for the Sustainability of SL in Health Professions Education

Based on these findings, a revision of Shediac-Rizkallah and Bone’s (1998) conceptual framework is warranted to make it specific to the sustainability of SL in health professions education (Figure 4). This revised conceptual framework identifies influencing factors within each of Shediac-Rizkallah and Bone’s categories of influences on sustainability. All of the boxes in the framework include facilitating factors, and the box representing influences in the organizational setting also includes challenges, reflecting the findings from this research. This conceptual framework also inserts a new category of influences on sustainability: the proven ability of SL to achieve organizational priorities.

This framework also depicts the interactions among these variables, as identified in the research findings. For example, it identifies a bi-directional relationship between the sustainability and impact of SL in order to reflect the influence of proven impacts on sustainability. It also identifies a bi-directional relationship between organizational setting and program design and implementation factors, to demonstrate how the setting influences the shape of SL, but how factors in the design and implementation of SL can also influence the organizational setting.
Figure 4: Conceptual Framework of Sustainability and Impact of SL in the Health Professions


**Key Strategies for Sustaining SL in Health Professions Education**

Our research identifies key strategies for sustaining SL. Our finding provide support for Furco’s (2002) assertion that attaching SL to “institutional hooks” helps to secure SL as an institutional priority. We found that an important difference between institutions that did and did not institutionalize SL was not the presence or absence of competing organizational priorities -- which existed across the spectrum of sustainability of SL -- but instead, the ability of SL champions to respond to competing educational priorities by attaching SL to “institutional hooks.” Sometimes SL initiatives even created
these “hooks”, themselves, such as the SL initiative that developed interdisciplinary education as a new organizational priority.

Our research also provides examples of how SL initiatives in different institutional and community contexts have implemented this strategy. We identified three commonly-used “institutional hooks”: educational objectives, student recruitment, and “town-gown” relations. This research also described the methods that SL initiatives used to attach SL to these “hooks”, including: internal marketing, cultivating individual champions for SL among high-level administrators, collecting evaluation data that demonstrates the value of SL to these organizational priorities, and publishing these data.

Our findings also lend support to Furco and Holland’s (2004) recommendation that, to ensure its sustainability, SL should be connected to high-value institutional initiatives where it can contribute to accomplishing broader goals. Again, our findings provide examples of how this strategy is being implemented in practice. These include the SL initiative that allied itself with a high-profile health disparities center; the SL initiative that was working to integrate SL into a highly-valued elective track program; and the SL initiative that was integrated into the institution’s larger economic development partnership, something that was crucial to the public reputation of the university. All three of these SL initiatives were institutionalized.

The three aforementioned SL initiatives contrasted with a fourth initiative that carved out a niche as an expert center on underserved populations in its urban area, but was only routinized and was also in decline at the time of this study, in terms of the number of participating students and the number of hours these students were each involved in SL. At first, this SL initiative was appreciated by the institution for the
attention it attracted from the local health department. But a reputation for expertise in
caring for the underserved was not an institution-wide priority. In addition, the SL
initiative was not linked to any high-value initiatives on campus, but was, rather, a
freestanding entity. Over time, the SL initiative became marginalized due to a competing
educational priority that did address a permanent “institutional hook,” namely, training
students in research skills. This anecdote provides an example of how SL initiatives must
be careful to hook themselves to long-lasting institution-wide priorities, including long-
lasting educational objectives. It also offers evidence for Furco and Holland’s (2004)
warning not to “compartmentalize” SL, but instead to connect SL to other high-value
institutional initiatives. That said, there were institutions in this cohort where SL in
health professions education was institutionalized but SL was not linked to other
institutional initiatives. But at these institutions, the organizational culture was such that
SL was, itself, considered a high-value initiative. This contrast provides evidence for the
importance of the institutional culture in determining what strategies are necessary to
sustain SL.

Another key finding was that an ability to adapt to changing trends in academia
and in partnering communities helped to sustain SL, because it maintained the value of
SL for everyone involved. This finding is distinct from Furco’s concept of “institutional
hooks” because, rather than appealing to existing institutional priorities, some SL
initiatives provided leadership to create new institutional priorities. These included, for
example, the SL initiative that created a new institutional priority around interdisciplinary
learning, and the SL initiatives that were teaching to “hot topics” such as immigrant
health, electronic medical records, and doctor-patient communication. In this way, these
SL initiatives became leaders for educational innovations and created their own institutional value.

All of these strategies for success suggest the importance of having a leader for SL, preferably a full-time SL director with sufficient status in the academic institution to earn the attention and respect of high-level decision makers who can engage in internal marketing, develop connections to high-value initiatives, and provide leadership for program adaptability.

*New Knowledge About the Long-term Impacts of SL*

Finally, our findings provide evidence that SL in health professions education is achieving many of its long-term goals, including fostering engaged scholarship, building capacity for additional community-academic partnerships, and improving “town-gown” relations. These findings support the IOM’s claim that SL can be a mechanism for health professions institutions to develop ties to, and better serve, their local communities (2003a). They also echo findings from the few existing descriptive papers on sustained SL initiatives in health professions education (Andrus & Bennett, 2006; Davidson & Waddell, 2005; Meyer, Armstrong-Coben & Batista, 2005).

Our research also suggests it may be a challenge for SL to contribute to building capacity in community agencies to address health needs independent of collaborations with academic partners. Findings from the two SL initiatives that reported this result, however, suggest two key strategies. One is to invest in a SL partnership with a single community agency – a strategy also reported by Meyer and colleagues (Meyer, Armstrong-Coben & Batista, 2005) – and the other is to collaborate with community partners to develop permanent resources that will be preserved even if the SL partnership
no longer exists. These two stories of capacity building also suggest that adaptability may be a factor not only in sustaining SL, but also in building capacity among community agencies. Specifically, to reap the benefits of increased capacity, one of these community agencies changed its mission, while the other revised longstanding procedures related to patients’ medical records.

**Strengths, Limitations and Suggestions for Future Research**

The results of this study should be interpreted in light of the limitations of the study design. The HPSISN cohort provided a naturally occurring group of early SL initiatives in health professions education that was ideal to assess the long-term sustainability and impact of SL. In addition, the diversity of the cohort also was ideal to identify facilitating factors, challenges, and strategies for success that cut across these differences.

But using the HPSISN cohort for this research also introduced a number of limitations. In particular, the HPSISN cohort is not representative of SL in health professions education nationally, so these findings may not be generalizable to other institutions. Specifically, the HPSISN cohort comprised a group of early adopters of SL. Early adopters tend to be both innovators and champions. As a result, their initiatives may differ from those of later adopters, particularly as related to implementation and sustainability – key issues under exploration in this study. In addition, the HPSISN cohort controlled for initial start-up factors that may have had an influence on sustainability, including the presence of outside grant funding and matching internal support. This, too, suggests that these findings are not generalizable to other SL initiatives. A second limitation is that, by controlling for these start-up variables, this
study was unable to explore the importance of these factors for the long-term sustainability and impact of SL. However, the fact that the findings so closely mirror the literature on sustainability of SL in higher education provides support for their validity.

A third potential limitation of this study was that sustainability was not an initial goal of HPSISN upon implementation. As a result, these institutions were not required to develop plans to sustain SL by the HPSISN program. An assessment of the sustainability of SL in this context may have produced different findings as to both the degree of sustainability of SL and influences on sustainability in participating SL initiatives that an evaluation of an initiative that included sustainability as an initial goal that was planned for in a deliberate manner.

A fourth limitation of this study was that it included only the perspectives of administrators, faculty and SL staff. Existing literature on the sustainability of SL in higher education also tends to reflect this single viewpoint, so comparability with the existing literature cannot rule out bias from this source. The absence of community voices from this research may be particularly relevant as related to understanding the long-term impact of SL for community agencies.

A fifth limitation of this research is that it did not focus, in particular, on the long-term impact of SL on students. Interview participants were asked to describe the long-term impact of SL, and the main impacts they reported were related to impacts on faculty member, academic institutions, community agencies, and town-gown relations. They did not focus on long-term impacts for student. In fact, this study design was not ideal to study the impact of SL on students. Rather, a study design that allowed students to speak about their personal experiences of the long-term impact of SL would have been
appropriate to assess this outcome. Because students are, arguably, the primary beneficiaries of SL, the absence of a focus on the long-term impact of SL on students is a limitation of this study.

A sixth limitation of this research is the possibility of reporting bias. For nine of the SL initiatives that participated in this research, only one individual was interviewed. This may have produced undetected reporting bias, particularly a related to social response bias. For the other seven participating SL initiatives, two interviews were conducted per initiative, which provided some protection against reporting bias. To reduce the risk of reporting bias for all of these SL initiatives, we provided a written disclosure statement that ensured all participants that everything they said would be completely confidential, and would be reported in such a way that there would be no possibility of tracing quotation to their sources. Nevertheless, there is the potential that some reporting bias remained. A seventh and final limitation of this research was that it asked participants to retrospectively report on influences on their SL initiatives from 1998 to 2007-2008. This method was likely to introduce recall bias.

Future research on the sustainability and long-term impact of SL could select for institutions that had a variety of early start-up experiences. It could also include the views of community partners. To reduce reporting bias, it could include multiple interviews to collect data on each participating SL initiative. To reduce recall bias, future research on the sustainability of SL could use a longitudinal design, following SL initiatives over time and collecting data every few years. However, financial constraints might make this study design unrealistic.
In addition, future research might explore in greater depth two new findings that emerged in this study: 1) the influence of broader trends in academia on the sustainability of SL in health professions education and 2) the importance of competing educational priorities, specifically, high-technology training methods and a focus on teaching clinical care and research skills. It might also explore the suggestion that adaptability in community agencies may be a relevant factor if SL is to build capacity in partnering community agencies to address community health. Finally, future research should explore the long-term impact of SL on students, such as their attitudes, career choices, and behaviors as professionals.

Conclusions

Furco and Holland (2004) write that “funders are increasingly assertive about their expectation of sustainability” for SL. Our findings identify strategies that champions for SL can use to advance the sustainability of SL in health professions schools and programs, including creating organizational settings that provide support for SL and adopting approaches to the design and implementation of SL that are conducive to sustainability. These findings also identify common challenges to sustaining SL that exist across institutions that have a wide range of levels of sustainability for SL, as well as strategies to address these challenges. The revised conceptual framework for the sustainability and impact of SL produced from this research can be used as a practical tool to guide champions for SL in 1) identifying challenges in their own settings, and 2) selecting strategies that may help to successfully sustain SL at their institutions, given their particular organizational settings.
Finally, these findings provide evidence that SL is achieving many of its long-term goals. These findings may be used to confirm the value of directing grants toward SL as a means of enhancing civic engagement in health professions academic institutions. They may also be used by champions for SL to argue for the implementation of SL at their own institutions. Most institutions in this cohort had not yet maximized the potential of SL to build capacity in partnering community agencies. This finding suggests that this is an area where health professions institutions should direct their attention, in order to maximize the benefits of SL for everyone involved.
CHAPTER 5: MANUSCRIPT 2

Maximizing the Quality and Sustainability of SL in Health Professions Education: A Comparative Case Study of two Sustained SL Initiatives

Abstract

As increasing numbers of health professions schools and programs adopt service-learning (SL), two priorities are how to maximize the quality of SL and how to sustain SL. To explore how health professions institutions are working toward these goals, we conducted a comparative case study of SL initiatives at two health professions institutions that have each been sustained since 1995. One SL initiative is in a faith-based teaching institution, while the other is in an academic health center (AHC).

The first SL initiative provides an example of how to institutionalize SL and offers models for how to maximize the quality of SL as an educational tool, including integrating SL into core courses and offering high-intensity SL immersion experiences. However, this initiative has faced challenges to maximizing the quality of SL service experiences for students and community partners due to inadequate resources and procedures to maintain community-academic partnerships for SL. It has responded by creating different levels of partnerships to suit different community agencies, and relying on faculty to maintain some partnerships. The second SL initiative provides examples of how to maximize the quality of community-academic partnerships for SL, by implementing procedures that foster equity, collaboration, and co-learning, and requiring that SL projects contribute to capacity building in community agencies. But it has faced ongoing challenges to sustainability, due to competing educational priorities, competition for faculty time, and turnover among program champion. It has responded by actively
publicizing how SL contributes to other institutional priorities and building a web of interconnections between SL and other valued initiatives at the institution.

A cross-case comparison highlights how the organizational culture has a strong influence on the goals of SL and these goals, in turn, shape the design and implementation of SL, including its resulting strengths and challenges. These two cases suggest ways to maximize the quality of SL as a teaching tool, and the quality of community-academic partnerships for SL. They also present two different strategies to sustain SL, given different institutional settings.
Introduction

Over the last 20 years, civic engagement has become a growing priority of U.S. health professions schools. This trend has created interest in how to increase community engagement in all of the core activities of health professions academia, including research, service, and teaching (Allan, et al., 2004; Association of Schools of Public Health [ASPH], 2004; Green, 2003; Higgins & Metzler, 2003; Institute of Medicine [IOM], 2003a; IOM, 2003b; IOM, 2004; Nyden, 2003). While there is a long history of practice-based training in health professions education, the recent focus on civic engagement has led to a growth of interest in service-learning (SL) (ASPH, 2004; O’Neil, 1993; O’Neil and the Pew Health Professions Commission, 1998).

SL is a pedagogical method built on community-academic partnerships. It is characterized by the “reciprocal nature of both the service and the learning among all parties in the relationship” (Jacoby, 1996a). Through SL, academic institutions partner with community agencies to identify community needs, and students provide services that respond to these needs. Students engage in service in the context of a structured learning experience that includes preparation and reflection that link their service to educational goals.

Ideally, SL produces benefits for all participants. It provides needed services in communities and trains future health professionals in community and population health competencies and an ethic of civic engagement (ASPH, 2004; Cauley, et al., 2001; O’Neil, 1993; Seifer, 1998b). It may also build capacity among community and academic partners to participate in additional partnerships, develop community partners’ ability to address community health needs, and improve “town-gown” relations.
SL has been endorsed by the Pew Health Professions Commission and the Institute of Medicine (IOM, 2003a; O’Neil, 1993; O’Neil and the Pew Health Professions Commission, 1998), and has recently been recommended by the accrediting agencies for schools of medicine and pharmacy and the Association of Schools of Public Health (Accreditation Council for Pharmacy Education, 2006; ASPH, 2004; Liaison Committee on Medical Education, 2007).

As SL becomes more prevalent in health professions education, two priority areas for research are 1) how institutions can maximize the quality of SL, and 2) what factors are important to sustain SL. A large body of literature from the field of education provides principles for implementing high-quality SL in higher education. A number of publications also provide principles for implementing SL in different health professions, including public health, health administration, medicine, nursing, dentistry, physical therapy, and occupational therapy (ASPH, 2004; Bailey, Carpenter, & Harrington, 2002; Cashman & Seifer, 2008; Cauley, et al., 2002; Hoppes, Bender, & DeGrace, 2005; Seifer, 1998b; Stefl, Gelmon, & Hewitt, 2006; Yoder, 2006).

From this literature key principles emerge for how to implement high-quality SL in health professions education. These principles for high-quality SL focus on two areas: 1) how to structure SL as a learning experience, and 2) how to operate community-academic partnerships for SL. Principles for how to structure SL as a learning experience include: integrating SL into the curriculum and linking SL to learning objectives; clearly distinguishing SL from clinical training; providing facilitated opportunities for student preparation and reflection; fostering co-learning among faculty, community partners and students; involving a diverse array of community partners; and providing SL experiences
of long enough duration and intensity to achieve intended student learning outcomes (ASPH, 2004; Bailey, Carpenter, & Harrington, 2002; Cashman & Seifer, 2008; Cauley, et al., 2002; Eyler and Giles, 1997; Eyler and Giles, 1999; Honnet & Poulsen, 1989; Jacoby and Associates, 1996; Seifer, 1998b; Yoder, 2006). Principles for how to operate community-academic partnerships for SL include: creating equitable and collaborative partnerships; investing in relationships through open communication, and commitment; fostering co-learning; producing reciprocal benefits for academic and community partners; and creating benefits that go beyond service to capacity building, engaged research, and practice (Cashman & Seifer, 2008; Community-Campus Partnerships for Health, 2006; Honnet & Poulsen, 1989; Jacoby and Associates, 1996; Jacoby, 2003; Jones, 2003; Torres, 2000; Yoder, 2006).

Another body of literature provides guidance for sustaining SL. In general, it focuses on how to institutionalize SL, meaning how to support SL with institutional policies, procedures, infrastructure, and values (Goodman and Steckler, 1989). It stresses the importance of support for service in an institution’s mission and vision (Holland, 1997; Rubin, 1996); the active support of the university president and other top administrators (Furco, 2002; Furco & Holland, 2004); internal funding for SL staff and faculty time (Bringle & Hatcher, 2000; Jacoby, 1996b; Jacoby & Hollander, 2009); infrastructure to support SL, including a coordinating center that is centrally located in the organizational structure (Bringle & Hatcher, 2000; Gray, et al., 1998, as cited in Furco, 2002); consideration of SL in strategic planning (Bell, et al., 2000 as cited in Furco, 2002; Rubin, 1996); and support for SL in promotion and tenure policies (Holland, 1997; Jacoby, 1996b; Jacoby & Hollander, 2009). This literature also offers strategies to
increase buy-in for SL among administrators, faculty, students and community partners. These include: identifying a model for SL that is consistent with the organizational culture and mission of both academic and community partners (Rubin, 1996; Torres, 2000); linking SL to other organizational priorities, something Furco calls “institutional hooks” or “leverage points” (Furco, 2002); operating SL out of preexisting program offices in order to identify the value of SL to other institutional objectives (Furco & Holland, 2004; Rubin, 1996); publicizing the value of SL internally and externally (Hutchison, 2005); engaging in a “partnership process” for communication and decision making (Torres, 2000); and conducting regular evaluations of SL that involve all stakeholders, including community members and students (Torres, 2000; Gelmon, 2003).

Long-term sustained SL initiatives in health professions education can provide helpful models for how to implement these principles for SL quality and strategies to sustain SL. There is a growing literature on SL in health professions education, but most of these publications describe initial start-up experiences, program design and implementation, and short-term impact, including student learning outcomes and services delivered to community partner agencies (Baumberger-Henry, Krouse, & Borucki, 2006; Brown, Heaton & Wall, 2007; Elam, et al., 2003; Gregorio, DeChello and Segal, 2008; Hamner, Wilder, Byrd, 2007; Hayward & Weber, 2003; Young, Bates, Wolff, & Maurana, 2002). This is true even among articles that report on SL initiatives that have been sustained for a period of five years or longer (Bittle, Duggleby & Ellison, 2002; Kemsley & Riegle, 2004; Kushto-Reese, Maguire, Silbert-Flagg, Immelt, & Shaefer, 2007; Mihalynuk, Odegard, Kang, Kedzierski, & Crowley, 2007).
We could identify only a few articles that describe the strategies that long-term sustained SL initiatives have used to foster the quality and sustainability of SL (Andrus & Bennett, 2006; Davidson & Waddell, 2005; Greenberg, Howard & Desmond, 2003; Meyer, Armstrong-Coben, & Batista, 2005). They provide valuable guidance, however, with regard to how to implement a number of key principles for high quality SL. Davidson & Waddell (2005) describe how faculty members for an interdisciplinary SL course at the University of Florida maintain a strong connection between SL and learning objectives even as learning objectives change over time, by constantly reassessing how SL addresses learning objective and revising SL projects as appropriate. Greenberg and colleagues (Greenberg, Howard & Desmond, 2003) and Meyer and colleagues (Meyer, Armstrong-Coben, & Batista, 2005) describe how their SL initiatives, at the University of Maryland and Columbia University, respectively, implemented principles of SL partnerships including relationship-building, power-sharing, and communication, by appointing community partners to faculty positions and creating opportunities for structured dialogue between community and academic partners. Finally, Andrus and Bennett (2006) relate how an SL initiative at the University of Rochester changed from one- and two-semester SL projects to longitudinal partnerships maintained by faculty members, which students cycled through. These partnerships led to greater benefit for everyone involved, contributing to faculty members’ scholarly work, and enhancing the quality and products of SL for students and community partners (Andrus & Bennett, 2006).

We wanted to learn more from the experiences of sustained SL initiatives about what strategies they have used to foster the quality and sustainability of SL. Authors
have recognized the critical influence of contextual factors, especially the institutional setting, on the success of SL (Gelmon, Holland, Driscoll, Spring, & Kerrigan, 2001). In addition, prior research we conducted confirmed the important influence of the institutional environment on the sustainability of SL (Chapter 4). We therefore wanted to explore, in particular, how the institutional setting influenced how SL initiatives were implementing principle for high-quality SL and strategies to sustain SL.

In addition, we wanted to learn from the perspectives of all of the stakeholders in SL, including academic administrators, faculty members, SL staff, students, administrators of partnering community agencies, and staff at community partner agencies who are directly involved in SL. Only two of the articles cited above about SL in health professions education were co-authored by academic and community partners (Andrus & Bennett, 2006; Meyer, Armstrong-Coben, & Batista, 2005), while all the others were authored by faculty members, and did not reflect the viewpoints of any of these other stakeholder groups. To pursue these goals, we conducted a comparative case study of two health professions SL initiatives in very different institutional settings, each of which has been in continuous operation since 1995. For each case study we interviewed members of all the stakeholder groups mentioned above.

**Methods**

**Aims and Research Questions**

The goals of this research were: 1) to explore how sustained SL initiatives in health professions education have fostered the quality and sustainability of SL, and 2) to produce strategies for success and lessons learned from their experiences. We aimed for this inquiry to identify some strategies that are appropriate to specific institutional
contexts and other strategies that are applicable across different institutional contexts.

Our research questions were: 1) How have sustained SL initiatives been implemented? 2) What strategies have they used to foster the quality and sustainability of SL? 3) What challenges have they encountered related to fostering the quality and sustainability of SL? and 4) How, if at all, have these challenges been addressed?

**Sampling Strategy**

Cases for this research were selected from the cohort of institutions that participated in the Health Professions Schools in Service to the Nation (HPSISN) program. Implemented from 1995 to 1998, HPSISN was a coordinated national demonstration program that provided funding and technical assistance to support SL in 17 health professions schools and programs around the U.S. (Seifer, 1998b). HPSISN was administered by the Center for the Health Professions at the University of California-San Francisco and was supported by the Pew Charitable Trusts, the federal Corporation for National and Community Service (CNCS), and the Health Resources and Services Administration (HRSA).

Our primary goal for case selection was to include two SL initiatives that could offer strategies to foster the sustainability and quality of SL in different institutional contexts. We used prior research we conducted on the entire cohort of HPSISN-supported SL initiatives to screen these initiatives for three related case selection criteria (Chapter 4). First, each SL initiative had to have been institutionalized, meaning that SL was supported by institutional policies, procedures, and infrastructure (Goodman & Steckler, 1989). In this sense, SL had reached a very high level of sustainability, and the research could explore strategies to achieve this outcome. Second, in our prior research,
participants from both SL initiatives had to have described strategies their initiatives used to foster the quality of SL. Third, the two SL initiatives had to vary significantly in terms of the culture of the academic institution where they were located, a factor our prior research identified as an important influence on sustainability. This was reflected in institutional traits such as whether the institution was faith-based or secular, public or private, a teaching institution or a research institution. This variability would allow the research to identify strategies to maximize the sustainability and quality of SL that were specific to different institutional settings and that were relevant across settings. Another goal for case selection was that the full range of stakeholders in SL needed to be available for interviews. In addition, for each case, at least three community partner agencies had to be available to participate, in order to reflect an array of experiences.

Community agencies were selected for variability in characteristics that might be associated with the research questions, including: 1) the length of time the agencies had participated in the SL partnership, 2) the populations and health issues their SL partnerships addressed, and 3) the SL projects that students participated in at the agencies. Individual participants were selected for maximal variation in their perspectives on the implementation, quality, and sustainability of SL and their perspectives on the related influence of the institutional setting (Creswell, 1997). They included: academic administrators with oversight over SL, faculty who participated in SL, specialized SL staff, student participants in SL, administrators of partnering community agencies, and the staff members at these community agencies who were directly involved in SL. A second goal was to include participants who had maximal knowledge about the SL initiative, for example, those who were most closely involved in
implementing SL and those with longitudinal perspectives on the SL initiative from the time it began in 1995 to the time this research was conducted in early 2009.

Data Collection

Each case study consisted of site visits, qualitative semi-structured in-depth interviews, and document review. Each site visit lasted five days, and included visits to the academic institution and two of the three participating community agencies. During site visits, the research investigator toured the academic institution and community partner agencies, took field notes, conducted in-person interviews with members of all the stakeholders in SL, and collected documents for review. For each case, for logistical reasons, a site visit to one community agency was not possible. Therefore, their interviews were conducted by telephone.

Most in-person interviews were conducted one-on-one. A few were conducted in small groups when individuals shared the same role in relation to the SL initiative, for example students who participated in SL. All telephone interviews were conducted one-on-one. Individual interviews ranged from 25 to 60 minutes and small group interviews ranged from 60 to 90 minutes. The semi-structured interview guides were tailored to each participant or group of participants according to their relationship to the SL initiative (Appendices F and G). All participants provided informed consent and agreed to have their interviews tape recorded. The Johns Hopkins Bloomberg School of Public Health Institutional Review Board approved this study.

Data Analysis

All interviews were professionally transcribed. The study investigator read all of the transcripts, field notes, and documents to identify major themes within each case.
Within-case and cross-case analyses were conducted (Miles & Huberman, 1994). Major themes were identified within each case and these were compared across cases. In addition, within each case, respondents were stratified by their role in the SL initiative: academic administrators, faculty, SL staff, students, administrators of community agencies, and staff of community agencies. Similarities and differences were explored between and among these groups, both within each case and across the two cases.

Matrices and memo-writing were the primary analytic tools used throughout this process (Miles & Huberman, 1994). In addition, thematic coding was used, when necessary, to clarify differences between related themes. Finally, all interview participants who are quoted in this article were sent their quote or quotes with the surrounding text, and all approved of the use of their quotes in these contexts.

**Findings**

A total of 47 individuals participated in interviews, as summarized in Table 4. Of these, 41 participated in in-person interviews, and 6 participated in telephone interviews.

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<th>Table 4: Summary of Interview Participants, Comparative Case Study</th>
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<td>Academic administrators</td>
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<td>Faculty members</td>
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At University 1, 18 academic partners participated. They consisted of five high level administrators including the university president and the dean of the college of health professions; seven faculty members in nursing, pharmacy and physical therapy
who taught courses that included SL; the director and assistant director of SL in health professions education; the director of SL in the liberal arts; and three students who had provided leadership for SL. The three community agencies were a rural public elementary school serving a low-income largely Native American community; a faith-based independent living facility for older adults; and a faith-based private urban high school serving youth from a mainly Latino low-income community. They had partnered with the university for SL for 11, 5, and 5 years, respectively. Seven community partners participated in interviews. At each organization they included one administrator and one staff member who was the active partner for SL. A cultural consultant for SL at the elementary school also participated.

At University 2, 14 academic partners participated. They consisted of four administrators including the dean of the division of health sciences and two assistant deans; six faculty members in physical therapy, physician assistant, nursing, and public health who participated in SL; the director of SL in health professions education; and three students who had served as SL team facilitators. The three community agencies were a community health center providing health, education, and social services for multicultural populations; an agency providing housing, health, case management, and education services to homeless and low-income individuals and families; and an agency providing housing, health and employment services for homeless and low-income women. They had partnered with the university for SL for 12, 10, and 1 years, respectively. Eight community partners participated in interviews. At each organization they included one administrator and between one and three staff members who directly
participated in SL. A list of all interview participants’ job descriptions is provided in Appendix H.

