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Using Polvika's Model to Create a Service-Learning Partnership

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ABSTRACT: *Collaboration can maximize limited resources of universities, school systems, and public health departments by offering learning from experience. Polvika's theoretical model and principles from Community-Campus Partnerships for Health guided development of a service-learning partnership among a university, a county health department, and an alternative school in a large public school district. Of three commonly identified patterns of service-learning, this partnership demonstrated the pattern that equally emphasizes service to a community or agency, and mutual learning by all participants. All organizations in the partnership share a common goal to optimize the health of children in schools, and to provide quality learning for professional students. The partnership is in its fourth year. Formal interagency agreements now exist among all partners. Individuals continue to demonstrate flexibility and mutual awareness of strengths and limitations of respective organizations. Public school students receive more services, many high-risk children achieve better learning outcomes, school nurses offer expanded services in many schools with the help of nursing students, and undergraduate and graduate nursing students gain meaningful learning experiences. Some nursing students state that school nursing has become a career goal. The partnership continues to evolve to meet changing needs of the partners. Members remain satisfied with the collaboration.* (J Sch Health. 2003;73(8):305-310)

Collaborative interagency partnerships offer a time-honored method to maximize limited resources of professional academic institutions and community agencies. Such partnerships are gaining popularity among health professionals as a result of recommendations from the Pew Commission[1] that health care providers of the future be prepared to practice in partnership with communities and diminishing clinical placement opportunities for students.

The Centers for Disease Control and Prevention (CDC) continues to call for greater collaboration among public schools, academic centers, health care institutions, and local communities to improve health and learning outcomes for children.[2,3] Examples of partnerships to provide school-based health care are numerous. An issue of the *Journal of School Health* was devoted to examples of partnerships to achieve specific services.[4] None of those authors, however, offered a theoretical framework to guide planning, implementation, and evaluation of new partnerships. This article describes how a university, a large public school system, and a health department used a theoretical framework to guide development of a new partnership to provide additional health services for students in an alternative school, expand nursing services in selected schools, and provide supervised clinical experiences for undergraduate community health nursing students.

In 1995, Polvika[5] developed a theoretical model to guide development of interagency relationships. In her model, interagency relationships can be predicted based on prepartnership factors and the process followed to develop relationships. She addressed: a) environmental factors such as social and economic resources, political resources or will, and a need for particular services; b) situational factors such as information about resources needed to meet goals, degree of agreement among agencies about goals, issues, tasks, and overlapping activities; and c) specific tasks essential to establish and maintain a partnership before a collaborative relationship begins.

Issues such as how the partnership is structured, who controls access to resources, relative contributions of agency staff, and pattern and flow of relationships, all must be negotiated and decided during development of a relationship. Ineffective relationships result from power inequities.[5] According to Polvika,[5] outcomes from interagency collaboration include: a) success or failure of desired programs, measured by organizational structures that develop, amount and quality of services clients receive, and degree to which organizations meet their own goals; b) degree of responsiveness of programs to changing needs; and c) satisfaction of participating organization members.[5]

Partnerships between academic and community agencies typically were sought and controlled by academic health professionals to provide clinical learning experiences for students. Health departments traditionally provided clinical learning experiences for community health nursing students. As a result of changes in the organization and financing of health care, traditional clinical experiences for students have diminished. Consequently, faculty are interested in developing collaborative arrangements with community agencies that will benefit both academic institutions and community agencies.[6]

Such academic-agency partnerships, termed "service-learning," represent any type of activity that provides opportunity for student learning and to provide a service to a designated community. Service-learning encompasses three essential components: learning through experience, reflection on the experience, and simultaneous learning among students, faculty, and community members.[6] As the locus of control shifts from academia, the term "community-campus partnerships" was introduced as a term to reflect collaboration that emphasizes equal power-sharing between academic institutions and community agencies.[7]

Three major approaches exist to learning by experience. The first approach stresses use of community activities to provide service experiences for students – *service* learning. The goal is for students to provide service to communities, learn general lessons about society and its structure, and