University 1: SL in Health Professions Education at a Faith-Based Teaching University

Institutional Setting

University 1 is a private, faith-based teaching institution located on a pastoral campus in a major urban area. It includes a college of liberal arts, a college of health professions, and a college of continuing studies that caters to working adults. In total there are about 15,000 students at the university, including 2,500 in the college of health professions. The college offers degree programs in nursing, physical therapy, pharmacy, and health administration. SL is incorporated into the required curriculum in all of the degree programs in the college.

The university has a very strong identity as a faith-based teaching institution. This is reflected in its mission statement, which identifies teaching and service as the two primary goals of the University. The mission statement describes the university’s educational goals as the provision of “value-centered” education that promotes both intellectual development and “personal development,” including a lifelong “commitment to community service” and skills and values for “leadership” in society.

The university’s faith-based identity is also reflected in its strong commitment to providing service as an institution. Interview participants described how the university does this through significant annual charitable donations and direct service to community agencies that serve the poor, including a community health center and a transitional program for women re-entering society after being incarcerated. The University
President described how the university also makes a point of making annual donations to SL partner agencies, recognizing the “cost” of SL to them, in terms of human energy. The university encourages community service by faculty as well. All faculty members are given a number of paid hours each year to use for community service. The office of the university vice president also sponsors a monthly faculty lecture series highlighting faculty members’ community service.

In 2008, the institution successfully applied for the Carnegie Endowment for the Advancement of Teaching elective classification for Community Engagement, which formally recognizes the “a university or college has institutionalized Community Engagement into its identity, culture, and commitments” (Carnegie Foundation, 2007). It was also included in the 2008 President's Higher Education Community Service Honor Roll, which “recognizes colleges and universities nationwide that support innovative and effective community service and SL programs” (Learn and Serve America, n.d.).

**Goals for SL**

**Academic Partners**

Academic partners described three main goals for SL in health professions education: 1) to help students develop personal and professional values of service and social justice, 2) to enhance the quality of the work students would do as health professionals, and 3) to provide meaningful service to community partners.

Academic partners described how regular participation in SL that provided a valued service to community partners could help students to develop an understanding that service should be a part of their professional lives and also enable them to recognize
that they had valuable skills to contribute to society. They believed that this would lead students to develop a “habit of service.”

Academic partners also intended for SL to help students develop a more “expansive” idea about the roles and responsibilities of health professionals in society that went beyond donating their clinical services to also providing leadership to improve the health and welfare of society more broadly. This might involve, for example, serving on the boards of directors of community agencies, or advocating for policies that would enhance the welfare of the underserved. They described these roles as a way that individuals could move beyond service to social justice work.

Academic partners felt that SL experiences could both inspire students to provide leadership for social justice and equip them with the knowledge and skills they would need to do so. They described how SL could expose students to population health needs and educate them about the social inequalities underlying many population health problems. They believed that SL could also help students to develop a broader definition of the “community” in which they were members. For example, through SL, students could develop interpersonal relationships that broke down stereotypes related to class, age, and race/ethnicity and that fostered respect and a sense of connectedness. Academic partners also described how SL provided opportunities for students to develop leadership skills for service, such as skills to identify community needs and work with others to develop responses. These experiences could enable students to identify how, as citizens and health professionals, they could personally contribute to “effect[ing] change that is moving towards a society that takes into account the common good of all people” (SL director).
Academic partners’ second goal for SL was to enhance the quality of care that students would provide as health professionals. Faculty and administrators described how SL could foster respect for others, cultural competency, and communication skills, and could enhance students’ understanding of the social determinants of health in such a way that it would improve their care of the whole person. They described how classroom-based reflection helped achieve these goals:

“We have them reflect on social justice issues. We have them reflect on, outside of this patient that you’re caring for, what kinds of broader social concerns do this patient and their family have? What else [do] they have to deal with? And how do you as a person, not just as a nurse, help them work through some of these [things]? … So we talk about, ‘how are you in relationships with your fellow human beings?’” (dean of nursing)

Academic partners’ third goal for SL was to provide meaningful service to the community. When asked to define success for SL, the university president said that, first and foremost, it was to make a positive contribution to the lives of those who are served. Administrators and faculty described how institutionalizing SL was a concrete way that the University could “live its mission” to provide service in society.

Community Partners

Community partners for SL in health professions education also described three main goals for SL: 1) to receive direct services that benefited their clients, 2) to educate future health professionals about their clients and communities, and 3) to benefit their clients through exposure to the university students. Community partners described how SL provided valuable services for their clients that their agencies could not provide with their own resources. Students participating in SL brought enthusiasm, expertise, material resources, and time that community agencies did not have internally to develop and
implement health fairs, provide injury prevention education, develop physical fitness programs, and form interpersonal relationships with their clients.

Community partners’ second goal for SL was to participate in educating future health professionals. They equally valued the services they received and their role as educators. Community partners described how, through SL, their agencies provided valuable opportunities for experiential learning that could teach cultural sensitivity and skills for communicating with a wide range of patient populations, including a variety of racial/ethnic groups and age groups. They described how the relationships students developed with their clients were an important contributor to these educational outcomes. But the most important educational goal for community partners was that future health professionals learned about the client populations they served and the settings where they worked. They wanted to prepare students to be better care providers to their clients, and potentially inspire them to work in their communities or with their populations. One community partner said:

“It's so interesting for them to see the Native culture. … [And] just being able to come to the reservation area is something that most people aren't able to experience. And I think that's a huge thing for those students. … They take a tour and go and visit the Indian Health Service. … Because there's such a strong need for that kind of service and those kind of [health care providers] on our reservation. And I think that they look at that and see the need.”

Community partners’ third goal for SL was to expose their clients to the university students. All of the community members who participated in interviews described the benefits this produced for their clients. For example, at the two schools serving low-income communities, the university students were seen as role models for pursuing higher education: “Most of our kids are the first in their family to go to college.
... So it's great for our students to see young people who are studying [in the health professions] to say, ‘Hey, that's a neat idea. I could do that too.’” (community partner)

**Design and Implementation of SL**

At University 1, each college has its own office of SL with two full-time staff members. In the college of health professions, the SL office is located in the office of the dean of the college, and the director of SL reports directly to the dean. The SL office is funded mainly by the office of the dean of the college and also receives discretionary funding from the office of the president of the university and from schools and departments in the college.

Each of the training programs in the college has integrated SL into its core courses. Nursing, physical therapy and pharmacy all took advantage of times when they were designing or redesigning the curriculum to integrate SL into core courses. Each degree program at the college has identified how SL meets specific learning goals. The programs in nursing, physical therapy and pharmacy have also identified how SL teaches to educational objectives that are included in their accreditation guidelines. Across the college, each semester-long SL course incorporates preparation and reflection into classroom sessions and assignments and requires that students participate in 10 hours of service outside of the classroom.

The SL office provides support for SL to all courses in the college that use SL. It is staffed by a full-time director and assistant director and a part-time assistant. The SL office supports faculty members who teach courses that use SL by providing professional development opportunities and technical assistance. It also coordinates SL experiences in the community for all of the courses that use SL. This involves maintaining relationships
with contact persons at community agencies that participate in SL and collaborating with faculty members to identify the SL needs for their courses based on learning objectives and numbers of students enrolled. Typically, the SL office coordinates multiple community partnerships for each course that uses SL. Finally, the SL office manages intercultural SL immersion experiences that occur over semester breaks and during the summer. This is a growing feature of SL at the college that is described in further depth, below.

Over 40 community agencies participate in SL with the college. They are very diverse in their missions and client populations and include, for example, community health clinics, elementary and high schools, assisted living facilities for older adults, food banks, homeless shelters, local government agencies, and international development agencies. The common thread among all of these partner agencies is that they cater to underserved or marginalized populations. Many of these agencies are also part of the same faith community as the university. Students’ service activities vary dramatically, as determined by their degree program, course goals, needs of the community agency, depth of the SL relationship, and course format. Students may participate in SL as individuals or in teams. For online SL courses, students create connections with agencies that serve the underserved in their own communities, where they engage in service as individuals.

**Strategies for Success: Institutionalizing SL through Leadership and Infrastructure**

This university provides a model of how to successfully institutionalize SL in health professions education. It has relied on two major strategies to institutionalize SL: 1) leadership from top administrators, and 2) the creation of infrastructure that supports faculty and student participation in SL.
Leadership “from the President Down”

Interview participants described how leadership among top administrators at the university and the college were both critical to sustaining SL at the college. The president of the university is a national champion for SL who served on the board of directors of Campus Compact, the national organization supporting civic engagement in US higher education. Many academic interview participants described how both his influence on the culture of the institution and the resources he has committed to SL have been important to sustaining SL throughout the university. The university president asserted that significant institutional-level financial commitment is essential to sustain SL:

“I’ve found a lot of schools salute the flag, but they aren’t committed in their own finances to doing [service-learning]. And when that’s the case, then the amount of service-learning that they do tends to dry up, because they don’t have the support for their faculty, in training them how to find good assignments, as well as the support … [of service-learning] employees going out and helping to find the service projects.”

Another source of support for SL was that it was implemented not at the level of the department or the school, but at the level of the college, under the leadership of the dean of the college. The dean increases funding for SL each year. In addition, the dean includes the SL director in strategic planning meetings at the college level, along with the deans and directors of the schools and departments. This helps to sustain SL as part of the core curriculum of all of the degree programs in the college, across the various disciplines.

In addition, the deans of the schools of nursing and physical therapy are both vocal champions for SL. Even as deans, both continue to lead SL immersion
experiences. One dean described how their leadership was essential to integrating SL into the curriculum:

“I think a critical piece is that leadership needs to illustrate that [service-learning is] important … if you really want to … integrate it in a curriculum. And health professions education programs are often core curriculums with expectations and criteria from each of our accrediting bodies. How these criteria are interpreted, and where time is spent, relates to the interpretation of the faculty and administration and what value is placed on [service-learning]. Without leadership support it’s just more difficult to effectively integrate [service-learning] into academic curriculums.”
(dean of physical therapy)

But the deans attributed their ability to provide leadership for SL at their schools, ultimately, to the fact that SL is supported “from the president down.”

Infrastructure to Support Faculty and Student Participation

The college has created infrastructure that both guarantees faculty and student participation in SL and provides support for their participation. Perhaps the most important source of support for faculty participation is that promotion in rank policies [there is no tenure] at the college recognize teaching and community service along with scholarship and academic service. As a result, said one dean, community service “is part of the expectation if you choose to be a faculty [member] at [the university].” SL is one of a number of ways that faculty can meet this expectation.

The integration of SL into core courses also supports faculty participation. Faculty members are assigned to teach these courses as needed, so sufficient faculty participation in SL is guaranteed. Because SL is part of recognized teaching responsibilities, faculty members receive a number of sources of professional development for SL. All new faculty members receive basic training in SL as part of their general orientation. In addition, when a faculty member is assigned to teach a
course for the first time, he or she is mentored by a more senior faculty member who taught the course in the past. This provides a system of peer-to-peer professional development for SL.

Integrating SL into core courses also supports student participation. Students described how integrating SL into core courses has led them to perceive SL as an integral part of their training, and not just as an “add-on.” In addition, students appreciated that SL was integrated into their course schedule, and they were not expected to find the time for SL preparation and reflection outside of their core coursework. In fact, students recommended that SL service hours be blocked into their schedules, as well.

Many administrators and faculty said that the presence of the SL office at the level of the college, rather than the university, was also important to provide support for faculty participation. The SL staff at the college have specialized knowledge of how to implement SL in health professions education. As such, they can provide enhanced technical assistance to faculty. Faculty described how the SL staff collaborated with them to design new SL courses, maintained community partnerships, provided technical assistance for preparation and reflection activities, and gave guest lectures in their courses to prepare students for SL. The SL staff were available for trouble-shooting and also provided a periodic faculty professional development series on SL. Faculty members described how this technical support gave them the confidence to engage in SL:

“Logistical support is probably one of the key things that helped with buy-in [from the faculty] – to know that there was someone there to help us manage that. Because I'm not sure, being a new faculty member who’s never done formal service-learning, that I could go out and build those community partnerships in a constructive [way]. I wouldn't know the pitfalls. So having that expertise has just really been very comforting and makes us feel a little more secure about what we're doing.” (faculty member, pharmacy)
Strategies for Success: Maximizing the Quality of SL as an Educational Tool

This case highlights two strategies to maximize the quality of SL as an educational tool. The first is to integrate SL into core courses. The second is to provide opportunities for transformational learning.

*Integrating SL into the Core Curriculum*

Each of the degree programs in the college of health professions has identified how SL achieves learning objectives for the degree program as well as for specific courses within the degree program. In addition, the schools of nursing, pharmacy, and physical therapy have all identified how SL teaches to learning objectives that are part of their accreditation requirements. The explicit use of SL to achieve core learning objectives maximizes the quality of SL as an educational tool, by making the purposes of SL very clear. For example, in nursing, physical therapy, and pharmacy, SL has been integrated into core course series that focus on professional roles development. In health administration, meanwhile, SL has been integrated into a capstone course that functions as a transition to professional practice. Situating SL in these experiences helps to make explicit for students that civic engagement is a part of their professional roles:

“We really felt that if we were going to engage students and get them to appreciate the importance of service in their professional careers that we should attach it to courses where they’re exploring ‘what is their role as a practitioner?’ so it becomes integral to their role in practice.” (dean of physical therapy)

In nursing, physical therapy and pharmacy, this message is reinforced by the fact that SL is not provided in a single one-semester course, but is, instead, generally part of a multi-course sequence. Nursing students participate in one to three SL courses, depending on their degree program. In the longer physical therapy and pharmacy
doctoral programs, SL is incorporated into one course every semester for the duration of the three-year program.

In all of the degree programs at the college, SL is also designed to achieve educational objectives specific to the course where it is embedded. These typically focus on learning about a particular population and its health needs, or learning about particular professional skills:

“In the first [professional] roles [development] course for the juniors, … that course focuses on social justice issues, healthcare issues related to the elderly. So all of the students, all of the juniors, spend their service-learning time in assisted living facilities.” (dean of nursing)

Another way that integrating SL into core courses helps to maximize the quality of SL as an educational tool is that preparation and reflection are included in classroom lectures and discussions, as well as in course assignments such as readings and graded papers. Faculty described how this helps students to connect their service experiences with learning goals:

“At the beginning of each academic class, [we] have students share their experience of their service-learning for the past week and how it ties into, for example, access [issues for persons with disabilities], which would be a theme of service throughout the course. They’re getting course content that may relate in some way to access. But it makes it more explicit if they can identify their [service] experience with the content.” (faculty member, physical therapy)

“As part of that written paper … we ask them to think about how they worked in the group, and what did they learn from the group and from the project itself, and then what do they think their contribution was. So it’s that evaluative sort of reflective piece. And making sure that they understand that this just isn’t volunteer work. You learn something from this and consciously evaluate your impact.” (faculty member, physical therapy)

Faculty described how the school of nursing has successfully incorporated SL into online learning by using the same strategies to build preparation and reflection into course
activities. Preparation includes streaming video of a lecture by the SL staff and testimonials by former students. Reflection involves an online discussion shaped by guiding questions and a graded paper.

Creating Opportunities for “Transformational” Learning

While SL delivered through the curriculum can foster important educational outcomes, as demonstrated in the quotes above, the SL office has found that more intensive SL experiences are especially useful to promote educational outcomes related to attitudinal changes, such as cultural humility and breaking down stereotypes. It has developed one-week to month-long intercultural SL immersion opportunities in Latin America, Africa, and on a Native American reservation. Both SL staff and faculty members accompany students on these trips.

A partner for the immersion on the Native American reservation described how he involves students in a sweat lodge ceremony to shape their understanding of Native culture and healing practices:

“I thought, ‘Hey, what an opportunity for the [university] students to be able to learn more and more about the culture,’ … Them all being nursing students, or into the medical field, I thought, ‘What better way than to be able to come out and get some hands on, first hand experience with our [healing] ceremony at the sweat lodge?’ … I think what I really want them to do is get interconnected, knowing that there's only one God, only one Creator, and not come in here and blaze that one way is the only way. … Our ceremonies have been going on from the beginning of time, ever since our Indian people have been on this continent. … I like to let them see the difference between the cultures, and also the difference of … how the healing actually works.”

A faculty member who had recently returned from one of these immersion experiences described how the intensity of the experience, and the relationships that were formed across cultures, helped both faculty members and students to break down stereotypes.
The SL director related how, “In terms of their personal transformation that takes place, we see people moving in leaps and bounds through those kinds of experiences.”

To promote educational outcomes related to these immersion experiences, students participate in retreats both before and after the experiences that provide preparation and reflection opportunities. Students are also required to translate their SL experiences into some sort of action in their local community, such as engaging in related advocacy work or speaking about their experiences at the university or in a community setting.

Challenges and Responses: Maximizing the Quality of SL Service Experiences for Both Students and Community Partners

Challenges

While the college provides a model of how to maximize the quality of SL as an educational tool, there is still a great deal of variation in the quality of the partnership component of SL. Students, community partners, faculty and SL staff members described how students’ service experiences through SL varied widely. The types of service they described fell into three categories: 1) providing direct service that could be done by any high quality volunteer, 2) creating new services that would not exist without the students’ participation, and 3) making significant permanent contributions to community agencies, that resulted in capacity building to address health issues. In the first category, for example, students packed boxes of medical supplies for overseas medical trips, served meals in a soup kitchen, and directed traffic at one-day health fairs. In the second category, students collaborated with faculty members to plan and implement an annual health fair in the local community that had 500 attendees in the
prior year. In the third category, over the course of four semesters, physical therapy students helped an assisted living facility develop a physical activity program for its residents. By the end of the two-year collaboration, they had trained staff members at the facility to manage the program.

This variation created inconsistency in the quality of the SL service experiences both to advance educational outcomes and to maximize benefits for community partners. In some cases (category 3), students and community agencies benefitted from a co-learning experience and community agencies benefitted from capacity building. In other cases (category 1), students were simply supplying extra hands, and this did not further their educational goals or produce any long-term benefits for community agencies. In the majority of cases (category 2), students were using their health knowledge to provide needed services that also advanced their education. But sometimes these services filled an immediate need so well that community partner agencies developed a dependency on the SL relationship. Individuals from two of the three community agencies that participated in this study described being at a loss when students were unavailable to provide services they counted on.

This wide variation in the quality of SL service experiences was due to a number of factors in the college and the community. Academic partners recognized the added value of SL that focused on capacity building. But the design and scope of SL at the college were barriers to this partnership model. With only two staff members to maintain relationships with over 40 community agencies and provide support to many faculty and students, the SL office did not have sufficient resources to maintain the sort of deep relationships with community agencies that were necessary for capacity building.
The SL director described how many community partners did not have the time to engage in this level of partnership, either. This was corroborated by community partners who participated in this study. Interview participants from all three community agencies said that constraints on their own time limited their interactions with the SL office. In addition, these time constraints seemed to be a major limiting factor on their relationships, something that became evident when community partners were asked how their SL partnerships could be improved.

Two of the three agencies received services that fell into the second category described above, while the third received services in both the first and second categories. Partners from all three agencies expressed great appreciation for the services they were currently receiving, and at first, they had no recommendations for how their partnerships could be enhanced. But, when probed, administrators at two of the agencies had ideas for how the SL partnership could be enhanced in ways that would support their internal capacity to address the health needs of their clients. For example, one suggested that students could conduct needs assessment that would support the agency’s strategic planning and grant writing projects. The other, a school principal, described how the university could provide financial support to purchase health textbooks for students. Yet both said they had never shared these ideas with the SL director, and in fact, had never communicated directly with the SL office. They attributed this to competing demands on their time: “probably because life gets crazy with the day-to-day operations of things.”
Responses

The SL office has adopted three responses to the challenge of maximizing the quality of the SL service experience. These are: 1) adopting a tiered system of partnership levels, 2) relying on some faculty members to sustain SL partnerships, and 3) developing two-semester-long SL service experiences. To address limitations in time and staffing for both academic and community partners, the SL office has consciously decided to engage in two different forms of community relationships: a clearinghouse model and a partnership model. The SL staff members invest their energy in maintaining and developing this latter set of relationships. The SL director described how whether a community agency participates in one model or the other is determined in an intentional manner, “through the process of communicating with the partner … based on what the needs are and what we’re able to bring to those needs.” It is also based on whether a staff member is available at the community agency to engage in a more time-intensive collaboration.

To adjust to time and staff limitations on the academic side, in particular, the SL office has come to rely on some faculty members to develop and maintain deeper community partnerships. In some of these cases, the faculty members provide professional service to the organizations on their own time, for example, serving on their boards of directors, fundraising for the organizations, or providing services such as program development. Their involvement not only spreads the burden of maintaining partnerships, but also enhances the quality of the partnership process. The personal relationships they form and their demonstrated commitment to the agencies open up lines of communication and establish a sense of trust that can lead to deeper relationships.
However, these faculty members maintain only a small percentage of the college’s community partnerships for SL.

Finally, the SL staff believed that another constraint on the ability to move to more capacity-building relationships was the turnover in students each semester, which precluded the development of collaborative relationships between students and community partners. To address this limitation, the college is considering developing two-semester course sequences through which students would partner with the same organization for a full academic year.

**Rethinking the Relative Value of Service and Capacity Building**

No academic partners who participated in this research – including administrators, faculty members, SL staff, and students – saw the fact that not all relationships were collaborative as a deficit. (As described above, neither did community partners.) Rather, taking multiple approaches to community engagement was seen as a way to work with communities on their own terms, itself a hallmark of high-quality SL. The SL director reflected on this approach as follows:

“It’s responding to a variety and diversity of community needs. And recognizing that the needs are so varying and so different, it’s hard to say that one is greater or more important than the other. [So] we try to be flexible with our community agencies and respond to those needs, too, and not always say, ‘our students can only do this, because this is what we want, and nothing else.’ … [I]t’s a responsibility that we have when we try to work with community.”

The SL director’s comments captured an attitude that was conveyed in many interviews that what is most important in a SL relationship is the presence of co-learning and equity, and that these characteristics can be achieved with direct service as well as with capacity building.
Many academic partners also described the idea that there is a “spectrum” of social engagement, with service on one end, and collaborative partnerships and social justice work on the other. They described how both community partners and students needed to “progress at their own pace” along this continuum:

“I’ve found that community agencies are much more responsive and much more willing to work with you, and it’s easier to form long-term, deeper relationships if we can also [at first] accommodate some of the needs that they really need filled that might be a little less sexy to us or to our students.” (SL director)

Faculty members described how service might be more appropriate for younger students, while older students who already have some professional experience, or students who are in the later stages of their education, might feel more comfortable becoming involved in capacity building or activism. By providing opportunities for community engagement ranging from service to capacity building to activism the college could engage all of these students in the form of SL that would be most appropriate for their level of readiness to engage with the community.

Finally, community partners uniformly echoed the value of direct service (as opposed to capacity building) to their agencies. Partners from all three agencies described how the services they receive through SL met the needs of their populations in ways the agencies cannot meet with their internal resources. Each agency’s main priority is to foster the wellbeing of the population it serves, so a SL relationship that provides direct service aligns perfectly with the agency’s goals. Interview participants from one community agency said that the students participating in SL had enhanced the “quality of life” of their clients; while an interview participant from another agency said of SL:

“It's been one of the most wonderful things for our students, for myself, and for our community and district, because they just bring so much when they come, and
it's just a really wonderful experience. … And the program, itself, I don’t know how you could enhance it any more, because it’s wonderful.”

University 2: SL in Health Professions Education at an Academic Health Center

Institutional Setting

University 2 is a private, secular institution located in a major urban center. It has over 10,000 undergraduate students and 9 graduate colleges and schools and includes an Academic Health Center (AHC) that is home to schools of medicine and public health. The school of medicine includes a large division of health sciences that offers degree programs in nursing, physician assistant, physical therapy, and other allied health professions. A SL office is located in this division. It coordinates an interdisciplinary team-based SL experience for students in degree programs in medicine, physical therapy, physician assistant, nurse practitioner, and public health.

The mission statement of the AHC emphasizes its roles as a teaching and research institution and a provider of clinical care. Its vision statement reflects a strong emphasis on quality of care, new technologies, and engaging in partnerships that take advantage of the resources available in its urban area. Teaching goals mirror this institutional vision statement. Current educational priorities at the school of medicine are to provide high quality teaching by implementing the latest pedagogical innovations, such as computerized patient simulators and actors who serve as standardized patients, and offering elective courses of study that take advantage of local resources for experiential learning. These electives provide training in areas ranging from community health to clinical research to emergency preparedness.

Faculty and community partners described an institution that sees itself as a member of its local neighborhood. The AHC considers itself a core member of the web
of healthcare providers serving the local population. It also collaborates with other local providers and researchers to provide service, train students, and engage in research. The institution conducts community outreach including annual community service days in which administrators, faculty and hundreds of students engage in activities such as painting public elementary and high schools and doing landscaping at community agencies; hosts a faculty lecture series in the neighborhood; and maintains a public database of community engaged research where community agencies can identify potential collaborators.

Goals for SL

Academic Partners

Academic administrators and faculty members described two main goals for SL: 1) to train students in community and population health competencies, and 2) to “build bridges” to other agencies in the network of local health providers. They highlighted five community health competencies as educational goals for SL: interdisciplinary teamwork, cultural sensitivity, an understanding of the social determinants of health, skills to partner with community agencies, and an ethic of civic professionalism. The first four of these competencies were seen as ways SL could improve the quality of students’ future professional work, whether they pursued careers as clinicians or in community and population health.

Faculty and administrators saw SL as a singular way to give students experience with interdisciplinary teamwork, which could foster an understanding of and respect for other professions and prepare them to work in increasingly interdisciplinary clinical settings. SL provided the only structured opportunity at the AHC for interdisciplinary
teamwork. Similar to University 1, many academic and community partners saw SL as a tool to help students identify and break down racial and ethnic stereotypes and prejudicial attitudes about marginalized populations such as the poor, homeless or mentally ill. Both academic and community partners closely tied this outcome to the goals of dismantling power differentials between healthcare providers and patients, and between health professionals and community partners. One faculty member described how SL could contribute to this outcome:

“[Through SL, students] get to develop relationships with people they may not ever meet on an equal basis. You know, later on maybe they’re a provider or maybe they’re a program director or something and these are their quote, clients. But in this setting, they’re kind of equal. You know, they learn from each other – so that’s really valuable.” (faculty member, public health)

Academic partners also saw SL as a way to teach concrete skills for partnering with community agencies, including needs assessment, program design and implementation, and evaluation. But many stressed that the most important skill that SL teaches is an understanding of how to “relate to” community agencies:

“When they graduate, we want practitioners that can go into the community, and relate to the community, and provide services that are of value to the community. … [W]e want them to be current and up-to-date on how to be effective in the community.” (faculty member, physical therapy)

Finally, administrators and faculty described how they believe SL can enlighten students about the social determinants of health and introduce them to settings where they can contribute to community health. They believe these exposures could foster an ethic of civic professionalism in students that may lead some to provide some amount of pro bono care, and inspire other students to pursue careers in community health. Many
interview participants, including academic and community partners, described how SL is a way to show students that there is “another way to be” a health professional.

In addition to these goals for student learning outcomes, academic partners saw SL as a way to “build bridges” that connect the AHC to other agencies in the local network of health providers. They described how, while the institution has assets to offer to other members of this network, community agencies also have assets to share, particularly as related to training students. Academic partners also saw SL as a way to enhance public relations in the local community, and described students as “ambassadors” of the institution.

**Community Partners**

Community partners had two primary goals for SL: to receive needed service, and to participate in educating future health professionals. Mirroring community partners at University 1, they described how they equally value the services they receive and their role as educators. Community partners at University 2 saw SL partnerships as a resource to create and implement projects or create permanent resources that their agencies did not have the staff time or internal expertise to carry out. They described how students had produced curricula for health education classes, protocols for patient interactions, patient educational materials, and data analyses that were used to guide future activities.

Like academic partners, community partners saw SL as a way to improve the quality of students’ future work as clinicians or as leaders in community health. Like community partners at University 1, they saw themselves playing a valuable educational role by providing opportunities for experiential education, and saw SL as a way to educate students about how to be better care providers to the populations their agencies
served. But another priority for community partners at University 2 was to educate students about careers in community-based settings. Some spoke about how SL allowed students to “try out” community-based work before committing to a career path. More described how they hoped to “inspire” students to go into community-based work, and described how they saw themselves as role models and as resource persons who could answer questions about why they chose community-based careers. Some explicitly hoped to recruit students to work at their own organizations or similar ones:

“You know, an organization like this may be the pivotal point for a student to say, ‘Oh my God, I thought I was going to go back and work for Dr. Gonzales and his G.I. business. But gosh, I can actually look at the world from a much bigger view!’” (administrator, community agency)

While community partners saw SL as a way to build connections to the academic institution, they described the benefits of these connections as the general potential for partnership-building – rather than any specific goals for future collaboration -- and the enrichment of the professional lives of their staff.

**Design and Implementation of SL**

The SL office at the AHC is directed by a full time high-level staff member, with support from a part-time assistant. Organizationally, it is located in the office of the dean of the division of health sciences, and it is funded by that office. SL operates as a freestanding experience that degree programs can incorporate into an elective or required course, or that students can participate in as volunteers. The physical therapy and nurse practitioner programs each integrate SL into required two-course series. The faculty members who teach these courses described how these training programs identified SL as a means to fulfill accreditation guidelines for educational outcomes and curriculum content. The physician assistant program integrates SL into an elective course. Public
health and medical students participate to fulfill a requirement of the elective track in community health. To allow all interested students to participate, all of these degree programs have protected a two-hour time window each week for SL team meetings.

Students commit to participate in SL for one academic year. (Some participate for a second year, as volunteers.) They are grouped into interdisciplinary teams of about twelve persons, and each team partners with one community agency. Over the course of the academic year, each team develops a durable product or series of products to meet the needs of the community agency. SL teams meet twice a month during the protected time window and team members carve out additional time to work with their community partners, either as a team or as individuals. Each student is expected to participate for a total of ten hours per month.

In 2008-9, approximately 150 students participated. About a fifth each were in nursing, medicine, and physical therapy, and just under two-fifths were in public health. Physician assistant students accounted for less than five percent of participants. About a dozen community agencies participated. Almost all were located in the same geographic community as the AHC, and most were health clinics or health and social service providers that, among other services, offered health clinics. Of the remaining organizations, most provided educational services to underserved teens and adults. Almost all of these organizations served underserved and marginalized groups, including new immigrants, low-income and homeless individuals, and people with HIV.

Each SL team includes a faculty advisor, a community advisor, and a student facilitator. The community advisor is a staff member of the community agency. Some faculty advisors participate because they teach the courses that integrate SL, and others
volunteer. The role of the community and faculty advisors is to support the students in achieving their educational and service goals. Student team leaders are volunteers who keep the team on task to complete its project goals and who coordinate the team’s progress through an online curriculum, as described below.

The online curriculum consists of learning modules in three areas of skills and knowledge: 1) interdisciplinary teamwork, 2) culturally sensitive practices, social determinants of health, and asset-based approaches to partnering with communities, and 3) models for community based public health interventions, such as community oriented primary care and CBPR, as well as methods for needs assessment, program development and implementation, and evaluation. A portion of time in the bimonthly meetings is set aside to work through the curriculum, and the curriculum is peer-taught by student team members. For nurse practitioner and physician assistant students, related courses expand upon this curriculum.

**Strategies for Success: Maximizing the Quality of SL Partnerships**

SL at this institution provides a model of how to implement principles of high-quality SL partnerships, including equity, collaboration, and reciprocity in learning and program benefits. The key to success for SL at this institution has been to create infrastructure and procedures that foster the development of healthy partnerships between community partners, faculty members, and students. It does this by facilitating power-sharing, collaboration, relationship building, communication, and co-learning.

**Equal Roles for Faculty and Community Partners**

The advising structure for SL teams, in which each team includes a faculty advisor and a community advisor, fosters power-sharing, collaboration, and relationship-
building. The intention for this to be an equitable relationship is reflected in their shared title:

“we refer to both as advisors… because they both share that responsibility and role of guiding and providing [expertise based on] experience, which we value as knowledge along with research and technical expertise.” (SL director)

To solidify this equitable partnership, it is required that the first team meeting be held at the community partner agency. Teams also are encouraged to hold future meetings at the community agency, to make it easier for community advisors to attend.

Many community and faculty advisors described how they saw their counterparts as colleagues with complementary teaching roles:

“Sometimes the students actually watch me defer to [the community advisor]. So as a faculty person, they think that, ‘oh, you're deferring.’ And you’re like, ‘No, I defer to him because I think that he knows what he’s doing – he knows where he's at better than I know where he's at!’” (faculty advisor)

“[The faculty advisor] also brings it back, often, to more of the curriculum, to more of literature-based, evidence-based sort of things. Whereas I probably look at, ‘well, what’s possible? And how can we logistically do something?’” (community advisor)

Collaboration and Relationship-Building Among Faculty and Community Partners

Some faculty advisors described how their community counterparts were not available for meetings or much other communication due to competing job responsibilities. But other faculty and community advisors described how both advisors attended most of the team meetings and stayed in close contact with each other by email to discuss issues ranging from the choice of project to the details of project implementation to team dynamics. Some faculty advisors described how they had developed close relationships with their community counterparts that had led them to become involved in the community agencies in other ways. One described the resources
he provided through his relationship with the community advisor at a high school for health careers:

“I guess it’s not a requirement as a faculty person. It’s just that, as part of the relationship, I help bring [him] things also, and even help some of his students potentially get a summer job in the emergency room. … He’s always interested in exposing his students to other health careers. So … I got some pharmacists to come and talk with them. … The other day we were looking for forensic scientists. I... know some people who work in the medical examiner’s office… so I connected them.”

In addition to their contact through team meetings, faculty and community advisors for SL participate together in group professional development sessions three times a year. These sessions reinforce their equal roles and create dialogue that fosters co-learning. Sessions generally consist of facilitated group conversations on issues that will come up during that stage of the partnership. They range from expectations for the partnership to managing group dynamics to reflections on strengths and challenges in completed projects. These sessions also provide training on topics relevant to their roles as advisors. At one recent meeting a panel of experts spoke about the content of the curriculum. Faculty and community advisors described these meetings as a way to learn from each other:

“You see what their team’s doing, what issues they’re having. … You might also talk about how [each] team’s going, like, ‘Are there issues that are bothering the team? Slowing you down? Helping you?’ and how other people are handling that. …. Seeing what all the other teams do has been helpful.” (community advisor)

The SL director and a number of faculty advisors described how the meetings create a chance for “bonding” and help to develop a sense of “camaraderie” among the group.

Participants described how the results of these opportunities for collaboration and relationship-building are that community and academic advisors develop a shared
understanding of the process and goals of SL that helps to create high-quality SL projects that benefit both students and community agencies. Other characteristics of how the SL initiative is designed also contribute to relationship-building among academic and community advisors. Many of the community advisors are clinicians with the same degrees as faculty advisors, and this contributes to equitable relationships. In addition, many faculty and community advisors have participated in the SL initiative for years, and this has provided time to develop trust.

**A SL Director who “Connects” Everyone**

Faculty advisors, administrators, and students universally described the presence of a full-time director of SL who has an ability to connect with both community and academic partners as essential to fostering relationships. Faculty members described how the SL director made in-person visits to rebuild community partnerships after turnover in faculty and community advisors. Faculty and community advisors also described how the SL director invested in relationships with them, personally, with an open-door communications policy and by providing them with resources they needed to support their SL activities. They also described how the director created an opportunity to develop relationships among the group of SL advisors by establishing the group professional development meetings. A faculty advisor said: “Everybody knows who [the director] is, and is connected to her – the students, and the faculty, and the community settings, too.” Another said that through relationship-building the SL director “revitalized people's commitment to [service-learning] – the faculty and community [advisors].”
Finally, the presence of student facilitators on the SL teams contributed to co-learning. Student facilitators structure meetings and encourage full group participation. Faculty advisors described how their presence allows faculty advisors to “sit back” and allow students to lead the meetings. To prepare for this role, student facilitators participate in leadership development sessions twice a semester in which they learn techniques for fostering good group dynamics, facilitating meetings, leading group reflection, and collaborating with advisors. The SL director also described how the student facilitators serve as role models who help the other students to understand that the students are in charge of their learning:

“[It] kind of help[s] set those norms and standards about, this is a way that we can operate [as a student-led team]. And it gives more ownership to the teams … [and contributes] to the students feeling like they are self-empowered. It's the shared leadership thing. … Because [the alternative is that] then you're always looking to the faculty. This changes the dynamic very, very quickly [to] students figuring out with help from the advisors, ‘What are our strengths? How can we help address this? This is what has been asked. How do we meet that need?’”

The result is that students, rather than faculty, lead the progress through the SL curriculum and the SL project. Faculty and community advisors and students all described how the ideal role for the advisors was to find a “balance” in which they provided enough direction and technical assistance to support students in achieving their educational goals and completing their projects, but also allowed students to lead their own learning process. This resulted in co-learning among students and advisors. One faculty advisor described how this relationship to the students had affected her:

“…[M]y experience with them in [the service-learning program] has made me look at them as more adults than just students: that they can be independent, that they do have good ideas, that they can organize and carry out activities without my, the teacher's, leadership.” (faculty advisor)
Students also provided co-leadership for the administration of the SL initiative. Representatives from each participating health professions program sat on a student advisory board to the SL director, where they provided feedback on their SL experiences and participated in planning the student orientation to SL and the year-end wrap-up event, and revising the online curriculum.

**Challenges to Program Sustainability and Responses**

*Limited Facilitators of Sustainability*

Two major factors were responsible for the long-term sustainability of the SL initiative. The first was factors related to institutionalization. Faculty described how SL was sustained because early work was done to “hard-wire” it into the schedule of all the participating programs, by protecting the two-hour block of time each week. But what was more critical to sustainability was that SL was incorporated into core courses for nurse practitioner and physical therapy students, where it was used to teach to learning objectives that addressed accreditation guidelines. A faculty member described these students as the “backbone” of the SL teams, because their participation was predictable. In fact, they were two-thirds of the participants in SL.

The second factor responsible for the sustainability of SL was the presence of program champions among high-level administrators and faculty members. Three deans participated in this research, and two described how they had been involved in applying for the HPSISN grant and were still dedicated supporters of SL. Demonstrating the importance of these champions, as competing financial demands caused other programs to withdraw their funding for SL, the dean for the division of health sciences took over full responsibility to fund the initiative.
These deans, however, credited the faculty and SL director with sustaining SL. Meanwhile, faculty members and the SL director emphasized the importance of the “dedication” and “commitment” of faculty and community advisors. Both faculty members and the SL director explained that, in many cases, faculty advisors were the ones to sustain individual community-academic partnerships. Some faculty advisors were already partnering with these agencies as clinician-volunteers or for engaged scholarship before the agencies joined the SL initiative, and therefore had a particularly strong relationship. Champions for SL – including administrators and faculty members – also described how they advocated for the SL initiative in their departments and promoted the SL initiative through media contacts. From all of these interviews what emerged was the fact that there was a critical mass of support for SL among both the administration and faculty members, and among community agencies.

Challenges to Sustainability

Despite these important sources of support to sustain the SL initiative, there were a number of significant challenges to sustainability. These included: 1) competing educational priorities for students, 2) competing priorities for faculty time, and 3) the loss of program champions. All of these challenges were rooted in the absence of institutional policies and procedures to support student and faculty participation in SL.

Because SL was not incorporated into core courses in three of the five programs that participated, there was always a threat that these programs would schedule other courses in the two-hour time window protected for SL. Underlying this threat was the problem of competing educational priorities. Faculty described a basic dilemma in the growing amount of information that health professions students are expected to master.
They described how it is a challenge to defend the value of SL in light of new knowledge areas that also have to be incorporated into the curriculum:

“There will always be people in administration and in faculty who don’t see the value of [service-learning] – that one more lecture on the pathophysiology of who-knows-what is going to be way more critical than getting out and using your skills to help the community. And it’s true, there’s never enough time. Medicine keeps getting bigger. … I just stuffed in … a pharmacogenomics lecture … because they have to know this stuff now. Because if you don’t know genetics, you’re not going to know medicine in another five years. … [And] it’s not like anything’s dropped off of medicine! You know, there’s nothing we need to know less about now. There’s just everything we need to know more about.” (faculty advisor, physician assistant program)

This faculty member in the physician assistant program asserted that, eventually, SL would need to be incorporated into a core course in the program in order to increase student access. Another reason for the threat of competing educational priorities was that SL was not linked to accreditation guidelines in these disciplines, so its value was not clearly identified. The potential absence of physician assistant, medicine, and public health students from SL was a threat to the whole SL initiative because it would undermine its ability to teach interdisciplinary team skills, which was one of the main educational goals of SL.

A second challenge to the sustainability of SL was competing priorities for faculty time. Faculty members who taught the courses that integrated SL were recognized for their roles as faculty advisors. But all other faculty advisors described this role as something they “found the time for” on top of other responsibilities. As a result, there was no way to guarantee the participation of enough faculty advisors each year. For example, one faculty member described how when her supervisor changed, she was told she could no longer serve as a SL advisor because it took away from her other paid responsibilities.
Other faculty advisors described a dilemma that is common at research universities: although the mission of the university includes teaching, research, and service, faculty described research as the most important criterion for promotion, and service as the least important criterion. As such, faculty members described feeling pressure to spend less time on SL, which they defined as service. An administrator described how this competition for faculty time would only intensify because there was an increasing institutional focus on research, and this would be a major factor in future faculty hiring and promotion decisions. A final important challenge to the sustainability of SL was the loss of champions in the administration and among the faculty, due to employee turnover and retirements. This posed a threat to both faculty and student participation. In addition, with the growing focus on research in hiring decisions, this challenge might be magnified in the future.

**Responses**

Champions for SL used two strategies to enhance the sustainability of the SL initiative. These were 1) identifying and publicizing how SL contributes to achieving other institutional priorities, particularly educational priorities, and 2) creating a web of support for SL by linking the SL initiative to other valued initiatives at the AHC. Champions for SL believed these strategies could clarify the value of SL as a feature of education at the institution, and, by extension, as a component of faculty activities. In this way, they could cultivate champions among the administration and faculty, and encourage faculty participation.

One way the SL director has promoted a wide understanding of the value of SL is by assembling an advisory board consisting of the directors of each of the participating
degree programs. One goal of these board meetings is to ensure that SL continues to meet the educational goals of each program and to solicit recommendations for how to address challenges. The SL director explained how another goal of these meetings has been to foster buy-in among program directors by demonstrating:

“how [service-learning] supports the academic vision for each of the different programs. So in working with the physician assistant program, it's like, how can [service-learning] help their students develop into the kind of the students that they are charged with cultivating, or nurturing? So being able to align it and show them the value.”

To cultivate broader support for SL, the SL director and supporters among the administration have identified how SL contributes to two important institutional priorities: student recruitment and public relations. They have then publicized these connections through one-on-one communication with top administrators and extensive use of internal media, including the AHC’s newspaper and alumni magazine. The SL director described how she attended a school of public health information fair for prospective students and surveyed students who came to her booth about their interest in SL: “We have 25 people that said the [service-learning program] was part of the reason why they were looking at [the school].” She then informed the dean of the school, who acknowledged the contribution of SL to student recruitment.

An administrator with oversight over SL described how she and the SL director have publicized its service to the community through the AHC’s internal media outlets. She related how this has led to a mutually beneficial collaboration with the AHC’s public relations office:

“We’ve become very good friends with the media people here and the folks that do the newsletter and the folks that do the alumni magazine and things like that. … [A]nytime we did an event, you know, we’ve made sure that we let them know we’re having it. We ask for some photographers to come over and take
photographs. We wrote the pieces so that they could easily put them into the newsletter or any of their press releases. And then we became sort of the go-to people [with regard to publicizing local community engagement]. So then when public relations had a need, they would then call us. … And so we became resources for them.”

The second way administrators and faculty members have fostered the sustainability of SL has been to develop a web of support by linking the SL initiative to other valued initiatives at the AHC. Recently, an assistant deanship was created to oversee multiple training programs that rely on community-academic partnerships, including the SL initiative. This reorganization has led to coordination between SL and other community-engaged educational programs. They partner with many of the same community agencies for activities that include SL, clinical rotations, and summer internships. This has increased the benefits to the community agencies and led to efficiencies for each of these training programs. Now SL is seen as a way to maintain these other training programs, and vice-versa. In addition, participation in SL was recently made a requirement for the medical school’s valued elective track in community health, and it is seen by many as a way public health students can identify agencies for their required practica. In both these ways, SL contributes to achieving other educational goals. Finally, the SL director and assistant dean participate in university-wide committees on community engaged training and public relations. The result of all of these interconnections is to create a valued role for SL in achieving the priorities of the AHC and university as related to community-engaged learning, accreditation requirements, and public relations.
Cross-Case Analysis

The Influence of Institutional Setting on SL Goals, Design, and Implementation

These two cases provide support for the recommendation that, to sustain SL, its goals should be aligned with the institutional mission and vision and institutional priorities. They also provide evidence that it is possible to align SL with different sets of institutional values. For example, at both institutions, SL is valued for what it can teach students about both quality of care and an ethic of civic professionalism. Both institutions focus on the value of SL to teach cultural competency and to break down stereotypes that could undermine quality of care. In addition, both institutions believe that, by exposing students to social needs and social determinants of health, they may be able to inspire students to take leadership roles for population health. Yet, University 1 defines the ultimate teaching goal of SL as cultivating values of service and social justice in students, while University 2 defines the main educational goals of SL as the development of community health competencies and an interest in community-engaged practice. The very different language the two institutions use to frame these goals reflect their very different institutional cultures.

These cases also suggest that the institutional culture has an important influence not only on the way the goals of SL are framed, but, in fact, on the design and implementation of SL, and that therefore, on the strengths and weaknesses of SL. In particular, these cases suggest that an institution’s mission and teaching goals, its definition of “community,” and how it sees its role in the community are important influences on how SL was designed and implemented. For example, at University 1, the institutional mission focused strongly on teaching and service. Its goals for teaching
included a “value-centered” approach and the cultivation of a “commitment to community service” in students. The University defined “community” globally and saw its institutional role in the community primarily as one of service.

The design and implementation of SL reflected these values and goals. Teaching goals for SL were 1) to help students develop an ethic of service and social justice, and 2) to enhance the quality of patient care that students would provide as professionals. Most community partners for SL were agencies that provided services to the underserved, and many of the agencies were, themselves, under-resourced. Many SL experiences consisted of direct service, and many involved one-on-one interactions that helped to break down social barriers, expand students’ definition of their “community”, and develop an ethic of care for others. Community partners and the university shared an understanding of the value of direct service to their agencies and to foster these learning outcomes in students. Many community partners were members of the same faith community as the University, and this may have undergirded their common understanding of the value of direct service.

A major strength of SL at University 1 was that it was so well institutionalized. This reflected the perfect alignment of the goals of SL with the institution’s teaching goals and institutional culture. The other major strength of SL at University 1 was the high quality with which SL was designed as an educational tool. This reflected the centrality of teaching to the institutional mission. The major weaknesses of SL at University 1 were the inconsistent quality of SL partnerships and SL service experiences. There were structural challenges to creating collaborative relationships that could lead to capacity building. These were related to the scale and design of the SL initiative at the
college of health professions, in which the responsibility to maintain partnerships fell largely to two individuals. But perhaps the more fundamental challenge to collaborative relationships that might lead to SL projects for capacity-building was the underlying core value of “service to,” rather than “partnership with” or “collaboration with” community agencies.

The same connections between the institutional mission and goals, the institution’s definition of and relationship to the community, and the design and implementation of SL can be seen at University 2. At the AHC at University 2, the institutional mission and vision focused equally on research, teaching and provision of care. Educational priorities were to implement the latest pedagogical innovations and to take advantage of local resources to create opportunities for experiential learning. The AHC defined “community” as the local neighborhood and saw its role in the neighborhood as one of membership in the local network of health providers. In addition to seeing itself as an asset to the rest of the network, it also took an asset-based view of the other members of the network, and believed they could be valuable partners in training students and conducting research.

The design and implementation of SL at University 2 reflected these values and goals. Teaching goals for SL were to develop students’ community and population health competencies and foster an ethic of civic professionalism. Community partners for SL were other care providers in the local community that had resources to co-train health professions students, and also provided care to underserved populations. Many community advisors were health professionals. SL experiences generally consisted of collaborative work between faculty and community advisors and students to define
agency needs to which students responded by creating durable products. These experiences taught students how to collaborate with community agencies and gave them opportunities to develop and practice community based public health skills such as needs assessment, communications, and program implementation. Community partner agencies and the AHC shared an understanding of the value of SL to “build bridges” between them, and to expose students to opportunities for future work in community-based settings.

The major strength in how SL was implemented at this institution was the infrastructure created to support collaborative relationships among community and academic partners. This reflected the institution’s orientation to partnering with community agencies to educate students, and its goal to train students in skills to work with or in community agencies. The major weakness of SL at this institution was that it was not integrated into the curriculum in all of the participating degree programs. This resulted in widely varying educational experiences for students, depending on whether they accessed SL through courses or as volunteers. It also meant that both student and faculty participation in SL was insecure, and that energy and resources had to be spent on promoting the value of SL in order to encourage their participation. This inability to integrate SL into the curriculum was a reflection of the institutional culture. Faculty members and administrators described how the AHC prioritized faculty research over service and teaching, and while the institution valued the benefits of SL to students, other areas of knowledge competed with SL for time in the course schedule.
Strategies to Maximize the Quality and Sustainability of SL: Learning from Similarities Between These Cases

While SL at these two institutions was adapted to very different institutional environments, there were four key similarities in these SL initiatives that suggest strategies to maximize the quality and sustainability of SL that can be applied in very different institutional environments. First, at both institutions SL was centrally located and operated out of the office of a dean. These traits allowed the SL office to coordinate SL for multiple degree programs, and to have access to decision-makers such as the directors of degree programs and deans, whose decisions influence the sustainability of SL. These similarities provide support for the recommendation that, to sustain SL, institutions should create centrally-located SL offices. They also provide examples of how to do this in different organizational settings.

Second, the roles of SL staff members, faculty members, and administrators were similar in important ways across the two cases. At both universities, SL staff members were identified as critical support persons to maintain community partnerships and provide professional development to faculty. They were seen as the “connection” among faculty members, students, and community partners that kept SL operating. At the same time, at both institutions faculty members also were valued for their roles in maintaining some partnerships. While faculty roles to maintain partnerships were formalized only at University 2, University 1 was coming to recognize that this would be needed to maintain the quality of community partnerships as student and community participation in SL continued to grow. In addition, at both institutions the leadership and financial support of
high-level administrators were critical to sustain SL and to provide the resources necessary for the operations of the SL office.

These similarities suggest the importance of full-time SL staff members who have the status and skills necessary to navigate both academic and community relationships; draw together a community of faculty, students and community partners; provide professional development; and engage with high-level administrators. These traits may serve as guidelines for the skills to look for when hiring specialized SL staff members. In addition, these similarities suggest that faculty members must be involved in sustaining community-academic partnerships for SL if SL is to expand to include large numbers of students and community agencies. University 2 provides an ideal model for how to formalize these relationships. Finally, these similarities provide support for the literature emphasizing the importance of leadership for SL from high-level administrators to sustain SL, and to provide the resources necessary for high-quality SL. In addition, the correlation between the status of the highest level champion for SL and the scope and institutionalization of SL across these two institutions suggests that champions for SL should aim to cultivate the support of the highest-level administrators.

A third similarity between the two universities was that both identified ways that SL advanced institutional priorities beyond educational goals. At University 1, institutional service to society was a part of the organizational mission, and SL was thought of as a way to “live its mission.” As such, SL became central to the identity of the institution. At University 2, SL was seen as a method to improve “town-gown” in the local community, to recruit new students, and to improve public relations. This similarity between the two institutions provides support for the recommendation that an important
strategy to sustain SL is to identify how SL achieves other institutional priorities. This is Furco’s concept of “organizational hooks” or “leverage points.” University 2 provides examples of how to make the value of SL explicit in institutional settings where its value may not be immediately clear to decision-makers and faculty members, through one-on-one communications with decision-makers, by using internal media, and by creating linkages between SL and other valued institutional initiatives.

Fourth, and finally, both institutions provided high-intensity and high-duration SL experiences in the community. At University 1, the nursing, physical therapy and pharmacy programs integrated SL into core course series, which provided students with a longitudinal experience. Intercultural immersions provided opportunities for high intensity SL. At University 2, students committed to participate in SL for a full academic year, and sustained a partnership with one community agency, providing both intensity and long duration. In a similar development, University 1 was considering creating opportunities to maintain a SL partnership for a two-semester course series, based on the recognition that this would create a longer-duration, and hence higher-quality, SL experience for community agencies. The fact that each university identified methods to provide high-intensity and high-duration SL experiences suggests the importance of these approaches for other institutions. These cases also demonstrate different ways to implement this recommendation, which is prevalent in the literature providing principles for high-quality SL in health professions education.
Strategies to Maximize the Quality and Sustainability of SL: Learning from Differences Between These Cases

Major differences between how each of these two institutions has implemented SL also highlight key strategies for success. The main strengths of SL at University 1 were its institutionalization and the quality of SL as an educational tool. A contributor to each of these strengths was that SL was integrated into the core curriculum. A comparison with SL at University 2 demonstrates the benefits of this approach. Integrating SL into the core curriculum guaranteed the participation of faculty and students and led to related sources of support for faculty participation. These included professional development, technical assistance, and recognition of SL in their required teaching responsibilities. Many of these factors were among the main challenges to sustaining SL at University 2.

In addition, integration of SL into the curriculum at University 1 guaranteed the quality of SL learning experiences for all students. In contrast, at University 2 the quality of SL as an educational tool varied by training program, based on whether SL was integrated into a core course or an elective, or whether students participated as volunteers. While University 2 attempted to prepare all students for SL with the online curriculum, for students who participated in SL through an elective course or as volunteers, SL was not integrated into the learning objectives for their degree program or for any core course. Meanwhile, at University 1, SL was central to achieving educational objectives for the degree program and for the courses that integrated SL. This enhanced the quality of SL as an educational tool and supported the attainment of educational outcomes for the degree program. This comparison suggests that a key strategy to both
sustain SL and maximize the quality of SL as a teaching tool is to integrate SL into core course sequences. University 1 provides an exemplary model for how to do this.

The major strength of SL at University 2 was the existence of infrastructure to support community-academic collaboration. A comparison with SL at University 1 demonstrates the benefits of this approach. This partnership infrastructure at University 2 fostered collaboration, relationship-building, communication and co-learning among community and academic partners. Compared to SL at University 1, it produced higher quality service experiences for students and left community partners with durable products that enhanced their capacity to achieve their agencies’ objectives. Relationships, communication and co-learning within community-academic relationships for SL were present at University 1, but these characteristics were not consistent across community-academic relationships. Rather, they were related to unsystematic factors such as the voluntary leadership of a faculty member to maintain a community partnership and the evolution of some community relationships from the clearinghouse to partnership model. As a result, the quality of service experiences for students and the products of SL for community partners varied dramatically. This comparison suggests that a key strategy to maximize the quality of SL partnership methods is to create infrastructure that shapes intentional, collaborative partnerships between community partners, faculty members, and students. University 2 provides an exemplary model for how to do this, offering guidance for how to implement the recommendation in the literature to engage in a “partnership process” (Torres, 2000).
Discussion

These two SL initiatives provide examples of how to successfully implement principles for high quality SL, strategies to foster the sustainability of SL, challenges to achieving these goals, and practical responses to these challenges. Our findings suggest that the design and implementation of SL and its related strengths and weaknesses, in terms of both quality and sustainability, are strongly influenced by the institutional environment. However, similarities across the two cases suggest that there are key practices to sustain SL and maximize its quality that can be successfully implemented across very different institutional environments.

Differences between these cases highlight model practices for maximizing the sustainability of SL, the quality of SL as an educational tool, and the quality of community-academic partnership for SL. These may serve to guide other health professions colleges, schools or departments as they work toward the same goal. However, the extent to which these strategies can be successfully applied may depend upon the institutional setting and the resources available, including funding and the leadership and participation of administrators, SL staff, faculty members, community partners and students.

Our findings also are consistent with the small literature describing the strategies that sustained SL initiatives in health professions education have used to foster the quality of SL. Our results echo this literature in asserting the importance of integrating SL into the core curriculum (Davidson & Waddell, 2005); investing in relationship-building, communication, and equity in community-academic partnerships for SL (Meyer, Armstrong-Coben, & Batista, 2005); and creating longitudinal SL experiences to
enhance the quality of the service experience for faculty members, students, and community partners (Andrus & Bennett, 2006).

Our findings also add to the literature on SL in health professions education. Similar to the literature on SL in higher education more broadly, this research suggests that key practices to maximize the quality of SL in health professions education are to establish a centrally-located SL office and to staff this office with specialized employees who can provide support to faculty, student, and community partners for SL (Bringle & Hatcher, 2000; Gelmon, Holland & Shinnamnon, 1998; Gray, et al., 1998, as cited in Furco, 2002). This research also identifies strategies to foster the sustainability of SL in health professions education, including aligning SL with the institutional mission and vision, identifying how SL advances other institutional priorities, and publicizing the value of SL. Again, these findings echo the literature on SL in higher education more broadly (Furco, 2002; Furco & Holland, 2004; Hutchison, 2005; Rubin, 1996). This research adds to the literature by providing examples of how these strategies for sustaining SL have been implemented within very different institutional settings.

This is the first study we are aware of to explore the viewpoints of all stakeholders in SL to develop an understanding of the experiences of long-term sustained SL initiatives in health professions education. It provides a rich and complex picture of the experiences of each of these SL initiatives. However, the results of this study should be considered in light of its methodological limitations. First, this research has the limitations of case study research, in general. Our findings may not be generalizable to other settings, or to other faculty members, students, community agencies, or community partners for SL in these settings, because we did not attempt to recruit a representative
sample. Rather, we purposefully selected these cases to provide examples of sustained SL in very different institutional settings, and we purposefully selected participants to provide a wide range of perspectives and experiences on SL at each institution.

A second important limitation of this research was the limited participation of community agencies. Due to limited resources to conduct this study, only three community agencies participated in each case study. While for University 2, these agencies represented one-quarter of all community partnerships for SL, for University 1, they represented less than 10% of community partnerships. This may have introduced unknown sources of bias into the research, particularly for the case study of SL at University 1.

A third limitation was in how the three participating community agencies for each case study were selected. There were two flaws in how these agencies were selected. First, for each case study, the SL director selected these agencies, based on the case selection criteria we provided. However, the SL director may have also selected these agencies on additional variables, such as the presence of interpersonal relationship, or ease of scheduling. These factors may have introduced bias into the findings, because they may be associated with the quality of the community agency’s experiences with SL.

A second flaw in how the community agencies were selected was the composition of the case selection criteria. While the three case selection criteria were certainly relevant influences on the topics this research explored, in retrospect there were more important factors that could have been included in these criteria. Specifically, the case study of University 1 identified three categories of SL, which essentially represented three levels of quality. In retrospect, it would have been ideal to select community
agencies from each of these categories, in order to explore what factors led to each level of quality. In fact, of the three agencies selected by the SL director, two received services that fell into the second category, and the third received services in both the first and second categories. In addition, the case study of University 2 identified two major groups of community agencies: health providers and education providers. It would have been ideal to select community agencies from each of these groups. However, all three selected by the SL director were from this first group. Underlying these limitations was the fact that the case selection criteria for the community agencies were identified before data collection began. If the study investigator had been able to conduct the academic interviews before selecting the community agencies to participate, these patterns would have emerged, and this may have led to these changes in the case selection criteria.

A fourth limitation was that the individual interview participants at both the university and the community agencies were selected in collaboration with the SL director. This may have also resulted in unintentional bias, for example of the SL director selected some equally qualified individuals over other, based on factors that may have been related to their experiences with the quality and sustainability of SL. To reduce this limitation, we created a detailed initial list of potential interview participants by job description. In many cases, there was only one individuals in each of these job descriptions, and this limited to some degree the discretion of the SL director in selecting interview participants. A fifth and final limitation is the possibility of reporting bias. By conducting multiple interviews for each case, we were able to reduce the likelihood that this sort of bias influenced the final analysis of these data. In addition, for both cases, most of the administrators and faculty members who were involved in SL participated in
this research. Meanwhile, for each community agency that participated in this research, typically only the two individuals we interviewed were involved with SL.

Despite these sources of bias, there are parallels between our findings and the literature on sustained SL initiatives in health professions education, as well as the literature on SL in higher education. These parallels lend support to the validity of our findings. Additional research is needed to explore how to foster the quality and sustainability of SL in health professions education. Future case study research on sustained SL initiatives in health professions education could be designed for greater generalizability. Specifically, it might include a greater number of cases selected not only for differences but also for similarities in hypothesized causal factors, such as institutional culture. Commonalities among cases in similar institutional environments and contrasts between cases in different institutional environments would enhance the generalizability of the findings. In addition, future case study research should consider first conducting data collection with academic partners to identify key characteristics of their SL initiatives, before creating case selection criteria to select community agencies. Doing so would allow for future research to use interviews with community partners to explore in further depth their findings from interviews with academic partners.
CHAPTER 6: MANUSCRIPT 3

Student Leadership for Service-Learning in Health Professions Education: A Case Study

Abstract

Increasing numbers of health professions schools are adopting service-learning (SL), both to train students in community and population health competencies and to partner with local community agencies to address unmet local health needs. Recently, there has been growing interest in how students can provide leadership to advance SL at their institutions. This article summarizes the literature on student leadership for SL in health professions education. It then describes how a student organization at the Johns Hopkins Bloomberg School of Public Health provided leadership to advance SL by 1) using internal advocacy methods to demonstrate student interest in SL, 2) providing support for efforts led by faculty and staff to develop SL, and 3) leading a partnership of students, faculty and staff to create a Certificate in Community-Based Public Health grounded in SL. Drawing on public health advocacy principles, this article suggests that students have a unique role to play in advancing SL in health professions education that is distinct from, and complementary to, the roles of administrators, faculty and staff. It suggests that by including students as partners, faculty and administrators who are providing leadership for SL can both enhance their efforts to implement SL and improve the quality of SL at their institutions. This article concludes with recommendations for how health professions academic institutions can engage students as colleagues in order to take advantage of student leadership for SL.
Introduction

In recent years a national consensus has developed on the need to reform health professions education to better serve the public. One focus of attention has been the need to enhance the curriculum to train students in the skills, knowledge, and values they will need to provide leadership for population and community health (Allan, et al., 2004; Association of Schools of Public Health [ASPH], 2004; Institute of Medicine [IOM], 2003a; IOM, 2003b; IOM, 2004; O’Neil, 1993; O’Neil and the Pew Health Professions Commission, 1998). Another focus has been the public purposes of higher education, and the need for health professions academic institutions to increase their level of civic engagement to better support the health of the public (Astin, 1999; Boyer, 1990; IOM, 2004).

Service-learning (SL) has been proposed as a response to both of these goals. Founded on community-academic partnerships, SL creates experiential learning experiences for students, who provide service in response to community-identified needs (Seifer, 1998b). In SL partnerships, students, faculty and community partners are all seen as co-learners and co-creators of knowledge (Jacoby, 1996a; Seifer, 1998b). SL aims to train students in competencies for community and population health, such as those recommended by the Pew Health Professions Commission for all health professionals, including: cultural sensitivity; an ethic of civic professionalism; an understanding of the social determinants of health; critical thinking, reflection, and problem-solving skills; and skills for population health, community partnerships, interdisciplinary teamwork, and lifelong learning (O’Neil and Pew Health Professions Commission, 1998). An equally important goal of SL is to build equitable partnerships between academic institutions and
community agencies that create benefits for everyone involved, including academic institutions, faculty members, students, community agencies, and the communities these agencies serve (Jacoby, 1996a; Seifer, 1998b). SL has the potential to build capacity in both academic and community partners to participate in additional partnerships that address community health (IOM, 2003; Seifer, 1998b). It also has the potential to develop community partners’ capacity to address health concerns, contribute to a culture of civic engagement in participating academic institutions, and improve “town-gown” relations (IOM, 2003; Seifer, 1998b; Seifer and Maurana, 1999). Principles for high quality SL in health professions education are explained in detail in a number of articles (Bailey, Carpenter, & Harrington, 2002; Cashman & Seifer, 2008; Cauley, et al., 2002; Seifer, 1998; Yoder, 2006).

A growing body of literature describes how SL is being implemented to train student in medicine (Davidson & Waddell, 2005), nursing (Bittle, Duggleby & Ellison, 2002; Hamner, Wilder, Byrd, 2007; Kushto-Reese, Maguire, Silbert-Flagg, Immelt, & Shaefer, 2007), public health (Greenberg, Howard & Desmond, 2003; Gregorio, DeChello and Segal, 2008), pharmacy (Brown, Heaton & Wall, 2007), and dentistry (Hood, 2009). While these publications focus on how SL is designed, they also highlight the importance of teamwork among administrators, faculty members, community partners, and funding agencies to successfully implement SL.

**Student Leadership for SL**

An emerging area of interest is how students can provide leadership for SL. The national membership organization Campus Compact, which promotes civic engagement in higher education, has published a number of student authored or co-authored
publications that highlight student leadership for civic engagement at the undergraduate level (Germond, Love, Moran, Moses, & Raill, 2006; Long, Saltmarsh, & Heffernan, 2002; Raill & Hollander, 2006). The volume, *Students As Colleagues: Expanding the Circle of Service-Learning Leadership*, includes 19 chapters authored or co-authored by undergraduate students that describe how students are providing leadership for SL in particular (Zlotkowski, Longo, & Williams, 2006). The forthcoming *Handbook of Engaged Scholarship: The Contemporary Landscape (Volume One: Institutional Change)* includes two chapters on student leadership for engagement (Fretz & Longo, in press; Vogel, Fichtenberg, & Levin, in press). In health professions education, the not-for-profit organization Community-Campus Partnerships for Health (CCPH) has a history of cultivating leadership for SL and civic engagement among health professions students. Its 2000, 2005 and 2006 annual conferences included tracks that highlighted student leadership. As early as 1998, the Pew Health Professions Commission recommended that all health professions schools adopt a community engagement requirement for graduation, preferably integrated into the curriculum through SL, and that students should assist in the design and development of these opportunities (O’Neil and the Pew Health Professions Commission, 1998).

Only a small number of articles describe student leadership to implement SL in health professions education. But they describe how students are making unique contributions to SL by creating innovative models that have clear benefits for both students and communities, and by catalyzing the integration of SL into the curriculum. Perhaps the signature way health professions students have provided leadership for SL is by creating student-run free community health clinics, where students enhance their
training to care for the poor and underserved and address unmet health needs in their communities. A recent survey identified these clinics at 40% (49) of US medical schools (Simpson & Long, 2007). The literature documents how students around the country have created partnerships with community agencies where they have established clinics, secured funding for clinics, and staffed these clinics with students from across the health professions (Beck, 2005; Eckenfels, 1997; Moskowitz, Glasco, Johnson, & Wang, 2006). This literature also describes how health professions students have collaborated with faculty and administrators to formalize community partnerships and integrate clinic-based SL into the curriculum, and have collaborated with students in other health professions, such as social work and law, to expand the services provided in these clinics (Albritton & Wagner, 2002; Eckenfels, 1997; Moskowitz, et al., 2006; Peabody, Block & Jain, 2008).

The academic and gray literature also document how health professions students have created innovative extracurricular SL opportunities in population health. For example, a student at the Johns Hopkins Bloomberg School of Public Health (JHSPH) collaborated with the director of the student community service and SL center to develop The Connection, a consulting service in which teams of student volunteers engage in short-term grant-writing, needs assessments, and applied research projects to support local community health organizations and learn skills for public health practice (Rutkow, Levin, & Burke, in press). Students at the Emory and Morehouse Schools of Medicine founded HealthSTAT, a student-run not-for-profit organization that provides extracurricular SL experiences for health professions students around the state (Mohan & Mohan, 2007). Participants either design and deliver health promotion and disease
prevention services in underserved communities or conduct policy advocacy on legislation affecting the health of the poor and underserved. They receive preparation for these experiences from community partners and faculty mentors. A Stanford medical student directs Unite for Sight (UFS), another student-run not-for-profit organization that provides community service and SL opportunities to address eye health in the U.S. and abroad. UFS Global Health Fellows engage in SL immersions at eye clinics in India, Ghana and Honduras where they participate in clinical services, support preventive health outreach, and are encouraged to conduct applied research and develop preventive health programs that expand the clinics’ scope of services (UFS, n.d.).

This article adds to our understanding of the leadership students can provide for SL. It describes how students at JHSPH formed an advocacy group called SPARC (Students for a Positive Academic paRtnership with the East Baltimore Community) that led a successful effort to create a school-wide Certificate in Community-Based Public Health. The Certificate provides a coordinated course sequence that teaches competencies for both community-based research and practice and culminates in a two-term SL capstone experience. This case highlights how students can use organizational change techniques typically unavailable to faculty and administrators to foster support for new SL opportunities. It also identifies how students’ unique perspectives may enable them to introduce innovations into how SL is designed. This case also describes challenges specific to student leadership for SL and identifies the importance of support from faculty, administrators, and staff to the success of student-led initiatives. Further, it suggests that partnerships among students, administrators, faculty and staff can improve the effectiveness of their collective efforts to create new SL opportunities, and can
enhance the quality of SL for both students and community partners. This article concludes with recommendations for how health professions academic institutions can provide additional support for student leadership for SL.

**Methods**

Methods for this case study included participant observation, document review, and member validation. The primary method used was participant observation. The author was a founding member of SPARC, a member of the group’s executive committee from 2005 through 2008, and the chair of SPARC’s curriculum committee. In these roles, she participated in all major SPARC meetings related to strategic planning, chaired most curriculum related meetings, and was the primary author of SPARC’s curriculum related products.

In order to craft this case study, the author reviewed all public documents and key internal documents produced by SPARC. Public documents included: 1) SPARC’s mission and vision statements, 2) the results of SPARC’s first student-body survey, 3) the group’s report to the School’s administration summarizing survey findings and offering recommendations for action, 4) its proposal for a Certificate in Community-Based Public Health, 5) an accompanying memo providing the rationale for the Certificate and reporting findings from SPARC’s second study body survey, and 6) the final Certificate guidelines. Internal documents included: 1) an early visioning statement, 2) internal emails and letters about key events, and 3) agendas and notes from important meetings about strategic planning and curriculum development.

Once a draft of the case study was created, member validation was sought from sixteen individuals who had been involved with SPARC’s activities (Bloor, 1983; Miles
& Huberman, 1996). They included active and former SPARC executive committee members (n=9), staff (n=4), faculty members (n=2), and a national leader for SL who partnered with SPARC. These individuals were asked to review the case study and assess whether it corresponded with their understanding of events. Eleven provided feedback.

Case Study of SPARC

Background

SPARC was created in 2005 by students and staff at JHSPH to promote a greater institutional commitment to investing in the health of the underserved community where the School is located. SPARC’s founders included nine graduate students representing six of the School’s ten departments, and three staff members, including two who became long-term allies: the Director of SOURCE (Student Outreach Resource Center), the community service and SL center for students at the University’s schools of Medicine, Nursing and Public Health; and the project manager of the Environmental Justice Partnership (EJP), a partnership created among faculty of JHSPH, another local university, and leaders of East Baltimore community-based organizations to promote equitable community-academic research partnerships in East Baltimore. SPARC’s founders were motivated by their personal commitment to serving the health of the poor and underserved; their desire to receive training in community-engaged public health; the profound public health challenges in the local East Baltimore community; and their belief that the School could make a meaningful contribution to the health of the local community, given the plentiful intellectual resources it has available for community health and the institution’s commitment to improving population health.
The East Baltimore community where JHSPH is located faces many public health challenges, including poverty, disproportionately high levels of preventable disease, and a decaying physical infrastructure. In the neighborhood immediately surrounding the School, median household income is $14,900 (Baltimore City Health Department, 2008). The area currently ranks among the least healthy third of Baltimore’s 55 neighborhoods for HIV/AIDS deaths, drug-induced deaths, low birth weight births, and childhood lead poisoning (Baltimore City Health Department, 2008). Residents are also disproportionately affected by heart disease and stroke, diabetes, and homicide (Baltimore City Health Department, 2008). Finally, there is a large number of abandoned homes in the neighborhood, a source of multiple health threats, including lead paint exposure, rat infestations, dumping, drug trade, and violence (Cohen, 2005; Farfel, et al., 2003; Gomez, 2005).

There is a long history of JHSPH faculty research in East Baltimore, and a number of faculty members have devoted their careers to work that supports the health of the local community. But in recent years, these activities generally have been uncoordinated and the product of faculty members’ personal motivation, rather than institutional policy or infrastructure to support engaged scholarship. Since about the year 2000, however, the Johns Hopkins University turned its attention to how it could provide support for the health of East Baltimore at an institutional level. It established the Urban Health Institute to foster engaged research in East Baltimore, and created SOURCE to support community engagement among students at the health professions schools (SOURCE, n.d.; Urban Health Institute, n.d.). But these new initiatives were constrained
by small staffs and budgets, and similar to prior institutional engagement in the community, they were not coordinated with each other.

SPARC’s formation was part of the movement at the University toward a greater focus on investing in the health of East Baltimore. SPARC’s founding members believed these recent initiatives for engagement were important steps in the right direction, but were too limited to effectively address the public health challenges in East Baltimore. They felt that a major challenge was that the institution’s activities in East Baltimore were not coordinated and, therefore, their value was not maximized. SPARC’s founders wanted to contribute to fostering greater institutional investments in the health of the local community by the School of Public Health, and they believed that students could provide leadership toward this goal.

SPARC’s founders were convinced that to make a significant contribution to the health of the community, the School needed to adopt an institutional approach involving faculty, administrators, community partners, and students that would coordinate research, teaching and service in East Baltimore. What SPARC envisioned was an organizational culture change, consisting of a school-wide commitment to civic engagement in the local community. In an early internal visioning document the group wrote:

“We believe JHSPH has an ethical responsibility as an educational institution, as a public health institution, as an employer and as a neighbor to use its financial, intellectual and technical resources to help improve the quality of life of East Baltimore residents. … We would like the School to publicly recognize its responsibility towards the community in which it resides. We envision an institutional culture change whereby a community perspective would be acknowledged at the highest levels of the institution and incorporated into all aspects of the institution: teaching, learning, research and social activities.”

SPARC envisioned direct financial and technical assistance to East Baltimore community-based organizations addressing public health issues and the creation of a
center for community-academic partnerships that would coordinate all of the School’s community engaged projects in East Baltimore and serve as a portal for community members who wished to tap into the School’s expertise for information or collaboration.

As a student group, SPARC also was particularly interested in seeing more opportunities for student engagement in the community. While there were many existing opportunities for students to volunteer in the community, there were few opportunities for community engagement through the curriculum. SPARC envisioned opportunities for scholarly engagement with the community as an integral part of coursework at the School.

SPARC’s goals were reflected in the group’s mission and vision statements.

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<tr>
<th>Table 5: SPARC’s Mission and Vision Statements</th>
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<tr>
<td>SPARC is a JHSPH student advocacy group promoting greater institutional commitment to the East Baltimore community. We advocate for:</td>
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<tr>
<td>1) Improved training opportunities in community-based research and public health practice for JHSPH students through sustained, reciprocal community-academic partnerships; and</td>
</tr>
<tr>
<td>2) A greater investment of JHSPH institutional resources in supporting East Baltimore community organizations and improving the health of East Baltimore residents.</td>
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SPARC envisions an institutional commitment at JHSPH to improving the health of the East Baltimore Community through sustained, reciprocal community-academic partnerships based upon a foundation of mutual respect and trust.


This article describes SPARC’s activities to create more community-engaged training opportunities in the curriculum. A description of SPARC’s activities to promote other ways the School could invest in the local community is provided elsewhere (Vogel, Fichtenberg, & Levin, in press).
Internal Advocacy: Mobilizing Students' Voices to Create Organizational Change

SPARC’s founders recognized that student activities had a strong influence on public life at JHSPH, but that, similar to most traditional academic institutions, students had limited access to decision-making processes at the School. They therefore thought that internal advocacy was the best tool students had at their disposal to promote institutional change. They believed this approach could shape the discussion around community engagement at the School. SPARC’s advocacy campaign had two aims: 1) to demonstrate student demand for a greater institutional culture of civic engagement, and 2) to promote specific ways the School could enhance its involvement in the community.

SPARC’s first advocacy project was to demonstrate significant support from the student body for SPARC’s goals. SPARC’s founders believed a student survey would be particularly effective because it would appeal to the research-focused culture of the School. SPARC fielded this survey in the spring of 2005. It included both closed- and open-ended questions assessing students’ attitudes about institutional and personal engagement in the community and their reactions to proposed institutional changes that would promote greater engagement. The following summary highlights findings related to curriculum development.

Nearly 300 (16%) students responded to the SPARC survey, a response rate consistent with other surveys of JHSPH students (JHSPH Student Assembly, personal communication, March 15, 2008). There was strong support for SPARC’s goals among survey respondents. A large majority (90%) felt the School had a responsibility to be more involved with the East Baltimore community, and almost all (95%) supported a
greater emphasis on community involvement in the School’s mission statement. Slightly more than three-quarters (78%) indicated this would improve how they recommended the School to prospective students. Almost all (97%) of the respondents were in favor of having more courses that included community involvement. Qualitative comments from many students demonstrated their belief that experiential learning could have benefits for their professional development. For example, one student wrote, “Practical application is a must in public health, so if there can be classes that encourage a component of practical application that would be great.”

More than two-thirds (69%) of the respondents wanted to increase their community engagement, and 89% identified lack of time as the major barrier. Qualitative findings suggested this barrier could be addressed by creating curricular opportunities for community engagement.

“I think the largest barrier is the ‘time issue,’ because community service is coming on top of academic time, so if the two were merged then I would love to be involved. Prior to coming to Hopkins I volunteered a lot, but the schedule here is too rigorous, and doesn't appear to have the service for credit hours that helped to make my service in college easier, and which served in part as a catalyst for my getting involved in the 1st place... and led to my continued service.”

Almost half of the respondents (46%) also cited as a barrier their perception that the School’s faculty and administration did not value community engagement. Many qualitative comments elaborated on this finding.

“I feel like it's difficult to get faculty support for community involvement activities/programs that don't involve research. I've heard comments to the effect that service related activities take time away from research and working on publications.”

“Having faculty and institutional policies set an example of community service would mean a lot, and it's currently either missing or very underpublicized.”
The two major barriers to community engagement that students reported – a lack of time for community service outside the curriculum, and a perceived lack of institutional support for student community engagement – could both be addressed by developing opportunities for SL in the curriculum and enhancing the visibility of existing courses that included community engagement.

In the fall of 2005, SPARC produced a report to the School’s administration that summarized the survey findings and presented related recommendations for action. Five of these ten recommendations focused on enhancing community-engaged training, and five recommended policies and infrastructure development that would support broader institutional engagement in the community.

Table 6: Recommendations for Action from SPARC’s Report to the Administration (September 2005)

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<th>Curriculum:</th>
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<tr>
<td>1. Greater Encouragement and Support of Service-Learning</td>
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<td>2. Academic Credit for Self-Directed Community-Based Learning</td>
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<td>3. Support for Community-based MPH Capstone Projects</td>
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<tr>
<td>4. Development of a “Public Health in Baltimore” Course</td>
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<td>5. Development of a Community-Based Participatory Research (CBPR) Methods Course</td>
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<td>Institutional Infrastructure:</td>
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<tr>
<td>6. Recruitment and Retention of Community-Engaged Faculty Members</td>
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<tr>
<td>7. Creation of a Community-Based Participatory Research and Outreach Center</td>
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<td>8. Visible Direct Aid to East Baltimore</td>
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<tr>
<td>9. Financial Support for Student Community Involvement,</td>
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<tr>
<td>Including Research and Outreach</td>
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<tr>
<td>10. Encouragement of the use of CBPR Principles in Faculty and Student Research</td>
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SPARC widely publicized the report at the School. The group met with a number of deans involved in academic affairs and student affairs to present the report and discuss how students could support the School in working toward SPARC’s recommendations or
other community engagement goals. With support from SOURCE, SPARC developed a website where it posted the complete survey findings and report, and publicized the website on the student, faculty and staff listservs. SPARC also highlighted its initiative at Student Assembly meetings and at school Town Hall meetings, which are attended by hundreds of students as well as faculty and administrators.

High-level administrators had mixed reactions to SPARC’s recommendations. Some deans encouraged SPARC and saw a role for students in ongoing engagement initiatives. One high-ranking dean was enthusiastic about the group’s ability to support efforts to develop engaged curriculum. He invited SPARC to participate in the School’s upcoming accreditation process concerning a new requirement for engaged training, as described below. Other deans believed that SPARC’s advocacy was unnecessary. They argued that existing extracurricular opportunities for student engagement were underutilized, and there were ongoing faculty and administrative efforts related to civic engagement. But in response to SPARC’s broader awareness-raising activities, individual faculty, administrators, and staff members approached the group to voice their support, as did the national organization Community-Campus Partnerships for Health. These allies endorsed SPARC’s goals and expressed their belief that students could provide leadership for greater institutional engagement. They also offered their guidance and partnership for SPARC’s future activities.

These responses to the advocacy campaign helped SPARC to refine its focus and expand its organizational change strategies. First, the mixed responses from the deans suggested that the administration was open to engaging with SPARC on curriculum issues, but was not ready at the time to engage SPARC in addressing the group’s other
recommendations. In response, SPARC decided to create a curriculum committee to single-mindedly focus on advancing engaged teaching and learning in the curriculum. It created a second committee to continue advocating for SPARC’s other recommendations. Second, based on the one dean’s invitation to participate in the accreditation process, SPARC recognized that when it came to curriculum goals, the group could use two organizational change methods at once: internal advocacy and established pathways for organizational change. Third, SPARC learned that it had many allies at the School who were working toward the same goals. SPARC recognized that it could provide support for their activities and call on them for guidance and partnership for SPARC’s activities. Moving forward, SPARC adopted these two approaches to pursue its curriculum goals.

**Partnering with Administrators, Faculty and Staff: Providing Student Support for Ongoing Curriculum Development Efforts**

SPARC strategized that, by supporting activities led by administrators, faculty, and staff to promote community-engaged curriculum, it could establish SPARC as a partner in this area. SPARC recognized that its support could be very beneficial, because its survey findings provided hard data demonstrating students’ demand for greater engaged training opportunities. This might also help develop a foundation of trust that would enable SPARC to successfully lead additional curriculum development efforts in the future.

SPARC’s first opportunity to partner with administrators and faculty involved providing support related to a new requirement for engaged training included in the School’s accreditation by the Council on Education for Public Health (CEPH) in the fall of 2006. SPARC hoped that positive feedback on this requirement from the accreditation
panel would increase interest in engaged training at the School. When SPARC formed, one of its first activities was to compile a list of courses at the School that would train students in skills for careers in community-engaged public health. SPARC created this list to help interested students -- including the group’s members -- to identify these courses, which did not have any special designation in the School’s prospectus. On the invitation of the dean, SPARC enhanced the list to support the accreditation process, by designating those courses that included engaged learning opportunities in the community. It created a three-tiered ranking system for courses on this list: 1) SL courses in which students engage with the community on a project as part of their coursework; 2) courses in which students do not engage directly with the community, but are exposed to community members and/or advocates (e.g., as guest speakers); and 3) courses in which students have no direct exposure to the community, but are taught some principles of CBPR, community engagement, urban health-related issues, and/or public health practice. Courses included in the first category met the CEPH accreditation criteria (SPARC, n.d.). SPARC members also participated in the accreditation meeting on institutional service, where they spoke about student service opportunities.

In response to the same accreditation requirement, SOURCE proposed a new Master of Public Health course that included a community-based SL experience. It also advocated for funds to support an additional staff member who would facilitate engaged learning with local community agencies. SPARC endorsed these proposals in a letter of support addressed to the administration, where they cited their survey findings. The group’s support was one factor that led to the approval of both the course and staff line.
Introducing Innovation: Leading a Partnership of Students, Staff and Faculty to Develop a Curriculum Proposal

Having recognized a need for interested students to be able to identify courses in community-based public health, SPARC believed the School should create a coordinated course sequence in this area, in which cohorts of students could matriculate. This would raise the public visibility of community-engaged training at the School and make this training more accessible to future and continuing students. SPARC also believed this experience should include a longitudinal SL experience in the local community. This would fulfill students’ desires to increase their community engagement and to receive practical training.

SPARC wanted to provide leadership for this vision but did not know what the most successful approach would be. The group considered floating a curriculum proposal, but did not know how new curricula were developed at the School. SPARC’s new network of faculty allies was critical to moving forward. In late 2006, SPARC hosted a breakfast meeting to solicit faculty members’ advice about whether and how SPARC could provide leadership toward this goal. SPARC invited faculty who had expressed support for the group; were involved in community-academic partnerships, community-based research, or public health practice; and/or understood how to successfully make change at the School.

Participants at the meeting supported SPARC’s curriculum development goals, and believed that students could lead a curriculum development effort at the School. They also thought that SPARC was in a strong position to do so, based on its survey findings. Their support encouraged SPARC to pursue their goals. These faculty also
provided valuable strategic guidance for how SPARC might do this. First, they encouraged SPARC to work through the established curriculum development pathways at the School by developing a curriculum proposal in the same way a faculty member might. They recommended that SPARC propose a certificate because it would be the easiest type of curriculum change to make, given the financial considerations and decision-making processes involved in curriculum development. They also recommended that SPARC replicate the survey, adding a question specifically to demonstrate student support for a certificate.

SPARC fielded this survey in May 2007. This time, 447 students (34%) responded. Of these, 97% – one-third of the student body – supported the idea of a certificate in “community-based and practice-based public health.” Student comments provided strong support for SL as a part of the certificate.

“I think that every student at JHSPH has something to offer the East Baltimore community, and I also feel that every student has much to learn from involvement with the East Baltimore community. What better way to learn than to put to practice all of the concepts that we are learning in class?”

“Many of us come from other countries which are developing and have similar problems such as poverty, unemployment, social issues, development and empowerment of communities. If there is a PRACTICAL course, i.e. one with hands-on experience tackling these issues that are common to East Baltimore and developing countries, it would be beneficial. Students from other countries could learn these skills and at the same time give back to the community that they study in, thus benefiting East Baltimore.”

Over the next year, with partnership from SOURCE, SPARC developed a proposal for a Certificate in Community-Based Public Health, the centerpiece of which was a two-term SL experience. During this process, SPARC and SOURCE hosted a series of meetings in which faculty members with expertise in community-based public
health, public health practice, and workforce development provided guidance on the scope and content of the course sequence.

The Certificate curriculum was crafted to address students’ curriculum goals, as expressed in the student body surveys; to maximize the quality of the education it provided; and to maximize the ease with which the Certificate could be approved. Certificate courses were selected to prepare students in skills for both community-based research and public health practice. The Certificate would culminate in a SL capstone experience in the local community. Courses at the School are typically only 8 weeks long. But SPARC and SOURCE believed the Certificate’s SL experience should be longer, both to provide students with the opportunity to develop meaningful products for community partner agencies and because the literature has shown that SL experiences of longer duration produce better student learning outcomes (Billig, 2007). In response, SOURCE lengthened its new Master of Public Health SL course to two terms and opened the course to all students completing the Certificate. The Certificate also would provide opportunities for interdisciplinary learning, as recommended by the Pew Health Professions Commission (1998). It was open to any graduate student at the Johns Hopkins University whose participation was approved by the faculty sponsor. To make the Certificate more accessible to students outside of JHSPH, nursing students could take a School of Nursing SL course in lieu of the JHSPH SL course. Finally, the Certificate was composed only of existing courses, to allow for approval without having to wait for new course development. This was an imperative for SPARC members, who wanted the Certificate to be offered to students as soon as possible. New courses could be added
after the Certificate was established, and included courses could be enhanced over time to offer more engaged learning opportunities.

Faculty allies recommended that SPARC write an open memo providing the rationale for the Certificate, which could be circulated with the proposal. The memo drew on national recommendations for the training of public health professionals. It cited the Association of Schools of Public Health’s endorsement of SL to train future public health practitioners (ASPH, 2004), and identified how the Certificate would teach community and population health competencies identified by the Council on Linkages Between Academia and Public Health Practice (2001), the Pew Health Professions Commission (1998), and the Kellogg Community Health Scholars Program (n.d.). The memo also identified the value of the Certificate for the School. It would build bridges between the School and the community and contribute to the School’s role as an innovator in training public health professionals by orienting future practitioners and researchers toward collaboration, and building a cohort of highly skilled public health practitioners, a national priority identified by the Institute of Medicine (2003a). Finally, the memo reported survey findings demonstrating student demand for the Certificate.

In the spring of 2008, SPARC met with the chair of the Department of Health, Behavior and Society – which SPARC believed would be the best departmental home for the Certificate – as well as a departmental faculty member who was an engaged scholar, to solicit their advice on next steps. Both had been involved in SPARC’s curriculum development work to date, starting with the breakfast meeting over a year earlier. After reviewing the Certificate proposal and memo, they immediately agreed to sponsor the Certificate. This started the second phase of this project, in which a team consisting of a
student member of SPARC (the author), the director of SOURCE, and the faculty sponsor took the Certificate from the proposal stage to approval. The faculty sponsor’s participation was critical to seeing this project through to success. The curriculum review processes at both the departmental and School levels were not, until then, open to students or staff. The faculty sponsor provided leadership to take the proposal through reviews by the Department and School. She also gained entry to this process for the other team members, which provided them with a valuable professional development experience.


Up to this point, SPARC had introduced innovations in both the methods it used to make a case for more engaged training, and the design the group proposed for a community-engaged curriculum. Now, SPARC introduced innovations into how the final version of the Certificate proposal was developed. The Certificate team engaged in a variety of outreach activities to cultivate broader support for the Certificate before it was reviewed by the School. These innovations were based, in part, on the assumption that a student-proposed curriculum project might provoke some skepticism. Outreach would allow critics to voice their concerns – and perhaps have them allayed – before the proposal was reviewed. Another inspiration was the community engagement principles the Certificate would teach, including collaboration and open communication (CCPH, 2006).

During the six months it took for the Certificate proposal to be reviewed by the Department and School, the Certificate team reached out to the School community to raise awareness of the Certificate, gather feedback to enhance the final proposal, and cultivate support. First, the team opened the proposal to comments over the faculty
Second, it personally contacted all of the faculty members whose courses were included in the proposal to describe the Certificate, ask for their endorsement, and solicit comments. All but one of these faculty members replied, and all of those who did reply endorsed the Certificate. Many also recommended additional courses, resulting in a domino effect in which SPARC contacted additional faculty members, leading to more awareness-raising, endorsements, and revisions. Third, the Certificate team hosted a public forum about the Certificate where they presented the rationale for the Certificate and its content and solicited comments. The forum provided a final opportunity to solicit feedback from faculty, students and staff, and provided the first opportunity to publicize the Certificate to interested students. Fourth and finally, the team reached out to individual members of the School’s curriculum committee to inform them about the Certificate proposal, provide the rationale for the Certificate in advance of its review, and answer any questions.

The final Certificate proposal was a collaborative product of the leadership of SPARC, SOURCE and the Department of Health, Behavior and Society; the input of hundreds of students who participated in SPARC’s surveys; and the feedback of dozens of faculty who provided guidance to SPARC as it developed the Certificate proposal and responded to SPARC’s outreach efforts. This process had the expected effect of building support for the Certificate among a broad group of stakeholders. This lent support to the final Certificate proposal, as the School’s curriculum review committee was informed of this process, including the endorsements of dozens of faculty. But it also unexpectedly strengthened the content of the Certificate proposal, because of the revisions that resulted from this process. Faculty members’ feedback ensured that the final list of courses that
were included in the Certificate proposal all contributed to its learning objectives. These innovations would likely have similar benefits for any curriculum development effort.

The School’s curriculum review committee provided a final recommendation that further enhanced the content of the Certificate program. It requested that the Certificate team identify the specific community and population health competencies the Certificate would teach, and also pare down the list of elective courses for the Certificate to those that taught explicitly to these competencies. The Certificate team selected competencies from the Council on Linkages Core Competencies for Public Health Professionals and streamlined the list of electives (Council on Linkages Competencies Project, 2001). This also enhanced the effectiveness of the embedded SL experience by providing overarching educational objectives that could be used to structure the SL experience and ensure that it advanced the learning objectives for the full Certificate. The Certificate in Community-Based Public Health was approved in January of 2009 and will be offered for enrollment in September 2009. It was the first curriculum development initiative at JHSPH to be led by students. This is the first Certificate in CBPH to be offered in a school of public health in the U.S., and has the distinction of being grounded in SL.

**Discussion**

SPARC’s activities highlight key themes in the literature about the added value of student leadership for SL in health professions education, including how students are creating new SL opportunities and introducing innovations into how SL is designed. This case adds to the literature by documenting student leadership in the organizational change processes involved in implementing SL. It highlights how students can be effective advocates for SL; how partnerships between students, administrators, faculty, and staff
members can be especially effective to advance SL; and how students may introduce innovations into how community-engaged curricula are designed and developed that ultimately enhance the quality of SL for both students and community partners. It also provides a model for how students, administrators, faculty, and staff members can work together productively to advance SL.

Advocacy

This case describes how students can be effective champions for SL by using internal advocacy methods to promote organizational change. These methods can be highly effective to promote change, but are generally inappropriate for use by faculty and staff, particularly if they involve critiques of the institution. SPARC capitalized on its ability to use advocacy methods with the student body surveys, report to the administration, and communications campaign. These activities created pressure for organizational change by focusing public discourse on community engagement at the School on students’ demand for greater institutional investments in the health of East Baltimore. SPARC also introduced an agenda for change into the discourse, with its recommendations to the administration. In addition, in its student body surveys, SPARC defined curricular opportunities for student engagement and, later, a Certificate grounded in SL, as ideal ways the School could respond.

SPARC’s advocacy efforts were effective in part because they appealed to the organizational culture to promote SPARC’s goals. The literature has shown that organizational mission is a critical factor in expanding SL, and that identifying areas of incongruity can help institutions to move toward greater civic engagement, including SL (Furco, 2001; Holland, 1997; Rubin, 1996). Internal advocacy methods can be put to
good use to achieve this objective. The JHSPH institutional identity is strongly
influenced by important discoveries it has made that have improved the health of the
global poor. SPARC drew on this institutional commitment to the health of the
underserved, and turned the focus to East Baltimore. SPARC also promoted the
Certificate as a contributor to the School’s role as a global leader in educating public
health professionals, another core aspect of the institution’s mission.

**Partnerships**

Chapman identifies two types of methods for organizational change, which he
calls “moderate” and “vanguard” (2001). Internal advocacy falls into the “vanguard”
category, while established change processes, such as those for proposing new curricula,
fall into the “moderate” category. Chapman describes how combining these two types of
methods may be particularly effective to create organizational change because vanguard
methods apply pressure for change, while moderate methods allow for collaboration with
decision makers, which is ultimately critical to creating change. At traditional higher
education institutions, students generally do not have access to established processes for
curriculum development, while faculty and staff generally cannot use advocacy methods.
This case describes how students, faculty and staff members who are champions for SL
can form partnerships to coordinate the organizational change methods available to each
group in order to maximize the effectiveness of their efforts to pursue shared goals.

These partnerships also create benefits by virtue of their ability to call on different
voices, as needed, to provide the most convincing arguments for SL. Christoffel (2000)
describes how different stakeholders have different strengths when it comes to public
health advocacy, and how stakeholder groups can most effectively contribute to change
by focusing on those stages of the advocacy process where it can make the strongest
correlation and partnering with other stakeholders whose strengths are best suited to
other stages. SPARC and its allies in the administration, staff and faculty applied this
strategy to promote organizational change. For example, students are the most credible
voices on student experiences. Therefore, SPARC was a valuable contributor to the
accreditation process when testimony was needed as to students’ opportunities for service
to the community. Similarly, when the Certificate proposal was formally reviewed by the
School, it was essential that it was represented by a faculty member who could situate the
Certificate proposal in the context of broader curriculum development goals for faculty
peers on the review panel.

Finally, the student survey provided strong backing for the Certificate because
curriculum development is also motivated by student interest. There is an understanding
that, as the consumers of higher education, students have “purchasing power” to select
one school over another based on the curriculum. It should be noted that, while the
broader goal of SPARC’s founders was to promote an organizational culture of civic
engagement, they chose to focus their energies on advancing engagement through the
curriculum, an area where they recognized they had strong leverage as students.

**Innovation**

This case also highlights how students may introduce innovations into how
community engaged curricula are designed and developed. SPARC’s experiences
suggest that the innovations that students may introduce are rooted in their unique
perspectives. Students’ perspectives are shaped by their experiences at their institutions,
social trends such as the current generation’s strong focus on service and social change
(Kiesa, et al., 2007), and professional trends during their formative years, such as the current reemergence of interest in public health practice. The personal challenges SPARC’s founders had in identifying community-engaged training at the School, their focus on enhancing institutional service to the East Baltimore community, and their desire for curricular training in community-based public health competencies shaped the design of the Certificate. So did the findings from SPARC’s student-body surveys. A faculty-led effort therefore might not have produced the same curriculum design.

SPARC members’ understanding that, in a traditional academic institution, students typically are not included in creating organizational policies, and the mixed reactions to its advocacy campaign, led the group to rely on team-building and consensus-building to pursue its goals. SPARC first built a partnership of students, staff, and faculty members to create the Certificate proposal, and then opened the Certificate to public comment. This created a dynamic and inclusive curriculum development process that was a departure from the typical way curriculum proposals are created at the School – by a small group of faculty. It had the intended consequences of identifying the best way to structure the new curriculum proposal, and of building a critical mass of support for the Certificate before the School reviewed the Certificate proposal.

This consensus-building process also had the unexpected result of enhancing the quality of the Certificate proposal. It ensured that the certificate courses and the SL experience aligned with clear educational objectives and it also ensured that a wide range of courses were considered for inclusion, beyond the courses initially considered by the Certificate team. In addition, the Certificate included key characteristics of high-quality SL, including: the integration of SL into the curriculum and linking SL to clear learning
objectives, meaningful service, and SL experiences of long enough duration and intensity (Bailey, Carpenter, & Harrington, 2002; Cashman & Seifer, 2008; Cauley, et al., 2002; Eyler & Giles, 1997; Eyler & Giles, 1999; Jacoby & Associates, 1996; Seifer, 1998b). These results suggest that student leadership to design community-engaged curricula and the collaborative curriculum development processes SPARC might be beneficial for other curriculum development initiatives.

The results of this research should be interpreted in light of its methodological limitations. First, the participant observation method has the potential to introduce bias into these findings. Recognizing the potential for bias that this method may introduce, this research included two additional sources of data: document analysis and member validation. In addition, in order to reduce potential bias in the analysis, this work was informed by an extensive examination of the literature about student leadership in SL, as well as a reading of the literature on advocacy methods for both organizational change and public health policy change. Another limitation is that because this is a single case study, these findings may not be generalizable to other settings or to other groups of students and faculty in this setting. The institutional environment, and the particular point in time when these events occurred, played an important role in shaping SPARC’s activities and the extent of the support SPARC received from administrators, faculty and staff.

Future research might explore the ways that students are providing leadership for SL in different institutional environments, for example, in undergraduate health professions education and in academic institutions with a focus on teaching rather than research. It could also evaluate the impact of student leadership for SL as assessed by
administrators, faculty, and the student body. This research focused on the impact of student leadership in terms of creating new curricula and introducing innovations into how curricula are conceived and developed. Future research on student leadership for SL could examine broader impacts. Areas for exploration include impact on the curriculum more broadly, organizational culture, other forms of civic engagement, participating students’ professional development, and the professional activities and attitudes of participating faculty, administrators and staff members. Another area of interest is the different ways that academic institutions can include students as partners to advance SL. This article describes a model for how faculty members, staff, and students can collaborate. Additional more formal models for how to include students as partners to advance SL are discussed in the recommendations section, below. Future research might explore the impact of different partnership models.

Recommendations

Chambers and Phelps (1993) write that academic institutions have traditionally included students in decision-making processes as part of their mission to prepare individuals for active citizenship and leadership roles. Doing so provides practical opportunities for students to develop leadership skills. But this practice also has significant benefits for academic institutions. Chambers and Phelps assert that student leaders have “provided an invaluable, oftentimes irreplaceable, resource for many educational institutions” (p. 23). They write that students’ involvement in decision-making has “contributed to institutional vitality” in U.S. higher education, citing for example, how student activism in the 1960s created new student-initiated courses, policies and procedures (p. 23).
Today, students are providing leadership in the movement for civic engagement in higher education, including health professions education. SL is one area where they are making particularly meaningful contributions. Health professions institutions can maximize the benefits they receive from student leadership for SL by including students as collaborators on initiatives related to curriculum development and institutional civic engagement, and creating other opportunities for students to develop their leadership skills in these areas. This will require a significant shift in perceptions about the role of students in higher education, consisting of a reorientation toward students as colleagues. This process, however, is already underway, as demonstrated by the new literature on student co-leadership for SL. SL has played a role in ushering in this change, with its positioning of faculty, students, and community partners as co-learners and co-creators of knowledge. This case study prompts three related recommendations for how academic institutions can include students as colleagues for SL and other forms of institutional civic engagement.

Recommendation 1: To include students as colleagues, engage students in ongoing conversation about curriculum development and institutional civic engagement. Also involve students as colleagues in curriculum development efforts led by administrators and faculty.

SPARC’s leadership to create a curriculum development partnership with faculty and administrators is rare. More commonly, students have not been at an institution long enough to begin to know how to partner with faculty and administrators. Therefore, to support student leadership for SL, academic institutions should create visible avenues for student collaboration on curriculum development. Town hall meetings devoted to SL,
student forums on community engagement, and websites that describe an institution’s goals for engaged curricula and civic engagement and have a user interface that allows for public comments and responses by those leading these initiatives, are all ways schools can engage students on these issues. This sort of open communication with students will allow academic institutions to benefit from the student perspectives that are at the root of the student-led innovations in SL and also develop students’ interest in providing leadership for SL.

Academic institutions should also include students in curriculum development projects led by administrators and faculty. They can engage student groups that are interested in community engagement or SL, such as SPARC, to provide ongoing feedback to these project teams. Where these groups do not exist, academic institutions can create student advisory committees on SL. Including students in these activities will develop their leadership skills for SL, including an understanding of how organizational change is made and how the curriculum is developed. Student involvement should not be limited to a single student representative on a project or committee. Creating a student advisory committee can foster collaboration among students and support them in mobilizing, as SPARC did, to provide leadership that is complementary to the leadership of faculty, administrators and staff.

Student leaders for SL should also be included in other decision-making bodies whose activities influence the curriculum and civic engagement, including those addressing accreditation, public relations, diversity in faculty hiring, and promotion and tenure policies. Participation by students may broaden the perspectives considered by
these committees. Participating will also allow students to gain insights that may enhance their leadership for SL.

**Recommendation 2: To foster student leadership skills for SL, create opportunities for students to take on leadership roles with existing SL courses and campus SL and community engagement centers. Also provide incentives and rewards for student leadership for SL.**

Particularly at the graduate level, students can take on leadership roles with existing SL courses. Students can collaborate with faculty to create new community-academic partnerships, work with community partners to identify student projects, develop course learning objectives, and facilitate preparation and reflection sessions. At academic institutions where SL is coordinated through a center for SL or community engagement, students can serve as SL liaisons, representing the SL experiences of their cohort of students – for example, first or second year nursing students, or Master of Public Health or PhD students. These student liaisons can sit on the advisory board to the SL center, alongside faculty and administrators, to represent student voices in conversations that shape SL and other forms of community engagement. For examples of student leadership in these and other roles, see *Students as Colleagues: Expanding the Circle of Service-Learning Leadership* (Zlotkowski, et al., 2006).

Academic institutions should also provide compensation to enable students to provide leadership for SL. Students could receive payment for work supporting existing SL courses. They could also receive fellowships or stipends to develop new SL opportunities – including new community-academic partnerships, curriculum proposals and course syllabi – just as faculty at some institutions receive funding to develop new
courses. Work-study funds that are earmarked for community related work could be used to compensate these students. Ideally, student leadership for SL would be compensated at levels equivalent to other academic work, such as research and teaching assistantships, to make leadership for SL equally attractive and accessible.

**Recommendation 3: To foster student leadership skills for SL, create a leadership development program that provides training in relevant knowledge and skills areas and includes experiential learning that pairs student leaders with faculty mentors to contribute to advancing SL at their institutions.**

Academic institutions can maximize the benefits they receive from student leadership for SL by providing students with leadership training. The literature describes the different ways that students are providing leadership for SL, and the training students receive will need to address this range of contributions, speaking to such topics as: how to create organizational change in higher education; how to establish community-academic partnerships; how to create reciprocal benefits in community partnerships for SL; and how to implement the characteristics of high quality SL (Zlotkowski, et al., 2006).

This training could be provided through for-credit courses, or through a leadership development program in which cohorts of students who are already providing leadership for SL or civic engagement are invited to participate. Guest speakers who are experts on SL and civic engagement are a resource for student leadership training. So are conferences on SL and civic engagement, such as the annual conferences of the International Association for Research on Service-Learning and Community Engagement.
(IARSLCE) (http://www.researchslce.org) and CCPH (http://www.ccph.info), and regional conferences sponsored by Campus Compact (http://www.compact.org).

Leading national organizations promoting SL and civic engagement, such as Campus Compact and CCPH, could provide support for student leadership development for SL. For example, they could develop curricula for student leadership development that institutions could implement on campus. In addition conferences on SL and civic engagement might consider creating tracks that focus specifically on developing student leadership for SL. These could be open to students, faculty, staff and administrators, and could address institutional strategies to foster student leadership. Since 2005, the American Association of Colleges and Universities has hosted three student conferences on students’ leadership roles in promoting engaged learning and student civic engagement. Workshops or conferences modeled after these could focus specifically on training to student leaders in practical strategies they can use to advance SL in health professions education.

Similar to the community and population health competencies taught by SL, the skills and knowledge needed to provide leadership for SL may best be learned not in a classroom setting, but through practical application. Any leadership development program for SL should therefore include experiential learning. Student leadership training programs could pair students with faculty mentors to produce tangible products that enhance SL at their institutions. These faculty mentors could provide strategic guidance to promote the success of these projects and maximize their educational value to students through facilitated preparation and reflection. SPARC’s experiences highlight how these mentoring relationships may be invaluable to foster student leadership for SL.
They turned SPARC’s student advocacy initiative into an extended experiential learning opportunity in providing leadership for SL in higher education.

**Conclusions**

Students are providing leadership for SL in health professions education by engaging in advocacy for SL; building partnerships with administrators, faculty and staff to pursue shared goals for SL; and introducing innovations into how new engaged curricula are developed. By involving students as colleagues on decision-making around SL and civic engagement, academic institutions can maximize the benefits of student leadership for SL at their institutions. Doing so can also contribute to the same learning outcomes that are goals for SL, including a dedication to community health, an ethic of service, and skills for leadership and teamwork. By embracing students as co-leaders for SL, health professions institutions may contribute to developing a cohort of leaders in community and population health as well as the next generation of engaged scholars in health professions academia.

**Resources**

To access all of the SPARC products described in this chapter please visit: www.jhsph.edu/SOURCE/SPARC. To view the curriculum for the Certificate in Community Based Public Health, please visit:

http://commprojects.jhsph.edu/academics/prop.cfm?id=44.
CHAPTER 7: DISCUSSION

This chapter summarizes the findings from this dissertation research, discusses its implications, and makes recommendations for how stakeholders at the policy level can advance SL in health professions education. It then addresses the strengths and limitations of each manuscript and offers suggestions for future research.

Summary of Findings and Implications for Practice

This research adds to our understanding of the sustainability, impact, and quality of SL, as well as the role of students as co-leaders for SL. This section describes the specific contributions of this research in relation to the existing literature, discusses the implications of these findings for SL in health professions education, and explores the implications of these findings for engaged scholarship in health professions education, more broadly.

Long-term Sustainability of SL and Influences on Sustainability

This study of the ten-year outcomes of HPSISN is the first empirical research to assess the long-term sustainability and impact of SL in health professions education. Manuscript 1 provides evidence that SL is highly sustainable in health professions education. This research also found a number of key differences between SL initiatives with different degrees of sustainability. With increasing degrees of sustainability, SL initiatives were more likely to report the following three facilitators of sustainability: the organizational culture of the academic institution supported SL, most often as represented by the university mission; there was support for SL among high-level administrators both at the level of the university and in health professions education; and there was support for SL in hiring, promotion and tenure policies.
This research found that SL initiatives across the range of degrees of sustainability reported similar challenges to sustainability. But a difference between those with higher and lower degrees of sustainability was whether they were able to report strategies to address these challenges. SL initiatives with higher degrees of sustainability reported strategies they had used to successfully address these challenges. This research identified two strategies that were critical to address turnover among faculty participants in SL, loss of SL champions among the administration, and competing educational priorities. These strategies were to provide opportunities for faculty development, and to engage in internal marketing to demonstrate the value of SL to achieve institutional priorities. This study is unique among the empirical research on sustainability of SL to identify the importance of faculty development to sustainability. This finding as to the importance of internally marketing the value of SL is similar to Furco’s concept of “organizational hooks,” which posits that SL initiatives should be “hooked” to other high-priority initiatives at the academic institution.

These research findings also provide evidence that there are two major groups of factors that are important to sustain SL. Research participants for Manuscript 1 reported that most of the factors that influenced the sustainability of their SL initiatives fell into two categories: 1) the design and implementation of the SL initiative, and 2) the organizational setting at the academic institution. Most of the facilitators of sustainability that they reported fell about equally into these two categories. The challenges to sustainability that they reported, meanwhile, all fell into the category of the organizational setting, while their responses to these challenges fell into the category of the design and implementation of SL. The two cases featured in Manuscript 2,
meanwhile, suggested that the institutional culture had an important influence on the sustainability of SL, by shaping the design and implementation of SL.

These findings therefore suggest that the strong emphasis on the organizational setting that is present in the literature about sustaining SL in higher education may also be relevant to the sustainability of SL in health professions education. In particular, these findings echo the empirical literature on sustaining SL in higher education that identifies the importance of the following traits of the organizational setting: the university mission (Holland, 1997); the support of high-level administrators (Furco, 2002); the support of hiring, promotion and tenure policies (Holland, 1997); and the presence of funding and infrastructure for SL, to sustain SL (Bringle & Hatcher, 2000; Gelmon, Holland & Shinnamon, 1998; Gray, et al., 1998, as cited in Furco, 2002).

This research also identifies a number of additional factors in the organizational setting that appear to be important to sustaining SL. In particular, Manuscript 1 provides evidence that other aspects of the organizational culture, outside of the mission statement, can also facilitate the sustainability of SL, specifically, the institution’s strong self-identification as a member of the local community. Manuscript 2 also suggests that institutions that focus on teaching may provide more support to sustain SL as compared to institutions that focus on research. Manuscript 2 also provides evidence that a SL office that operates not simply from a central location, but from the office of a dean, can help to sustain SL, by giving the SL director access to decision-makers in multiple degree programs, and the administration.

Findings from both Manuscripts 1 and 2 about the influence of design and implementation factors on sustainability also both reflect themes in the existing literature
and add to this literature. The literature on sustaining SL in higher education focuses on the leadership of high-level administrators, and this emphasis is reflected in the current research. But this research provides new evidence that the leadership of the SL director is also important, and describes specific ways that the SL director can contribute to sustaining SL. While these findings make a new contribution to the literature on sustaining SL, they also reflect the emphasis on the leadership of mid-level champions that is present in the literature on sustaining community-academic partnerships for health, more generally (Roussos & Fawcett, 2000; Shediac-Rizkallah and Bone, 1998).

Manuscript 1 adds to the empirical literature on sustaining SL in higher education by identifying two new influences on the sustainability of SL that fall into the category of program design and implementation factors: 1) the ability to adapt SL to changes in the academic and community environments, and 2) the ability to maintain stable long-lasting community-academic partnerships by investing in the partnership process. While these findings are new to the literature on sustaining SL in higher education, they also echo two prominent themes in related literatures. Adaptability is a strong focus of the literature on sustaining organizational innovations, while the partnership process is a central theme of the literature on CBPR, and is also a theme. This research provides empirical evidence for the obvious connection between the quality of the partnership process and the sustainability of the academic innovation that relies on the partnership. The literature on sustaining community-academic partnerships also discusses the importance of organizational stability to sustain these partnerships (Shediac-Rizkallah and Bone, 1998). This emphasis is also reflected in this study’s finding on the importance of stable, long-term partnerships.
The one major distinction between these research findings and the literature on sustaining other community-academic partnerships is that this research did not identify community conditions, per se, as an important facilitator of sustainability. This contrasts with existing literature that does identify the importance of community conditions (Roussos & Fawcett, 2000). This research did produce one related finding, which was that improvements in town-gown relations were a proven impact of SL, and that this was important to sustain SL. But research participants did not describe community conditions as important to sustain SL in other ways. Rather, their focus was on the influence of facilitating factors that occurred in the academic organization. This finding suggests that the bottom line is that, to sustain SL, the proper conditions must be in place in the academic institution and the SL initiative.

These findings have practical implications for the actions of champions for SL. They suggest that leadership for SL is critical, and that this leadership must take the form of individual leadership among high-level administrators and SL staff, as well as concrete action, as embodied in the institutional mission and policies and the ability to address challenges to SL through programmatic activities. These findings also suggest that champions for SL should take the following steps to sustain SL: 1) revise the organizational mission to provide explicit support for SL; 2) foster support for SL among high-level administrators by identifying and publicizing the value of SL to achieve institutional priorities; 3) nurture a critical mass of support for SL among administrators, faculty, student, and community partners by identifying and publicizing the value of SL, providing professional development in SL to faculty members, and using peer-to-peer outreach in these activities; 4) allocate institutional funding for SL and establish a
centrally-located SL center, preferably in the office of a dean, with leadership from a full-time SL director.

These finding also provide guidance specifically for the activities of the SL director. Manuscripts 1 and 2 identified how the SL director engaged in five activities that were important to sustain SL. These were: 1) adapting SL to changing priorities in the academic institution and community; 2) maintaining stable, long-term community-academic partnerships by instituting principles of high-quality partnerships; 3) cultivating support for SL among high-level administrators; 4) engaging in internal marketing to promote the value of SL, particularly in regard to demonstrating how SL advanced institutional priorities; and 5) providing professional development and technical assistance to faculty participants. Manuscript 1 also identified that the latter two activities were particularly important in order to address challenges to sustaining SL.

While these findings produce recommendations that are specific to sustaining SL in health professions education, they are also relevant to sustaining engaged scholarship more generally in health professions academic institutions. All of the factors that this research found to be facilitators of and challenges to the sustainability of SL may be relevant influences on the sustainability of other forms of engaged scholarship, such as CBPR and scholarly practice in community setting. The same aspects of the organizational environment that this research found were important to sustain SL— including support for SL in the mission statement; organizational culture; hiring, promotion and tenure policies; the words and actions of high-level administrators; the presence of institutional funding and infrastructure to support the engaged activity; and
the presence of a critical mass of support – are also likely to be necessary to sustain other forms of engaged scholarship.

Likewise, all of the factors that this research found to be important facilitators of sustainability in the design and implementation of SL – including the leadership of mid-level champions; adaptability to changing priorities among both academic and community partners; and stable, long-term community-academic partnerships – may also be relevant to sustaining other forms of engaged scholarship. In addition, all of the challenges this research found to sustainability, and the responses to these challenges – including the challenges of turnover in supportive administrators and participating faculty members and competing institutional priorities; as well as the response of faculty development and internal marketing – may be relevant to sustaining other forms of engaged scholarship. This research provides direction for future inquiry to examine the sustainability of other forms of engaged scholarship. In the meantime, administrators and faculty who are interested in sustaining other forms of engaged scholarship may find this research to be helpful to inform their actions.

*Long-Term Impact of SL*

Manuscript 1 also reported the ten-year impact of SL for various stakeholder groups. Findings provided important evidence that SL is, in fact, able to achieve many of it purported long-term goals, including fostering engaged scholarship among participating faculty members, building capacity for future community-academic partnerships in both academic and community partners, and improving town-gown relations. This research is the first of its kind to provide empirical evidence of these outcomes of SL in health professions education. These data can serve to support the value of implementing SL and
providing continued funding for SL for those who see these outcomes as among the most important benefits of the pedagogy. The fact that this research found such clear benefit of SL in terms of building capacity for other forms of engagement in both academic and community partners suggests that other forms of engaged scholarship also might similarly increase capacity for partnerships, in general.

**Quality of SL**

There is a large literature providing case studies of how SL initiatives have implemented principles for high-quality SL. But most of this literature focuses on how SL was implemented at the time of program start-up. Only a small number of articles describe the experiences of long-term sustained SL initiatives in health professions education in order to learn from their experience about how to maximize the quality of SL. Manuscript 2 added to this small literature with data on two SL initiatives, each sustained for 14 years, and specifically aimed to produce strategies for success and lessons learned related to how to maximize the quality of SL as an educational tool and the quality of the partnership process for SL. Another contribution of this research was that it used empirical methods to address these topics, while the small existing literature consists of purely descriptive articles (Andrus & Bennett, 2006; Davidson & Waddell, 2005; Greenberg, Howard & Desmond, 2003; Meyer, Armstrong-Coben, & Batista, 2005).

The finding from this research have immediate applications for other SL initiatives. They highlight the following transferrable strategies that other SL initiatives may implement to maximize the quality of SL as an educational tool: 1) integrating SL into the core curriculum; 2) identifying how SL teaches to educational objectives for the
degree program and the course, and tailor SL accordingly; 3) incorporating preparation and reflection into course activities; 4) creating longitudinal SL opportunities of one academic year or longer; 5) creating opportunities for transformational learning, particularly as through high-intensity SL experiences, such as immersions or longitudinal experiences with a single community agency; and 6) involving faculty members in sustaining SL partnerships, in order to maximize the benefits of SL for both academic and community partners. These findings echo principles for high-quality SL from the literature, specifically the need to integrate SL into the curriculum and to provide SL experiences of sufficient duration and intensity. The finding from this research regarding the benefits of involving faculty members in sustaining SL partnerships reflects a similar finding in the work of Andrus and Bennett (2006), adding support to this recommendation, which is not included in most discussions of principles for high-quality SL.

This research also identified transferrable strategies to maximize the quality of the partnership process for SL, including: 1) creating dyads of community and academic advisors with equal status; 2) developing infrastructure to foster collaboration, relationship-building, and co-learning among community partners, faculty members, and students; 3) aiming for capacity-building as the product of SL projects, and 4) involving faculty members in developing and maintaining partnerships. Similar to the research findings on maximizing the quality of SL as an educational tool, these findings echo the literature that offers principles for SL partnerships, including equity, collaboration, relationship-building, co-learning and capacity building (CCPH, 2006). These findings also echo the principles of partnership for CBPR, which are generally the same (Israel,
Schultz, Parker, & Becker, 1998). Because this research demonstrates that these principles of partnership are vital to the quality of SL for everyone involved – including faculty members, students, and community partners – it suggests that the same connection between the partnership process and quality may be relevant to CBPR and other forms of engaged scholarship that rely upon community-academic partnerships.

**Student Leadership for SL**

Finally, this research added to the small literature on the leadership that students may be able to provide to advance SL in health professions education. Whereas the existing literature in this area focuses on the outcomes of student leadership for SL, this research made a unique contribution by exploring the organizational change processes that students may uniquely be able to use to advance SL at their institutions. It provided evidence that students can provide leadership for SL by engaging in internal advocacy to define SL as an institutional priority, and by designing new SL opportunities that address student’ training needs and interests. This research also provided a model for how students, administrators, faculty and SL staff may work together to achieve common goal around advancing SL. Finally, like the existing literature in this area, this research provided evidence to suggest that students may introduce valuable innovations into the development of new SL curricula. These findings suggest that administrators, faculty, and SL staff should include interested students as colleagues in efforts to advance SL in health professions education.

These findings may also have implications for how students may contribute to advancing other forms of engaged scholarship in health professions education. Specifically, the internal advocacy methods that are unique to students may be equally
effective to address a whole range of student interests in engaged scholarship, particularly if these are related to student training. Students may use the same methods to advocate for more opportunities for training in CBPR, community-oriented primary care, and public health practice, for example. In addition, students may be able to use these advocacy methods to address important related goals. For example, recognizing engaged scholarship in hiring, promotion and tenure is essential in order to have faculty available to train students in these skills. For this reason, students may be able to extend their internal advocacy efforts to successfully draw attention to issues of institutional policy that have an impact on engaged scholarship. In this way, students may be valuable partners on a whole host of agenda items related to fostering engaged scholarship in health professions academic institutions. In addition, if students are able to introduce valuable innovations into the design of SL curricula, it is likely that they can also introduce valuable innovations into the development of other forms of engaged training.

**Policy Implications and Recommendations**

This research focused on the roles of administrators, faculty, SL staff, students and community partners to advance SL in health professions education. It highlighted the importance of the academic environment to successfully sustain SL, maximize its quality, and involve student co-leaders in fostering SL. It also identified the importance of individual leadership to sustain SL and maximize its benefits and quality. Yet this research also provided evidence that the sustainability of SL is influenced by factors external to the academic institution or partnering community agencies. The activities and policies of funding agencies and accrediting agencies and the influence of broader trends in higher education and health professions education were all identified as influences.
This research suggests ways that funding agencies, health professional education associations, accrediting agencies, and national organizations promoting SL can provide additional support to advance SL in health professions education.

**Funding Agencies**

The recent proposal to dramatically increase the budget of CNCS in 2010 provides an important opportunity to provide support for SL through funding for both practice and research. Three recommendations for both federal and private funding agencies are below.

1. **Support for SL can also enhance civic engagement in higher education more broadly.**

   Whether a funding agency’s objectives are specific to fostering SL or are more broadly related to advancing engaged scholarship in health professions academic institutions, these findings suggest it can pursue these goals by supporting SL. The initial small investment provided through the HPSISN program – supported by the Pew Charitable Trusts, CNCS, and HRSA – jumpstarted SL in most of the participating schools and programs. In addition, Manuscript 1 provides evidence that in 15 of the 16 HPSISN sites that participated in this research, SL then continued for the next 12 to 13 years. At seven of these 15 schools and programs, SL was institutionalized. This is a significant long-term return on investment. In addition, Manuscript 1 found that the HPSISN-supported SL initiatives contributed to fostering engaged scholarship in the careers of participating faculty, increased capacity among both academic and community partners for future partnerships, and led to the diffusion of SL and SL principles to other departments and schools at these institutions. Based on these findings, funders whose aims are to advance SL in health professions education, or to foster greater engaged
scholarship among faculty members, should invest in creating new SL initiatives, and providing support for faculty involvement in SL.

2. Implementation funding is most needed for SL start-up, professional development, partnership quality, and self-study initiatives.

Manuscripts 1 and 2 identified that grant funding for start-up of SL can be leveraged for internal funding to sustain SL. But Manuscript 2 described how, as SL expands to meet the needs of more students and community partner agencies, it may be a challenge to maintain the quality of the partnership process. Manuscript 2 also provided evidence that aligning the goals and design of SL with institutional culture and priorities is important to sustain L. Meeting accreditation criteria may be one of these priorities.

Based on these findings, funding agencies may be most effective in supporting the sustainability and quality of SL by directing grant funding for SL to the following area: 1) start-up of new SL activities, 2) enhancing the quality of the SL partnership process, and 3) supporting self-study activities that help institutions identify how to align the goals and design of SL with institutional culture and priorities. In particular, grants might be earmarked to develop partnership protocols that can support collaboration and reciprocity.

3. Funders can advance the science on SL by directing grants to long term follow-up studies, transdisciplinary research, and research that includes community and student perspectives.

The three manuscripts in this dissertation used these three approaches to attempt to advance the literature on SL sustainability, quality and co-leadership. More research that follows these approaches and explores these topics is needed, and funding can direct
investigators to these methods and topics. Funding for future research on the long-term experiences of SL might support longitudinal methods. These methods can reduce both recall bias and reporting bias, both of which are concerns in retrospective studies such as that reported in Manuscript 1. As demonstrated in Manuscript 2, comparisons across sites can enrich the analysis of research findings, and should also be a priority area for funding. Dissertation awards could encourage students to pursue research that includes these methods and topics, and would also contribute to developing a cohort of scholars who will advance the science in these areas.

To foster transdisciplinary research and research that includes community and student voices, funding agencies might identify specific criteria for grantees. Grants could require research collaborations among scientists in SL and related fields. An approach to including community voices in SL research would be to fund community-academic research collaborations. Students might be funded to conduct research on student perspectives, in particular.

Health Professions Education Associations

Health professions education associations are able to provide guidelines to schools and training program in their fields that help to set norms for learning objectives and teaching methods. The following recommendations speak to specific steps they can take to foster SL in their fields.

1. Produce publications that provide technical support to implement SL.

To further expand SL in health professions education, expert guidance of the sort provided by HPSISN is needed. Health professions education associations are one group that can provide guidance for high quality implementation of SL. For example, the
ASPH publication, *Demonstrating Excellence in Practice-Based Teaching for Public Health* (2004) endorses SL as a practice-based teaching method, describes the theoretical underpinnings of SL, and provides recommendations for how to implement SL in public health. Additional publications of this sort, produced by different health professions education associations, can support the implementation and quality of SL across health professions education. Publications specific to each profession would be useful to address variations in educational goals and curriculum designs. They would also raise awareness of SL and create normative support for SL in different health professions.

2. Identify how SL can achieve key educational priorities.

Manuscripts 1 and 2 provide evidence of the importance of linking SL to institutional culture, goals and priorities to foster the sustainability of SL at any one institution. Manuscript 1 also suggested the importance of adapting SL to changing institutional priorities. The same principles can be applied to sustaining SL in health professions education more broadly. Health professions associations can provide leadership to advance SL by identifying how the pedagogy contributes to achieving current educational priorities. *Demonstrating Excellence in Practice-Based Teaching for Public Health* (ASPH, 2004) does this for public health, by identifying how SL can be used to train students for public health practice, which is a current educational priority in the field.

Another example is the Association for Prevention Teaching and Research (APTR) white paper, *Clinical Prevention and Population Health Curriculum Framework* (2009). This paper was the product of a task force comprised of representatives of eight health professions education associations representing allopathic and osteopathic
medicine, nursing and nurse practitioners, allied health, dentistry, pharmacy, and physician assistants, along with ASPH and CCPH. Its main purpose is to recommend four content areas for clinical education that can be used by health professions schools and programs to enhance their curricula in clinical prevention and population health (APTR, 2009). However, the document also identifies specific teaching methods for these content areas, including SL. This “leverage point” promotes SL to all groups interested in enhancing clinical prevention and population health training. In order to advance SL, other health professions associations should produce publications that identify SL as a method to train students in skills and competencies for other training priorities such as interdisciplinary teamwork, and for current population health priorities, such as reduction of health disparities and quality of care for multicultural populations.

**Accrediting Agencies for Health Professions Education**

Create accreditation guidelines that link SL to learning outcomes and curriculum requirements.

Manuscripts 1 and 2 provide evidence that identifying how SL may be used to teach learning objectives that are identified in accreditation guidelines may provide important support to sustain SL. In the research reported in both of these manuscript, nursing, pharmacy, and physical therapy faculty described how they were able to integrate SL into the core curriculum by identifying how it helped them address learning objectives in their accreditation guidelines. In contrast, as described in Manuscript 2, at University 2, participating faculty members did not identify how SL was relevant to accreditation guidelines in public health, medicine, or physician assistant training, and SL was also not integrated into the core curricula in these areas.
While accrediting agencies do not dictate teaching methods, they can indirectly influence the sustainability of SL by explicitly identifying service as an educational outcome or by identifying SL as a potential method to teach required learning outcomes or course content. For example, former National League for Nursing Accrediting Commission (NLNAC) accreditation guidelines included service as an optional outcome. In addition, the current Accreditation Council for Pharmacy Education (ACPE) guidelines specifically describe how SL might be used to achieve particular learning outcomes. These were two of the three disciplines that reported successfully identifying how SL helped to achieve accreditation guidelines.

Other accrediting agencies can provide support for the quality and sustainability of SL by crafting guidelines that similarly identify how SL can be used as a teaching tool for required educational objectives. These guidelines should: 1) explicitly identify how SL can be used to teach learning outcomes that are mentioned in accreditation guidelines, and 2) provide guidance for the implementation of high quality SL. The guidelines for the Doctor of Pharmacy degree provide a model. They describe how SL advances learning outcomes, including “broaden[ing] the professional horizons of students in areas such as scientific inquiry, scholarly concern for the profession, the relevance and value of research, and postgraduate education and training” (ACPE, 2006, guideline 23.4). They go on to recommend SL as one potential teaching tool for introductory pharmacy practice experiences, and provide guidance on how to create a high quality SL experience:

“Colleges and schools using service learning activities, whether as part of the introductory pharmacy practice experiences or not, should ensure that, in general, such activities: meet a community need, establish or enhance a relationship between the community and the academic institution, help foster civic and professional responsibility and the development of a sense of caring for others, are integrated into the required academic curriculum, provide structured time to
reflect on the service learning experience, enhance what is taught in the didactic curriculum by extending student learning beyond the classroom and into the community, provide opportunities for interaction with other health professional students and practitioners, and attempt to balance the service that is provided and the learning that takes place.” (ACPE, 2006, Appendices p. xvi)

**National Organizations Promoting SL**

National organizations promoting civic engagement and SL in higher education, including Campus Compact, the New England Resource Center for Higher Education (NERCHE), CCPH, IARSLCE, and others, have already done a great deal to foster the sustainability and quality of SL. As described in Chapter 1, they have created large bodies of resources to assist faculty and SL staff to implement and sustain high quality SL (Campus Compact, n.d., CCPH, n.d); are documenting and making publicly available models of campus policies and infrastructure that support SL and civic engagement (Jordan & Community-Engaged Scholarship for Health Collaborative, 2007); and creating forums to support the scholarship on SL (IARSLCE, n.d.). In the health professions, CCPH has provided extensive resources for SL quality and sustainability through its website, intensive SL workshops, and programs that provide sub-grants and technical assistance to cohorts of health professions schools and programs to foster SL and engaged scholarship. What else can these leadership organizations do to foster the sustainability and quality of SL? This research points to three potential contributions related to advancing the science on SL, enhancing the quality of community-academic partnerships, and fostering student co-leadership for SL:
1. Create research networks, interest groups, conference tracks, and publications that advance the science on SL.

National research associations can advance the science on SL particularly as related to encouraging transdisciplinary research on SL sustainability and promoting research on the sustainability and quality of SL that includes the perspectives of community partners and students. A transdisciplinary research network could be established to help faculty identify collaborators in other fields. The research has only touched the surface in terms of exploring how collaborations between faculty, staff and student leaders can advance SL in health professions education. An interest group devoted to this topic might help to advance the research in this area. In addition, national organizations might advance the science in these areas by creating awards that recognize high-quality research involving these methods and topics.

National organizations can also elevate the profile of research that advances the science in these ways through special sessions or tracks at major conferences, such as the annual IARSLCE conference, or theme issues of major journals in the field, such as the *Michigan Journal of Community Service Learning*. Similar recommendations apply to highlight this research in the health professions. There are multiple journals devoted to health professions education where a theme issue could be developed.

2. Create additional resources to foster the quality of SL partnerships.

Findings from Manuscript 2 suggest that a challenge for academic institutions is how to maintain the quality of the SL partnership process as growing numbers of students and community partners become participants in SL. National organizations could foster the quality of SL partnerships in a number of ways. Conference sessions, workshops and
publications might be devoted to highlighting methods and infrastructure that support a strong partnership process. Community partners should be included in conference sessions and as co-authors of these publications.

3. Foster student-co-leadership for SL by raising awareness of the contributions of student co-leaders and creating resources to foster student co-leadership.

As described in Chapter 6, national organizations can play an important role in supporting student co-leadership for SL. One way to do this is simply to increase awareness of the value of student co-leadership. As described in Chapters 1 and 6, Campus Compact has highlighted the value of student leadership for SL in undergraduate education in *Students as Colleagues: Expanding the Circle of Service-Learning Leadership* (Zlotkowski, et al., 2006). It would do a great deal to raise awareness of the value of student co-leadership for SL in health professions education to publish a similar book featuring student leadership for SL in health professions education. CCPH has been in the forefront in highlighting student leadership for SL in health professions education by featuring student tracks at annual conferences. It would dramatically increase the visibility of student leadership for SL in health professions education for multiple relevant health professions conferences to include student leaders for SL as featured speakers.

National organizations could also provide support for student co-leadership for SL by developing practical resources for student leadership development. They could create workshops to train student leaders in practical strategies to foster SL. Students would need to learn about such issues as developing community partnerships, creating new curricula, and promoting a culture of civic engagement. Training should also address
leadership strategies for different disciplines, professions, and institutional contexts. National organizations might also develop resources for faculty, administrators, and SL staff that describe methods to engage students as colleagues for SL and provide student leadership training on campus. National conferences on civic engagement and health professions education could highlight examples from institutions that have successfully engaged students as colleagues for SL and fostered student co-leadership for SL. In addition, national organizations could develop “turnkey” curricula for student leadership development that institutions could implement on campus. These would ideally be tailored to particular disciplines or professions.

Strengths, Limitations, and Suggestions for Future Research

Each of the studies included in this dissertation has unique strengths as well as weaknesses in its research design. These are described below and recommendations are given for how future research might build upon each of these manuscripts and address its limitations.

Manuscript 1

Strengths

This paper adds to the literature in a number of ways. As described in Chapter 2, it contributes to the empirical research on SL by borrowing theoretical concepts and a conceptual framework from related literatures. In so doing, it identified three levels of sustainability, and also structured a holistic inquiry into the influences on sustainability. This research also contributes to the literature on the sustainability of SL by exploring this topic in health professions education, specifically.
A major strength of this research is that it provides a ten year follow-up perspective. Furco and Holland (2004) suggest that a five-to-seven year initiative is needed to institutionalize SL, but Furco (2002) writes that most SL evaluations are conducted within three years of any intervention, and provides an example where this was the case even when the intervention was designed to foster institutionalization. Following Furco and Holland (2004), this study provided a sufficiently long follow-up window to capture the full process institutionalization, or lack thereof, and related influencing factors.

Using the HPSISN cohort as a case study provided a number of strengths. The cohort provided a naturally occurring group of early SL initiatives in health professions education that was ideal to assess the long-term sustainability and impact of SL and explore influencing factors. The diversity of the HPSISN cohort, in terms of the variability in the varying health professions schools and programs and community agencies that participated, was ideal to identify themes that cut across these differences.

Limitations

Like all qualitative research, this study is limited in its ability to address causality, because it is not representative. Case studies like this one are not designed to be representative, but rather to be illuminating of particular phenomena that one wishes to explore (Yin, 2003). The HPSISN cohort was ideal to explore the outcome of sustainability and influences on this outcome, but these findings may not be generalizable to SL initiatives at institutions outside of the HPSISN cohort. In particular, the HPSISN cohort comprised a group of early adopters of SL. Early adopters tend to be both innovators and champions. As a result, their initiatives may differ from those of later
adopters, particularly as related to implementation and sustainability – key issues under exploration in this study. In addition, the HPSISN cohort controlled for initial start-up factors that may have had an influence on sustainability, including the presence of outside grant funding and matching internal support. This, too, suggests that these findings are not generalizable to other SL initiatives.

A second limitation is that, by controlling for these start-up variables, this study was unable to investigate the importance of these factors for the long-term sustainability and impact of SL. However, the fact that the findings so closely mirror the literature on sustainability of SL in higher education provides support for their generalizability.

A third potential limitation of this study was that sustainability was not an initial goal of HPSISN upon implementation. As a result, these institutions were not required to develop plans to sustain SL by the HPSISN program. An assessment of the sustainability of SL in this context may have produced different findings as to both the degree of sustainability of SL and influences on sustainability in participating SL initiatives that an evaluation of an initiative that included sustainability as an initial goal that was planned for in a deliberate manner.

A fourth limitation of this study is that it included only the perspectives of administrators, faculty and SL staff members. The absence of community voices from this research may be particularly relevant as related to understanding the long-term impact of SL for community agencies. Existing literature on the sustainability of SL in higher education also tends to reflect the academic viewpoint, so comparability with the existing literature cannot rule this out as a potential source of bias.
A fifth limitation of this research is that it did not focus, in particular, on the long-term impact of SL on students. Interview participants were asked to describe the long-term impact of SL, and the main impacts they reported were related to impacts on faculty member, academic institutions, community agencies, and town-gown relations. They did not focus on long-term impacts for student. In fact, this study design was not ideal to study the impact of SL on students. Rather, a study design that allowed students to speak about their personal experiences of the long-term impact of SL would have been appropriate to assess this outcome. Because students are, arguably, the primary beneficiaries of SL, the absence of a focus on the long-term impact of SL on students is a limitation of this study.

A sixth limitation of this research is the possibility of reporting bias. For nine of the SL initiatives that participated in this research, only one individual was interviewed. This may have produced undetected reporting bias, particularly a related to social response bias. For the other seven participating SL initiatives, two interviews were conducted per initiative, which provided some protection against reporting bias. To reduce the risk of reporting bias for all of these SL initiatives, we provided a written disclosure statement that ensured all participants that everything they said would be completely confidential, and would be reported in such a way that there would be no possibility of tracing quotation to their sources. Nevertheless, there is the potential that some reporting bias remained.

A seventh and final limitation of this research is that it asked participants to retrospectively report on influences on their SL initiatives from 1998 to 2007-2008. This retrospective method is likely to introduce recall bias. Recall bias may be a particular
challenge in studies like this one, in which individuals are asked to reflect on factors that contributed to the current degree of success of an initiative. Here, “success” was defined as sustainability. Those from institutions where SL was institutionalized may have been biased toward recalling facilitating factors, while those from institutions where LS was not institutionalized may have been biased toward recalling challenges.

**Suggestions for Future Research**

Future research on the sustainability and long-term impact of SL could include institutions that had a variety of early start-up experiences in order to take into account the influence of these factors. In addition, future research would benefit from including the views of community partners, whose perspectives might broaden our understanding of the long-term impacts of SL. To reduce recall bias, future research on the sustainability of SL might use a longitudinal design, following SL initiatives over time and collecting data every few years. However, financial constraints might make this design unrealistic. A more efficient approach might be to conduct retrospective studies that utilize a broad array of historical documents, such as annual reports and internal evaluation data. Internal evaluators may be best able to collect these records over time.

Like all qualitative research, this study is limited in its ability to address causality. However, a strength of this research, as a qualitative investigation was it ability to identify new themes that have not been explored in depth in the literature. Future qualitative and quantitative research might explore two new findings that emerged in this study: 1) the influence of trends in academia, specifically the increasing support for engaged scholarship, on sustaining SL in health professions education and 2) the challenge of competing educational priorities, specifically, high-technology methods for
training students in patient care and a focus on teaching “hard science” and research skills. Another strength of this research is that, using inducting coding, it identified three tiers of sustainability. This analysis of levels of sustainability was not present in prior research. Future quantitative research might build on this inquiry to develop a scale for degrees of sustainability.

Finally, future research on the long-term impact of SL should focus on the long-term impact on students. Ideally, this research would involve students as research participants, but both qualitative and quantitative methods would be suitable to explore this outcome. Future research might explore the impact of SL on students’ attitudes, career choices, and behaviors as professionals, such as their interest and/or involvement in community and/or population health, or a history of pro-bono care, volunteerism, or professional service.

Manuscript 2

Strengths

The main contribution of this research is that it explores in detail how different health professions institutions have fostered the sustainability and quality of SL given very different institutional contexts. This was made possible by selecting the two cases for differences in institutional context but similarities in the outcome of sustainability. A second contribution of this research is that it includes the perspectives of all of the stakeholders in SL, including administrators, faculty members, SL staff, students, and community partners. Typically, when community partners and students are included in research on SL, this research examines the impact of SL. Community partners and students are rarely included in research that described the implementation and
sustainability of SL. A third contribution of this research is that it looked at the experiences of health professions schools that have successfully sustained SL for 14 years in order to identify strategies for implementing high quality SL. They may offer better strategies for success than schools and programs that have more recently implemented SL and have a shorter history from which to judge the effectiveness of their methods.

The use of the case study method was an important strength of this research. This method produced a complex account of the experiences of each SL initiative. Collecting multiple sources of data – through interviews, document review and site visits – and including the perspectives of all of the stakeholders in SL enhanced the reliability of the findings by allowing extensive opportunities for triangulation. The case study method also allowed for a review of data produced at various points in time, which provided some longitudinal perspective and also allowed for triangulation.

Limitations

One important limitation of this research is restrictions on generalizability. As in all qualitative research, the sample for this study – including the cases, the community partner agencies, and the individual interview participants -- was designed to achieve goals related to generalizability to theory, and not to be representative of SL initiatives more broadly. Rather, this research purposively selected SL initiatives, community partner agencies, and individual participants to represent a diversity of experiences with and perspectives on the quality and sustainability of SL. As a result, these findings may not be generalizable to other SL initiatives, or to other community agencies or individuals involved in the SL initiatives that were studied. However, selecting cases for variability on contextual factors that were hypothesized to be important influences on the outcomes
of interest did provide some support for the generalizability of the findings. This occurred when there was replication of some patterns and variability in other patterns across the two cases, as related to the presence of similar or dissimilar contextual factors.

A second important limitation of this research was the limited participation of community agencies. Due to limited resources to conduct this study, only three community agencies participated in each case study. While for University 2, these agencies represented one-quarter of all community partnerships for SL, for University 1, they represented less than 10% of community partnerships. This may have introduced unknown sources of bias into the research, particularly for the case study of SL at University 1.

A third limitation was in how the three participating community agencies for each case study were selected. There were two flaws in how these agencies were selected. First, for each case study, the SL director selected these agencies, based on the case selection criteria we provided. However, the SL director may have also selected these agencies on additional variables, such as the presence of interpersonal relationship, or ease of scheduling. These factors may have introduced bias into the findings, because they may be associated with the quality of the community agency’s experiences with SL.

A second flaw in how the community agencies were selected was the composition of the case selection criteria. While the three case selection criteria were certainly relevant influences on the topics this research explored, in retrospect there were more important factors that could have been included in these criteria. Specifically, the case study of University 1 identified three categories of SL, which essentially represented three levels of quality. In retrospect, it would have been ideal to select community
agencies from each of these categories, in order to explore what factors led to each level of quality. In fact, of the three agencies selected by the SL director, two received services that fell into the second category, and the third received services in both the first and second categories. In addition, the case study of University 2 identified two major groups of community agencies: health providers and education providers. It would have been ideal to select community agencies from each of these groups. However, all three selected by the SL director were from this first group. Underlying these limitations was the fact that the case selection criteria for the community agencies were identified before data collection began. If the study investigator had been able to conduct the academic interviews before selecting the community agencies to participate, these patterns would have emerged, and this may have led to these changes in the case selection criteria.

A fourth limitation was that the individual interview participants at both the university and the community agencies were selected in collaboration with the SL director. This may have also resulted in unintentional bias, for example of the SL director selected some equally qualified individuals over other, based on factors that may have been related to their experiences with the quality and sustainability of SL. To reduce this limitation, we created a detailed initial list of potential interview participants by job description. In many cases, there was only one individual in each of these job descriptions, and this limited to some degree the discretion of the SL director in selecting interview participants. A fifth and final limitation is the possibility of reporting bias. Conducting multiple interviews for each case was able to reduce the likelihood that this sort of bias influenced the final analysis of these data. However, it is possible that some reporting bias may have nonetheless remained.
Suggestions for Future Research

To improve the generalizability of their findings, future qualitative case studies in this area could include a greater number of cases selected not just for differences in hypothesized causal factors, but also for similarities. For example, future comparative case study research could include four cases including two at AHCs and two at teaching institutions, for example, or two at secular institutions and two at faith-based institutions. Future research could also include a greater number of community agencies. These agencies could also be selected for traits that appear to be influences on the sustainability and quality of SL, and could also be selected in pairs, as suggested for participating academic institutions. Commonalities among cases and community agencies selected for similarities, and contrasts between cases and community agencies selected for differences, would lend greater generalizability to the findings. In order to select community agencies for traits that are influences on sustainability and quality, future research should consider collecting data from academic partners before creating case selection criteria for community agencies.

Like all qualitative research, this study is limited in its ability to address causality. However, a strength of this research, as a qualitative investigation was it ability to identify new themes that have not been explored in depth in the literature. Future qualitative and quantitative research might explore in further depth some of the key finding from this study. For example, future quantitative research might build upon the finding from this study that the institutional culture seems to influence the goals of SL, as well as the design and implementation of SL, leading, ultimately, to the strength and weaknesses of an SL initiative. Future quantitative research in this area might look for
correlations between the institutional culture, goals of SL, and design features that were clear strength or weaknesses in these cases. These might include, for example, the integration of SL into core courses versus the delivery of SL as an elective or volunteer experience, or the presence of infrastructure and policies that support a strong partnership process, such as the involvement of faculty member in maintaining community partnerships and the availability of professional development opportunities for community partners.

**Manuscript 3**

**Strengths**

This research makes three contributions the literature on student leadership for SL. First, while most of the literature in this area focuses on the products of student leadership, this research introduces a new focus on the organizational change methods that students can use to foster SL. Second, this research applies public health advocacy principles to interpret students’ contributions to advancing SL. This theoretical lens highlights how students can play a unique role to foster SL in health professions education that is distinct from and complementary to the roles of administrators, faculty and staff. Third, this research highlights the importance of partnerships among students, faculty, and SL staff to maximize the effectiveness of student leadership for SL. Another strength of this research is that it used participant observation as the primary research method. This method allows for in-depth longitudinal data collection that produces a rich and complex account of events.
Limitations

The participant observation method also introduces limitations to this research. With this method, the subjective interpretation of the investigator is more obvious than in other research methods, both qualitative and quantitative (Breuer, Mruck, & Roth, 2002). For example, when interviewing or document review is used as the primary form of data collection, the data are created by other individuals – the interview participants, or the authors of these documents. But with participant observation, the data consist of the experiences of the investigator. This may have the result of biasing the finding.

Recognizing the potential for bias that this method may introduce, this research included two additional sources of data: document analysis and member validation. These other data sources provided the opportunity for triangulation. In order to reduce potential bias in the analysis, this work was informed by an extensive examination of the literature about student leadership in SL, as well as a reading of the literature on advocacy methods for both organizational change and public health policy change.

Another limitation of this research is that single case studies such as this one may not be generalizable to other settings or to other groups of students and faculty at this setting. The institutional environment at JHSPH during the time period reported in this case study provides the context for this case. During this time, there was a great deal of movement toward promoting engagement at the School, but mechanisms for engagement were still nascent. These conditions were important influences on SPARC’s formation, goals, activities, successes and limitations. They also influenced the manner in which academic administrators and faculty members partnered with SPARC. While the specificity of the single case study means that findings may not be generalizable, this
particular backdrop allowed for findings with particular theoretical relevance – as related to the advocacy role that students can play, and the innovations that students can introduce in terms of collaborative curriculum development – to emerge with extra clarity.

Suggestions for Future Research

Additional research is needed that documents student leadership for SL in health professions education, including the methods that students may use to advance SL, challenges to student leadership, and how these challenges can be addressed. Future research should also describe student leadership for SL in different institutional settings, for example, at health professions schools with different histories of engagement with their local communities, such as those in rural areas. As mentioned above, these contextual factors may be important influences that shape students’ leadership for SL and the support they receive from faculty, SL staff, and administrators.

A related area for further exploration is how different academic institutions are engaging students as colleagues for SL. Future research should describe different methods for partnership that have been implemented in different institutional settings and describe their impact. A perennial challenge to student leadership for SL is turnover in the student body. A topic to explore and document is how initiatives may be designed to sustain student leadership for SL. One model that has been described in the literature is peer-to-peer education in which student leaders for SL partner with faculty members and community partners to train the next generation of student leaders (Addes and Keene, 2004; Mohan & Mohan, 2007). Future research should document additional models to sustain student leadership for SL in health professions education.
This research focused on the impact of student leadership on the curriculum and the way that new curricula are conceived and developed. Future research on student leadership for SL could examine broader impacts. One area of interest is the impact on participating students’ professional development, for example whether providing leadership for SL leads students to have a greater interest in civic engagement or an interest in a career as an engaged scholar. A five- or ten-year follow-up study could also assess the impact of leadership for SL on students’ later professional activities. Another area of interest is the impact on administrators, faculty and staff members of partnering with students to advance SL. Potential impacts to explore include faculty and staff members’ professional activities related to fostering engagement in the curriculum and their attitudes about students’ contributions to academia.

A final area of interest that is not addressed in this article, but that might enhance our understanding of student leadership for SL in health professions education, is how students are forging and maintaining partnerships with community partners to create SL opportunities. Student leadership in this area has been documented in detail in a small number of articles, both as related to leadership in health professions education (Moskowitz, Glasco, Johnson, & Wang, 2006) and leadership in undergraduate settings (Alden and Norman, 2006; Meyer, 2006). This topic deserves additional attention due to the central role of community partners in SL.
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APPENDIX A

The Pew Health Professions Commission’s 21 Competencies for the 21st Century

| 1. | Embrace a personal ethic of social responsibility and service. |
| 2. | Exhibit ethical behavior in all professional activities. |
| 3. | Provide evidence-based, clinically competent care. |
| 4. | Incorporate the multiple determinants of health in clinical care. |
| 5. | Apply knowledge of the new sciences. |
| 6. | Demonstrate critical thinking, reflection, and problem-solving skills. |
| 7. | Understand the role of primary care. |
| 9. | Integrate population-based care and services into practice. |
| 10. | Improve access to health care for those with unmet health needs. |
| 11. | Practice relationship-centered care with individuals and families. |
| 12. | Provide culturally sensitive care to a diverse society. |
| 13. | Partner with communities in health care decisions. |
| 14. | Use communication and information technology effectively and appropriately. |
| 15. | Work in interdisciplinary teams. |
| 16. | Ensure care that balances individual, professional, system and societal needs. |
| 17. | Practice leadership. |
| 18. | Take responsibility for quality of care and health outcomes at all levels. |
| 19. | Contribute to continuous improvement of the health care system. |
| 20. | Advocate for public policy that promotes and protects the health of the public. |
| 21. | Continue to learn and help others learn. |

APPENDIX B

CCPH Nine Principles of Good Community-Campus Partnerships

These principles were adopted by the Community-Campus Partnerships for Health (CCPH) Board of Directors in October 1998. They were updated and adopted by the Board in October 2006. Both versions of these principles, and related background information, are available online at: http://www.ccph.info (Retrieved June 2, 2009)

1. Partnerships form to serve a specific purpose and may take on new goals over time.

2. Partners have agreed upon mission, values, goals, measurable outcomes and accountability for the partnership.

3. The relationship between partners is characterized by mutual trust, respect, genuineness, and commitment.

4. The partnership builds upon identified strengths and assets, but also works to address needs and increase capacity of all partners.

5. The partnership balances power among partners and enables resources among partners to be shared.

6. Partners make clear and open communication an ongoing priority by striving to understand each other's needs and self-interests, and developing a common language.

7. Principles and processes for the partnership are established with the input and agreement of all partners, especially for decision-making and conflict resolution.

8. There is feedback among all stakeholders in the partnership, with the goal of continuously improving the partnership and its outcomes.

9. Partners share the benefits of the partnership's accomplishments.
APPENDIX C

Principles of Community-Based Participatory Research

In a seminal article in the Annual Review of Public Health, Barbara Israel and colleagues proposed a set of principles for the practice of community-based participatory research (CBPR). While alternative guidelines for CBPR have been developed, these principles have been cited widely.


1. Recognizes community as an unit of identity
2. Builds on strengths and resources within the community
3. Facilitates collaborative, equitable involvement of all partners in all phases of the research
4. Integrates knowledge and intervention for mutual benefit of all partners
5. Promotes a co-learning and empowering process that attends to social inequalities
6. Involves a cyclical and iterative process
7. Addresses health from both positive and ecological perspectives
8. Disseminates findings and knowledge gained to all partners
9. Involves long-term commitment by all partners
APPENDIX D

Interview Guide, HPSISN Follow-up Study, Phase 1

INTRODUCTION

We have two goals in conducting this study, which I’d like to share with you to help frame this interview. First, this is an opportunity to better understand the long-term impacts of a short-term grant for service learning. Second, this is a chance to learn from the experiences and knowledge of a cohort of early adopters of SL.

In this interview we’re going to focus on two topics:

- First, whether SL at your institution was sustained after the HPSISN grant ended in 1998, and what factors were facilitators or challenges to sustainability, and
- Second, what impact SL may have had for the institution, and for participating faculty, staff, and community partners. And again, we’re going to look at what factors were facilitators or challenges to these impacts.

If you don’t know the answer to a question, feel free to skip it.

QUESTIONS

INTERVIEW PARTICIPANT’S INVOLVEMENT IN SL

1) Before we go to our first substantive questions, I want to get a sense of your involvement in service-learning. What percent of your time do you spend involved in the SL program?

2) How has the amount of time you’ve been involved varied over the last ten years, since the HPSISN grant ended?

3) What is your familiarity with the SL program right now?

4) What was the last year you were significantly involved with the SL program, in a way where you could describe the day to day operations of the program?
   a. Who else at [Institution Name] should I interview about the day to day operations of the SL program there?

SUSTAINABILITY

5) After HPSISN funding ended in 1998, did SL continue in the curriculum uninterrupted?

6) Since HPSISN funding ended, would you say that SL at [Institution Name] has increased, decreased, or remained the same?
7) Could you walk me through the life of SL at [Institution Name] from the time the HPSISN grant ended in 1998 to the present?

8) Were there any significant changes to SL at [Institution Name] from the end of the HPSISN grant to the present? And if so, could you describe those for me?
   a. Why were those changes made?
   b. What were the impacts of those changes?

9) How is SL at [Institution Name] implemented now/in the last year you were familiar with it?
   a. Is it integrated into the curriculum or freestanding?
   b. Is it required or voluntary?
   c. What is its administrative home?
   d. What is the level of faculty involvement in SL?
   e. What is the level of student involvement in SL?
   f. What types of community partners are involved, and how many?
   g. Are there rewards for involvement for faculty?
      i. For students?
      ii. For community partners?
   h. How are community-academic partnerships structured?
      i. How do you communicate?
      ii. What are the goals of your communication?

10) What factors have facilitated the sustainability of SL at [Institution Name]?
    a. How did you maximize the value of these factors?
    b. What advice can you offer to other institutions interested in engaging in SL, about how to take advantage of these factors?
    c. What was the role of HPSISN in supporting SL?

11) What factors have been challenges to the sustainability of SL at [Institution Name]?
    a. Were those challenges addressed, and if so, how?
    b. What advice can you offer to other institutions interested in engaging in SL, about how to address these challenges?

IMPACT

Now I want to turn to the second theme of our interview, and explore the impacts of the SL program at your institution. In this section of the interview, I want you to think broadly about the impact of SL, including impact on the academic institution, faculty, students, community partner organizations, and community health.

12) Has SL at [Institution Name] had any impact on the institution?
    a. On faculty?
    b. On students?
    c. On community relations?
13) Has SL at [Institution Name] had any impact on community partners?
   a. On participating communities?

14) What factors facilitated these impacts?
   a. How did you maximize the value of these factors?
   b. What advice can you offer to other institutions interested in engaging in SL, about how to take advantage of these factors?

15) Did [Institution Name] do any formal evaluation of the impacts that you mentioned? If so, could you describe them for me?

16) What challenges were there to achieving these outcomes?
   a. Were those challenges addressed, and if so, how?
   b. What advice can you offer to other institutions interested in engaging in SL, about how to address these challenges?

17) What does SL mean to you?

18) Do you think SL works as a teaching method? And if so, how do you think it contributes to student learning?

19) Do you think SL is where we should be investing our resources, or do you think they should go to other teaching methods, or other types of community partnerships?

20) Did participating in HPSISN have any impact on your career? If so, would you describe that for me?

21) Now I want to read you the CCPH definition of SL, and then on a scale of 1 to 10, where 1 is not at all, and 10 is completely, please rate to what extent the SL program at [Institution Name] has achieved this definition of SL (in the last year you were familiar with the program).

   CCPH defines SL as: “a structured learning experience that combines community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens.”

   To what extent has SL at [Institution Name] achieved this definition?
   a. Could you explain your answer to me?

22) That concludes our formal questions. Is there anything that we didn’t get to talk about regarding your HPSISN program or SL activities at [Institution Name] that you’d like to share?
SNOWBALL SAMPLING

23) Who should I contact at [Institution Name] to learn more about the SL program there from [year - year]?
   a. Can you provide any contact information?

CASE STUDY RECRUITMENT AND SCREENING

24) We are interested in doing some case studies of schools that participated in HPSISN. Case study data collection would involve me spending about a week at the institution and at community partner organization to interview faculty, administrators and community partners who have been involved with SL there. Would you be interested in participating in a case study?
   a. Who would I contact at [Institution Name] to ask about interest in participating in a case study?
   b. Do you think community partners might be interested in participating?

25) If I were to conduct a case study of SL at [Institution Name], would records about the SL initiative and its impact be available to me? These might include reports about SL at the institution, the mission and vision statements of the SL initiative, measurement tools used to capture impact and data produced from those tools, and partnership guidelines.

26) Is there anything you recommend I read to enhance my understanding of your SL program, for example, academic articles, articles from newsletters or newspapers, or websites?

CLOSING

Thank you very much for your time. (If expressed interest in participating in a case study:) I will be in touch when we have determined which schools we would like to invite to participate in the case studies.
APPENDIX E

Final Codebook, HPSISN Follow-up Study, Phase 1

I. FACILITATING FACTORS IN ORGANIZATIONAL SETTING
   1) ORGANIZATIONAL CULTURE/MISSION
   2) LEADERSHIP OF TOP ADMINISTRATOR AND FUNDING FROM THE TOP
   3) RESOURCES TO SUPPORT SL: FUNDING FOR FACULTY AND INFRASTRUCTURE TO SUPPORT SL
   4) VALUE OF ROUTINIZATION
   5) CRITICAL MASS OF SUPPORT FOR SL
      a. FACULTY CHAMPIONS
      b. CRITICAL MASS
      c. COMMUNITY CHAMPIONS AS PART OF CRITICAL MASS
      d. STUDENT CHAMPIONS AS PART OF CRITICAL MASS

II. FACILITATING FACTORS IN PROGRAM DESIGN/IMPLEMENTATION
   6) SL LEADER IS A CHAMPION FOR SL
   7) ADAPTABILITY – EVOLVE SL SO IT CONTINUES TO ADDRESS LATEST EDUCATIONAL PRIORITIES
   8) BUILDING TRUSTING, STABLE, LONG-LASTING COMM-ACADEMIC PSHIPS
      a. CONGRUENCE OF COMMUNITY AND ACADEMIC CULTURES

III. FACILITATING FACTORS IN EXTERNAL ACADEMIC ENVIRONMENT
   9) SEA CHANGE IN ATTITUDES ABOUT COMMUNITY ENGAGEMENT
      a. ACCREDITATION CRITERIA,

IV. IMPACT
   10) HELPS ACHIEVE INSTITUTIONAL GOALS

V. EXTRA
   11) STUDENT RECOGNITION AWARD FOR SL

VI. CHALLENGES AND RESPONSES
   12) TURNOVER AMONG FACULTY
      a. FACULTY DEVELOPMENT – CONTINUALLY
         i. PEER-TO-PEER FACULTY DEVELOPMENT
   13) TURNOVER IN CHAMPIONS AMONG ADMINISTRATION AND FACULTY
   14) SCHEDULING INTERDISCIPLINARY SL DIDN’T WORK
      a. RESPONSE: NONE
   15) SL IS MORE WORK FOR FACULTY
   16) COMPETING PRIORITIES THAT SL CANNOT APPEAL TO, LIKE HIGH TECH AND BENCH RESEARCH
   17) NOT ENOUGH INTERNAL OR EXTERNAL FUNDING
      a. RESPONSE: INTERNAL MARKETING – DEMONSTRATE HOW SL HELPS INSTITUTION TO ACHIEVE OTHER CURRENT PRIORITIES – DON’T HAVE TO COMPETE DIRECTLY – CAN DEMONSTRATE VALUE OF SL INDEPENDENT OF THOSE OTHER PRIORITIES
   18) ORGANIZATIONAL INSTABILITY

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19) RESPONSES TO LOSS OF CHAMPIONS AND COMPETING PRIORITIES: INTERNAL MARKETING, APPEAL TO “INSTITUTIONAL HOOKS”
20) RESPONSES TO FUNDING SHORTAGES:
   a. DIVERSIFY FUNDING SOURCES
   b. USE SL INFRASTRUCTURE AT UNIVERSITY LEVEL AND BUILD INTO CORE COURSES

VII. LONG-TERM IMPACTS
21) ON STUDENTS
22) ON COMMUNITY PARTNERS
23) ON PARTNERSHIP CAPACITY IN BOTH ACADEMIC AND COMMUNITY PARTNERS
24) ON FACULTY MEMBERS
25) ON “TOWN-GOWN” RELATIONS
26) DIFFUSION TO OTHER COLLEGES, DEPARTMENTS, ETC
27) MENTOR-MENTEE GRANTS
28) PUBLIC RELATIONS/FUNDRAISING
29) MORE GRANTS FOR COMMUNITY-BASED EDUCATION
30) ON COMMUNITIES: CHANGES IN LOCAL LAWS, POLICIES
APPENDIX F

Interview Guide for Academic Partners, HPSISN Follow-up Study, Phase 2

INTRODUCTION

We are conducting a ten year follow-up study of the HPSISN program, which provided financial and technical support for SL at this school and 16 other health professions schools from 1995 to 1998.

The SL programs that participated in HPSISN were some of the first ones in health professions education, so their experiences can provide valuable lessons about these questions. One of the aims of the study is to learn from experiences of SL programs that have had success with program sustainability and impacts since HPSISN ended.

Based on a phone interview I conducted last summer with [Individual Name] at [Institution Name], we learned that this SL program has had unique positive experiences with both sustainability and impact. We are conducting case studies with this SL program and another SL program that participated in HPSISN, to explore different paths to achieving these positive outcomes.

The purpose of today’s interview is to explore in depth your SL program’s sustainability and impact, what contributed to the successes it has had, and what challenges it has faced. I will be interviewing both community and academic partners in your SL program, and together your responses will give me a complete picture of the school’s experience.

What people tell me in these interviews will be used to create recommendations for other SL programs on how to remain sustainable, how to maximize their benefits for all those who are involved -- including the schools, community organizations and community members -- and how to address common challenges that SL programs face.

Do you have any questions before we start? (Provide opportunity to ask and answer questions.)

Were you able to review the description of the study that I gave you? (If person has not yet read the disclosure statement, give them time to do so now, and ask any related questions.)

I just want to remind you that in this interview everything you say will be completely confidential. I will not use your name in any reports about this interview, and no one will see the transcript of this interview except a professional transcriptionist who has no relationship to the school, and me.

In this interview, I’m interested in hearing your personal opinions. If you don’t know the answer to a question, or don’t feel comfortable answering it, feel free to skip it, or to
suggest someone else who might be able to answer it, at your school or your community partner organizations.

**QUESTIONS**

**KNOWLEDGE OF THE SL PROGRAM/ROLE IN THE SL PROGRAM**

1. First, could you tell me your current job title?

2. Could you describe for me your past and current involvement with the SL program?
   a. When did you first get involved with the SL program?
   b. Has your involvement with the program changed over time? If so, how?
   c. What percent of your time did you spend involved with the SL program when you were most involved, and when was that?
   d. What percent of your time do you currently spend involved in the SL program?

**IMPLEMENTATION**

Okay, I first want to improve my understanding of how the SL program is structured, and then we’ll talk about how it has been sustained.

3. Can you tell me how the SL program is organized and operated?
   a. What is its administrative home? Is it in one dept, or whole school or university?
   b. What is its staffing, office space, funding?

4. What kind of infrastructure is there to support the program?
   a. Is it integrated into core courses or electives?
   b. Is there a coordinating center for SL?
   c. Does the SL program have linkages to or relationships with other programs?

5. How do your community partnerships for SL operate? What is the partnership process like?
   a. How are relationships maintained?
   b. Do you have formal guidelines for how you work together?
      i. Is there a written document I could have a copy of?
   c. Do you draft memoranda of agreement? What do these entail? Are they updated regularly?
      i. Is there a template I could have a copy of?
   d. How would you describe the quality of your relationships with your community partners?
INFLUENCES ON SUSTAINABILITY

6. In your opinion, what factors have helped to sustain the SL program over the last ten years?
   a. What has the program done, to support its sustainability?

7. How has the program been funded over the past ten years?
   a. How important has funding been to program sustainability?

8. What factors have been the most important challenges to the sustainability of the SL program?

9. Were you able to address these challenges, and if so, how?
   a. Could you tell me more about one particularly significant challenge to the program’s sustainability, and how it was addressed?

10. Is sustaining partnerships with individual community organizations a goal of the SL program?
    a. If yes, in general, is to what extent have you been able to sustain these partnerships?
       i. Are your original community partners around?
    b. If no, why is it not important?

11. What has helped to sustain these community partnerships?
    a. What has the SL program done to support that?
    b. What have community partners done to support that?

12. Has your SL program changed or evolved in significant ways in the past ten years -- since HPSISN ended -- and if so, could you tell me about that?
    a. In particular, were there any major changes after the HPSISN program ended in 1998?
    b. What caused the program to make those changes?
    c. What were the results of making those changes?

13. Did any of these changes in the program contribute to sustaining the program, and if so, how?
    a. Were any of these changes made intentionally to promote program sustainability?

14. Has your SL program planned explicitly for sustainability? And if so, could you tell me about that process?
    a. When did you start planning for sustainability?
    b. What is the planning process like? How often? Who is involved?
       i. Is there a planning document that I could get a copy of?
          1. If not: why has that not occurred?
    c. What have been the SL program’s goals for sustainability?
i. To what extent, would you say, has the program succeeded in meeting those goals?
   1. Where is there still room for improvement?
   2. What have you done to work towards those goals?

15. What advice would you offer to other graduate health professions institutions that are in earlier stages with their SL programs, about how to plan for sustainability?

Now I want to ask you a few questions about factors we’re especially interested in looking at as potential influences on program sustainability. *(Only ask about topics that have not already been addressed.)*

16. In your opinion, are there particular characteristics of how your SL program is organized or operates that have contributed to its sustainability? And if so, what are they?

17. Have aspects of the organizational culture at the school had an influence on the sustainability of the SL program, positive or negative? And if so, can you tell me about that?
   a. If negative: Have you been able to address that? And if so, how?

18. Has the SL program had to work to get buy-in from members of the school community? And if so, what have you done that’s been effective?

19. Have characteristics of the participating community partner organizations been an influence on the sustainability of SL program, positive or negative? And if so, can you tell me about that?
   a. If negative: Have you been able to address that? And if so, how?

   Has the SL program had to work to get buy-in from community partners? And if so, what have you done that’s been effective?
   b. To what extent has the buy-in of community partners influenced the sustainability of the program?

20. Have factors outside of your institution and community partners influenced the sustainability of your SL program – either positively or negatively? And if so, could you describe that?

21. Did participating in the HPSISN cohort have any impact on the sustainability of your SL program? And if so, how?

IMPACT

Now I want to turn our focus to the second topic of this interview, which is the impact your SL program has had. We’re interested in understanding impacts broadly, including the impact of SL on students, participating schools, participating community
organizations, and the communities that are involved as recipients of services delivered through SL. I’ll give you the opportunity to address these impacts one at a time, as they’re relevant to your program.

22. What have been the explicit goals of your SL program?

23. To what extent has the program achieved these goals?

24. Which goals has it achieved, and what factors have been the most important contributors to achieving these goals?

25. Which goals has it not been able to achieve, and what have been the challenges?
   a. Were you able to respond to these challenges, and if so, how?

26. Has the SL program had other impacts outside of these goals? And if so, what were they?

27. What advice would you offer to other graduate health professions institutions that are implementing SL for the first time, about achieving program goals?

28. Have the SL program’s outcomes been measured or evaluated? And if so, can you describe that for me?
   a. Are those data available in a report or other form, that I could have a copy of?
   b. If not, why has that not occurred?
      i. Are there other demonstrations of the program’s impact, like articles in professional or lay publications?
         1. If so, is there a way I can get copies of those?

29. Did participating in the HPSISN program have any influence on the goals your SL program set for itself? If so, how?

Now I want to ask you about some specific potential outcomes of SL programs that we are interested in exploring, which have been some of the reasons schools have adopted SL. (Only ask about topics that have not already been addressed.)

30. What have been the impacts of your SL program on students?
    a. How many students have gone through the SL program?

31. Has the SL program had an impact on faculty?
    a. How many faculty are now involved in teaching through SL?
    b. What has been the impact on you, personally, of being involved in SL?
       i. Did participating in the HPSISN program have any impact on your career? If so, would you describe that for me?
32. What are the prevailing attitudes at the school about SL?
   a. Is SL seen as an approach to high quality learning? Is community-based training seen as effective?
   b. What are the purposes given to SL at the school?
      i. Did the SL program influence these attitudes?

33. Has the SL program influenced the school in other ways?
   a. Has the program expanded or informed the development of SL programs elsewhere in the school?
   b. Do your school’s promotion and tenure policies recognize community engagement by faculty? Do they recognize SL in particular?
      i. Did the SL program have an influence on that?

34. Has the SL program had any impact on the participating community organizations? If so, could you tell me about that?

35. Has the SL program had any impact on the health and wellbeing of the communities that were involved, outside of the community organizations? If so, could you tell me about that?

36. Has the SL program had any impact on how the school and community interact?
   a. Has it led to other community-academic partnerships

37. Has the SL program had an influence on community relations, or on the reputation of the school more broadly? If so, could you tell me about that?

38. Has your SL program had an influence outside of your institution and community? And again, could you tell me about that?

39. Has the SL program had any other impacts – positive or negative -- that we haven’t covered?

40. Were there any other factors that were facilitators of or challenges to the program’s impact that we haven’t touched on?

**VALUE OF SL**

41. Does your institution have its own definition of service-learning? And if so, what is it?

42. Based on your personal experience, do you think SL works as a teaching method? What does SL contribute to student learning that other teaching methods do not?

43. Based on your experiences, do you think SL is where we should be investing our resources if we want to train students in community health competencies?
44. Do you think it’s where we should be investing our resources if we want to build community-academic partnerships?

45. From your perspective, what would be the best way to promote and sustain SL programs in health professions education in this country?

WRAP-UP QUESTION

46. That concludes our formal questions. Is there anything that we didn’t get to talk about regarding the sustainability or impact of your SL program that you’d like to share?

SNOWBALL SAMPLING

47. Who should I contact at your school, and at your community partners for SL to learn more about some of the themes we talked about today?

DOCUMENT COLLECTION

48. I am interested in reading the following documents (hand individual list of the items described below), and wonder if you can tell me where to find copies or give me copies of any of these:
   a. School’s mission and vision statements
   b. School’s strategic plan
   c. SL program goals statements
   d. SL program strategic plan
   e. SL program community partnerships Memorandum of Agreement (MOA) template
   f. SL program community partnerships operating procedures
   g. SL program community partnerships goals statements
   h. SL program community partnership action plans
   i. Any evaluation tools you use to evaluate the SL program
   j. Any information you have, like evaluation results, or articles from the paper, and anything in between, about the SL program here at your organization, and in the community.

CLOSING

Thanks again for participating in this interview. Later this year we’ll complete this study, and at that time we will share our findings with you in a report about your SL program. We will also share any published abstracts or articles about the study with all of our study participants.
APPENDIX G

Interview Guide for Community Partners, HPSISN Follow-up Study, Phase 2

INTRODUCTION

We are conducting a ten year follow-up study of the HPSISN program, which provided financial and technical support for SL at [Institution Name] and 16 other health professions schools from 1995 to 1998.

The SL programs that participated in HPSISN were some of the first ones in health professions education, so their experiences can provide valuable lessons about these questions. One of the aims of the study is to learn from experiences of SL programs that have had success with program sustainability and impacts since HPSISN ended.

Based on a phone interview I conducted last summer with [individual name] at [Institution Name], we learned that their SL program has had unique positive experiences with both sustainability and impact. We are conducting case studies with this SL program and another SL program that participated in HPSISN, to explore different paths to achieving these positive outcomes.

The purpose of today’s interview is to explore in depth your SL program’s sustainability and impact, what contributed to the successes it has had, and what challenges it has faced. I will be interviewing both community and academic partners in your SL program, and together your responses will give me a complete picture of the school’s experience.

What people tell me in these interviews will be used to create recommendations for other SL programs on how to remain sustainable, how to maximize their benefits for all those who are involved -- including the schools, community organizations and community members -- and how to address common challenges that SL programs face.

Do you have any questions before we start? (Provide opportunity to ask and answer questions.)

Were you able to review the description of the study that I gave you? (If individual has not yet read the disclosure statement, give them time to do so now, and ask any related questions.)

I just want to remind you that in this interview everything you say will be completely confidential. I will not use your name in any reports about this interview, and no one will see the transcript of this interview except a professional transcriptionist who has no relationship to the school, and me.

In this interview, I’m interested in hearing your personal opinions. If you don’t know the answer to a question, or don’t feel comfortable answering it, feel free to skip it, or to
suggest someone else who might be able to answer it, at your organization, or at the school.

**QUESTIONS**

**BACKGROUND ON THE COMMUNITY ORGANIZATION**

1. To start out, could you tell me about your organization? What are its mission and vision, and what are its activities?
   a. How long has the organization existed?
   b. What is the organization’s role in the community?

**KNOWLEDGE OF THE SL PROGRAM/ROLE IN THE SL PROGRAM**

2. What is your current job title, and what are your job duties?

3. Could you describe for me your current and past involvement with the SL program?
   a. When did you first get involved with the SL program?
   b. Has your involvement with the program changed over time? If so, how?
   c. What percent of your time did you spend involved with the SL program when you were most involved, and when was that?
   d. What percent of your time do you currently spend involved in the SL program?

**SUSTAINABILITY**

I first want to improve my understanding of how the SL program works here, and then we’ll talk about how it has been sustained.

4. How long has your organization been involved with SL with [Institution Name]?
   And with [Department Name]?
   a. How did that relationship get started?

5. Why was the organization first interested in getting involved with SL?
   a. Since the organization has now been involved for a few years, have those reasons changed?

**IMPLEMENTATION**

6. Can you tell me how the SL program here is organized and how it operates?
   a. Who are the staff members who work on the SL program, and what are their duties related to the SL program?
   b. What do the students do while they’re here?
   c. How many students are here, and how many hours are they here per week?
   d. How do the staff and students interact?
7. How does the SL program relate to your other activities?
   a. Does the SL program have linkages to your other programs? Where is it located in your organizational structure?
   b. Does it help you pursue your other program goals?
   c. How does the SL program relate to your organization’s mission and vision?
   d. Is there funding that supports your SL activities? Where does it come from? Is it shared with other activities?

8. What is your partnership process like with the school?
   a. How is your relationship maintained? How often do you meet? How often do you interact in other ways?
   b. Do you have formal guidelines for how you work together?
      i. Is there a written document I could have a copy of?
   c. Do you have a formal memorandum of agreement?
      i. When was the last time it was updated?
   d. How would you describe the quality of your relationships with faculty and administrators at the school?

INFLUENCES ON SUSTAINABILITY

9. What factors have helped to sustain the SL program over the years?
   a. What has the school done to support the sustainability of your relationship?
   b. What has your organization done to support the sustainability of your relationship?

10. What factors have been the most important challenges to the sustainability of the SL program?

11. Were you able to address these challenges, and if so, how?
    a. Could you tell me more about one particularly significant challenge to the program’s sustainability, and how it was addressed?

12. Has your SL partnership with [Institution Name] changed or evolved in significant ways since it first started (or since 1998, if it started before then), and if so, could you tell me about that?
    a. In particular, were there any major changes after the HPSISN program ended in 1998?
    b. What caused the program to make those changes?
    c. What were the results of making those changes?

13. Did any of these changes in the program contribute to sustaining the program, and if so, how?
a. Were any of these changes made intentionally to promote program sustainability?

14. Does your organization engage in strategic planning for the future? And if so, does your plan include SL?
   a. If yes: can you tell me how SL fits into your plan?
   b. When did you start planning for sustainability of your SL program, and why?
   c. What is the planning process like? How often? Who is involved?
      i. Is there a planning document that I could get a copy of?
   d. What have been your goals for sustaining the SL program?
      i. To what extent, would you say, has the organization succeeded in meeting those goals?
         1. Where is there still room for improvement?
         2. What have you done to work towards those goals?

15. Does the school involve you in its strategic planning for the SL program? And if so, can you tell me about your organization’s involvement?
   a. How are you involved?
   b. What are your organization’s contributions?
   c. How often does that occur?
   d. When was the last time you were included in one of those processes?

16. What advice would you offer to this and other SL programs about how to sustain their community partnerships?

Now I want to ask you a few questions about factors we’re especially interested in looking at as potential influences on program sustainability. (Only ask about topics that have not already been addressed.)

17. Are there particular characteristics of how your SL program is organized or operates at your organization that influence the sustainability of the program? And if so, what are they?

18. Are there particular characteristics of the relationship you have with the school that influence the sustainability of the program? And if so, what are they?

19. Have characteristics of your organization been an influence on the sustainability of SL program, positive or negative? And if so, can you tell me about that?
   a. If negative: Have you been able to address that? And if so, how?

20. Have characteristics of the school – like the organizational culture and policies -- had an influence on the sustainability of the SL program, positive or negative? And if so, can you tell me about that?
   a. If negative: Have you been able to address that? And if so, how?
21. Have factors outside of the control of your organization and the school shaped the sustainability of the program -- either positively or negatively? And if so, could you tell me about that?

22. Before we move on, was there anything else we didn’t get to talk about, about how to promote the sustainability of SL program, or the challenges that can arise to sustaining these programs?

IMPACT

Now I want to turn our focus to the second topic of this interview, which is: your perspectives about the impact the SL program has had.

23. What have been the goals of your organization in becoming involved with the SL program?

24. To what extent has the program achieved these goals?

25. Thinking about the goals that have been achieved, what has helped to achieve these goals?

26. Thinking about the goals that have not been achieved, or have been hard to achieve, what have been the challenges?
   a. Was your organization or the school able to respond to these challenges, and if so, how?

27. Have you evaluated the impact of the SL program? And if so, in what ways?
   a. Are those data available in a report or other form, that I could have a copy of?
      i. If not, why has that not occurred?
   b. Are there other demonstrations of the program’s impact, like articles in professional or lay publications?
      i. If so, is there a way I can get copies of those?

28. What advice would you offer to community partners in other SL programs, about how to achieve their goals related to their involvement in SL?

29. What advice would you give to schools in SL partnerships, about how to help community partners achieve their goals?

Now I want to ask you about some specific potential outcomes of SL programs that we are interested in exploring, which have been some of the reasons schools have adopted SL. (Only ask about topics that have not already been addressed)

30. What have been the impacts of participating in the SL program on your organization? These could be positive or negative.
31. Has the SL program had impacts on the community? And if so, what are they? These could be positive or negative.

32. Has the SL program had any impact on how the school and the community interact?

33. Has the SL program helped to build relationships between the community and schools? And if so, how?
   a. As far as you know, has it led to other community-academic partnerships?

34. Overall, what’s been the value of participating in the SL program for your organization?
   a. For your community?

35. To wrap up this part of the interview, has the SL program had any other impacts – positive or negative -- that we haven’t covered?

36. And were there any other factors that we didn’t get to talk about, that can help achieve the goals of SL, or that can be challenges to achieving those goals?

VALUE OF SL

37. Based on your personal experience with the SL program, do you think SL works as a teaching method?

38. Do you think SL works to build bridges between schools and communities?

39. Do you think SL works to benefit community organizations?

SNOWBALL SAMPLING

40. Who should I contact at your organization, or at the school, to learn more about some of the themes we talked about today?

DOCUMENT COLLECTION

41. I am interested in reading the following documents (hand individual a list, comprised of the items listed below), and wonder if you can give me copies of any of these, or tell me where to find them:
   a. Your organization’s mission and vision statements
   b. Your organization’s strategic plan
   c. Any evaluation tools you use to evaluate the SL program
   d. Any information you have, like evaluation results, or articles from the paper, and anything in between, about the SL program here at your organization, and in the community.
CLOSING

Thanks again for participating in this interview. Later this year we’ll complete this study, and at that time we will share our findings with you in a report about your SL program. We will also be giving talks and writing articles about this study, and we will share that information with you and all of our study participants as well.
APPENDIX H
Detailed Description of Interview Participants, HPSISN Follow-up Study, Phase 2

University 1

<table>
<thead>
<tr>
<th>Academic Partners</th>
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<tbody>
<tr>
<td>Administrators</td>
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<tr>
<td>1. University President</td>
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<tr>
<td>2. University Vice President</td>
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<tr>
<td>3. Provost</td>
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<tr>
<td>4. Assistant Provost</td>
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<tr>
<td>5. Dean, College of Health Professions</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Faculty involved in SL initiative</th>
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</thead>
<tbody>
<tr>
<td>6. Dean and Professor, School of Nursing</td>
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<tr>
<td>7. Dean and Professor, School of Physical Therapy</td>
</tr>
<tr>
<td>8. Director and Professor, Health Administration</td>
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<tr>
<td>9. Associate Professor of Nursing</td>
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<tr>
<td>10. Assistant Professor of Nursing</td>
</tr>
<tr>
<td>11. Associate Professor of Pharmacy</td>
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<tr>
<td>12. Assistant Professor of Physical Therapy</td>
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</tbody>
</table>

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<tr>
<th>SL initiative staff</th>
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<tbody>
<tr>
<td>13. SL Director, College of Health Professions</td>
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<tr>
<td>14. SL Assistant Director, College of Health Professions</td>
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<tr>
<td>15. SL Director, College of Arts and Sciences</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Students</th>
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<tbody>
<tr>
<td>16. Doctor of Physical Therapy student</td>
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<tr>
<td>17. Doctor of Physical Therapy student</td>
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<tr>
<td>18. Doctor of Physical Therapy student</td>
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<tr>
<th>Community Partners</th>
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</thead>
<tbody>
<tr>
<td>1) Faith-based independent living facility for older adults</td>
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<tr>
<td>19. Executive Director</td>
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<tr>
<td>20. Activities Coordinator</td>
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<tr>
<td>2) Rural public elementary school serving a low-income predominantly Native American community</td>
</tr>
<tr>
<td>21. Principal</td>
</tr>
<tr>
<td>22. Physical Education teacher</td>
</tr>
<tr>
<td>23. Native American cultural consultant</td>
</tr>
<tr>
<td>3) Faith-based private urban high school predominantly serving a low-income Latino community</td>
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<tr>
<td>24. Vice Principal</td>
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<tr>
<td>25. School Nurse</td>
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<tr>
<td>University 2</td>
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<tr>
<td><strong>Academic Partners</strong></td>
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<tr>
<td>Administrators</td>
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<tr>
<td>1. Dean, Division of Health Sciences</td>
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<tr>
<td>2. Assistant Dean for Community Partnerships</td>
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<tr>
<td>3. Assistant Dean for Student Affairs, School of Medicine</td>
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<tr>
<td>4. Director, Medical Student Elective Programs</td>
</tr>
<tr>
<td>Faculty involved in SL initiative</td>
</tr>
<tr>
<td>5. Assistant Professor, Physician Assistant program</td>
</tr>
<tr>
<td>6. Assistant Professor of Counseling</td>
</tr>
<tr>
<td>7. Assistant Professor of Physical Therapy</td>
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<tr>
<td>8. Assistant Professor, Physician Assistant program</td>
</tr>
<tr>
<td>9. Adjunct Instructor of Public Health</td>
</tr>
<tr>
<td>10. Assistant Professor of Nursing</td>
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<tr>
<td><strong>SL initiative staff</strong></td>
</tr>
<tr>
<td>11. SL Director</td>
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<tr>
<td><strong>Students</strong></td>
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<tr>
<td>12. Master of Public Health student</td>
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<tr>
<td>13. Doctor of Physical Therapy student</td>
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<tr>
<td>14. Physician Assistant and Master of Public Health (dual degree) student</td>
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<tr>
<td><strong>Community Partners</strong></td>
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<tr>
<td>15. Executive Director</td>
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<tr>
<td>16. Pediatrician</td>
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<tr>
<td>17. Executive Director</td>
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<tr>
<td>18. Housing program staff member</td>
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<tr>
<td>19. Nurse practitioner at health clinic</td>
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<tr>
<td>20. Health educator</td>
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<tr>
<td>21. Deputy Director</td>
</tr>
<tr>
<td>22. Manager of health services</td>
</tr>
</tbody>
</table>
AMANDA L. VOGEL, MHS
1500 Park Avenue # 3, Baltimore MD 21217 * 410-419-4528 * avogel@jhsph.edu

ACADEMIC TRAINING

Johns Hopkins Bloomberg School of Public Health, Baltimore, MD
PhD in Health Policy and Management, Health and Public Policy Track  Expected, 2009

Dissertation: Advancing Service-Learning in Health Professions Education: Maximizing Sustainability, Quality, and Co-Leadership

Harvard School of Public Health, Boston, MA  1998-2000
MHS in Health and Social Behavior

Swarthmore College, Swarthmore, PA  1993-1997
BA in Sociology, BA in English Literature, Minor in Women’s Studies

Sociology and literature program in Guatemala and Colombia. All coursework in Spanish.

University of Geneva, Geneva, Switzerland  2000
Intensive beginning French language, 250 hour certificate program

Proyecto Lingüístico Francisco Marroquín, Antigua, Guatemala  1996
Intensive advanced Spanish language, 140 hour program

WORK EXPERIENCE

Context Journal, Atlanta, GA
Managing Editor, Policy & Practice  2006-2008
Context is the Journal of the organization Health Students Taking Action Together (HealthSTAT). Solicited submissions through national searches, developed peer review instrument, managed peer review process, edited articles. (www.contextjournal.org)

Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management
Research Assistant, Bioethics Institute  2004-2008
For a qualitative study of the experiences of Johns Hopkins Medical Institution faculty conducting community-engaged health research. Conducted original research and data analysis. Co-authored manuscript. Presented findings at national conference.
AMANDA L. VOGEL MHS, CONT’D

Johns Hopkins Bloomberg School of Public Health, Department of Health Policy and Management

Teaching Assistant. 2004-2006
For the following graduate courses: Introduction to Health Policy (classroom and online formats), The Politics of Health Policy, Doctoral Seminar in Health Policy and Management

New York City Department of Health and Mental Hygiene (DOHMH)
New York, NY

Consultant, Bureau of Chronic Disease Prevention 2003-2005
Co-authored manuscripts about research and programs I managed at DOHMH. Presented at conferences. Trained new staff.

New York City Department of Health and Mental Hygiene (DOHMH)

Community-Based Programs and Research

• Founded and directed Senior Wellness Project, providing health promotion and disease prevention services to older adults in 21 NYC public housing developments. Collaborated with Housing Authority, offices throughout DOHMH. Hired and supervised staff.
• Founded and managed service-learning program through Senior Wellness Project for nursing and nutrition students at New York University and Brooklyn College.
• Founded and managed exercise self-efficacy research study for low-literacy and bilingual adults living in public housing. Study funded by Robert Wood Johnson Foundation.

Occupational Health

• Provided technical assistance to the United Nations to create employee health promotion program.
• Founded, wrote and published DOHMH Employee Newsletter. 6000 person circulation.

Community Collaborations

• Chaired New York Women’s Healthy Heart Consortium of government, private industry and advocacy groups. Collaborated with City Council Speaker and Pfizer Inc. on media campaign and events.
• Founded and developed “Take a Walk, New York!” program of guided urban walks for heart health in collaboration with Neighborhood Open Space Coalition (NOSC) and City Council Speaker’s Office. Featured in local, national and international media.
New York University Steinhardt School of Education, New York, NY
Adjunct Assistant Clinical Professor, Division of Nursing 2002-2003
Preceptor for over 100 nursing students in service-learning placements through the Senior Wellness Project. Lectured at NYU. Supervised and assessed students. Presented at national conferences.

World Health Organization, Geneva, Switzerland
Intern, Programme on Water, Sanitation and Health. 2000

Harvard School of Public Health
Consultant, Department of Health and Social Behavior 2000
Participated in writing team producing academic publications and program materials related to "Sisters Together" community-based chronic disease prevention program.

Teaching Assistant, Department of Health and Social Behavior 2000
For graduate course on how to assess need for, design and evaluate community-based health programs.

New York Academy of Medicine, New York, NY
Consultant, Office of Special Populations 1999-2000
Co-authored monograph identifying unmet need for syringe exchange in New York City. Conducted original qualitative and quantitative search, including ethnographic research and secondary analysis of hospital records. Hired and supervised consultants for GIS mapping. Contributed to reform of New York State laws regulating syringe purchases.

Philadelphia Health Management Corporation, Philadelphia, PA
Research Assistant, Division of Research and Evaluation 1997-1998
HONORS AND AWARDS

- Agency for Healthcare Research and Quality National Research Service Award pre-doctoral training award, 2003-2005
- JHSPH Department of Health Policy and Management Victor Raymond Memorial Fund Award, for dissertation research with policy significance at the national and state levels, 2008
- JHSPH Department of Health Policy and Management John C. Hume Doctoral Award, for significance of dissertation research, 2007
- JHSPH Global Field Experience Fund Grant, to support dissertation field research, 2007
- JHSPH Delta Omega Honorary Public Health Society Scholarship, for best dissertation proposal in the category of Public Health Practice, 2007
- JHSPH Student Outreach Resource Center (SOURCE) Community Service Award, for service to the East Baltimore Community, 2006, 2007, 2008, 2009
- International Association for Research on Service-Learning and Community Engagement Graduate Student Scholarship, to attend the Eight International Research Conference on Service-Learning and Community Engagement, 2008
- Swarthmore College Joel Dean Grant for Independent Social Science Research, for undergraduate thesis field research, June 1996

ENGAGED SCHOLARSHIP AND ACADEMIC SERVICE

- Founding Executive Board Member, Students for a Positive Academic paRtnership with the Community (SPARC), JHSPH student group promoting engaged scholarship. www.jhsph.edu/source/SPARC 2005-2009
- JHSPH Department of Health Policy and Management, Committee on Practice. 2006-2007
- JHSPH Department of Health Policy and Management, Student Coordinating Committee. 2006-2007
- Student representative, Council on Education for Public Health (CEPH) reaccreditation of JHSPH, Committee on Service, 2006
- Co-chair, Harvard School of Public Health annual student community outreach day, 2000
PEER REVIEWED PUBLICATIONS


BOOK CHAPTERS AND MONOGRAPHS


MANUSCRIPTS IN PREPARATION

Vogel, AL. Long-term sustainability of service-learning in health professions education: Findings from a ten year follow-up study of the HPSISN program. (Journal manuscript in preparation).

Vogel, AL. Long-term impact of service-learning in health professions education: Findings from a ten year follow-up study of the HPSISN program. (Journal manuscript in preparation).
AMANDA L. VOGEL MHS, CONT’D

Vogel AL. Maximizing the quality and sustainability of service-learning in health professions education: A comparative case study of two sustained service-learning initiatives. (Journal manuscript in preparation).

Vogel AL. Student leadership for service-learning in health professions education: A case study. (Journal manuscript in preparation).

ORAL PRESENTATIONS AND POSTER SESSIONS


SKILLS

Expertise in qualitative research methods and software (NVIVO, NUDIST)
Trained in quantitative research methods and software (STATA)
Community-based research, program design, management and evaluation
Academic and professional writing, grant writing
Teaching and public speaking
Conversational Spanish, Basic French

PROFESSIONAL ASSOCIATION MEMBERSHIPS

Community-Campus Partnerships for Health
International Association for Research on Service-Learning and Community Engagement
American Public Health Association
Global Health Council