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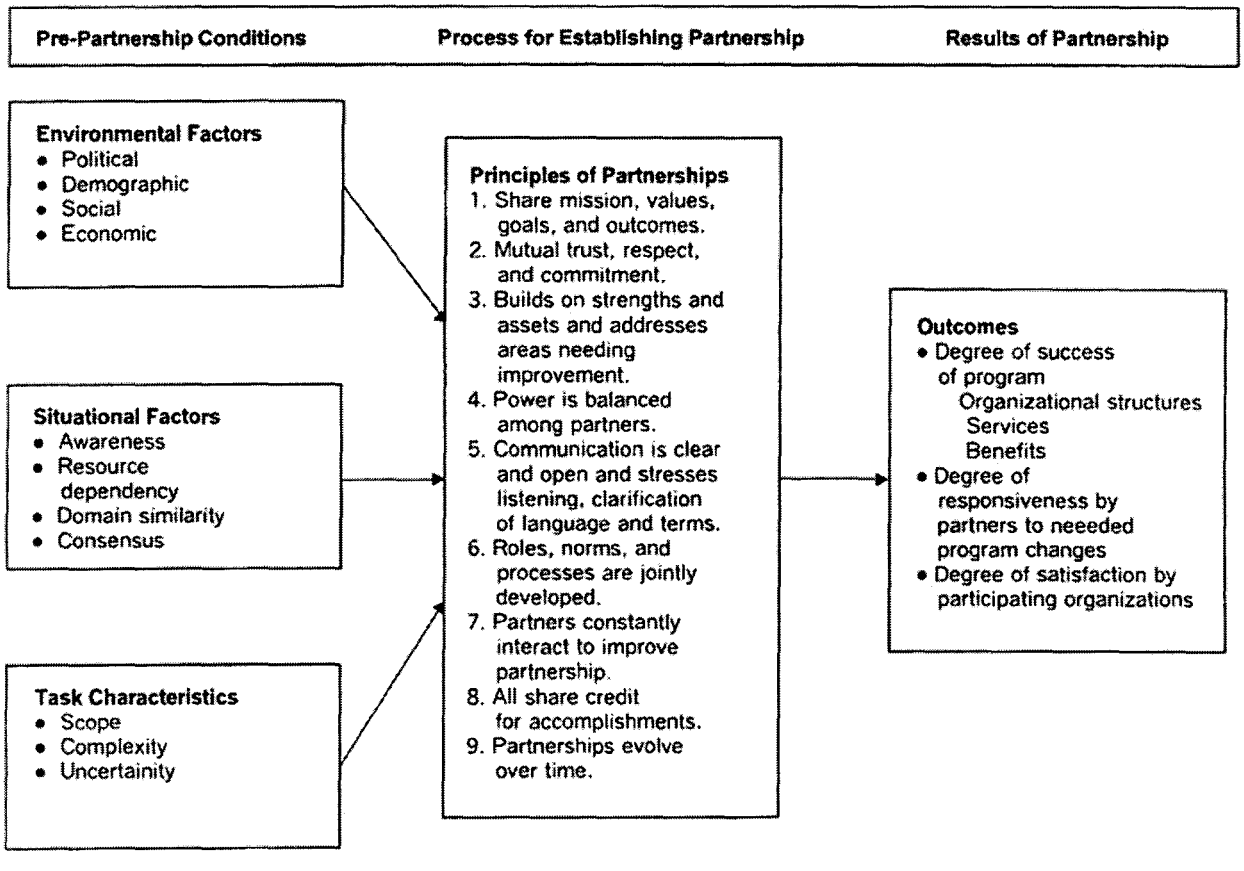
develop attitudes of community service to correct past and present social injustices. *Service* learning does not have to be linked to a course or course objectives, or be collaborative. As part of a broad liberal arts education,[6] it often is limited to short-term interaction between students and community members.

The second approach stresses use of community activities to provide specific learning experiences for students – service *learning*. The goal is for students to recognize and apply academic concepts experientially in a course with clear learning objectives. Students provide specific services to patients and their families such as home visiting, conducting agency or community assessments, or providing health education to individuals or groups.[6,8,9] Although service outcomes and community benefits are increasingly considered when planning such learning experiences,[10-12] educators maintain control over types of activities and time frames for service.

The third approach, *service* and *learning*, addresses the issue of control CDC identified as a major barrier to collaboration for comprehensive school health.[3] The goal is to "bring communities and [academic] institutions together as equal partners and build upon the assets, strengths and capacities of each."[7 p156] Academic and service organizations share control and decision-making for activities to achieve goals of education and delivery of services. Essential components of service learning are most evident in this approach. Faculty members become learners as community members articulate their needs and priorities. Students apply classroom learning to real situations, become co-learners with faculty about evolving communities, and all participants reflect on their experiences.[13]

Service and learning is gaining acceptance in academic medicine as evidenced by establishment of a center,

Figure 1
Conceptual Model for Service-Learning Partnerships



Modification of Polvika's Conceptual Model for Community Interagency Collaboration[5] represents development of a campus-community partnership. The first column, Pre-Partnership Conditions, (from Polvika) lists pre-existing conditions that contribute to a successful partnership. The second column lists the nine Principles of Partnership from Campus-Community Partnerships for Health. These principles guide development of the partnership in a manner that fosters equality among partner organizations. Polvika's Outcomes of a Successful Partnership are listed in column three. When the listed pre-conditions are met, and the Principles of Partnership are followed, positive outcomes are more likely to result.

Community-Campus Partnerships for Health (CCPH), in 1996.[7,10,12] The CCPH published nine principles that characterize collaborative campus-community partnerships.[14] When partners adhere to these principles, *service* and *learning* outcomes reflect power-sharing with joint responsibilities for success or failure, open communication, and willingness to modify approaches to service and learning. The principles are summarized here.

- Partners share mission, values, goals, and measurable outcomes for the partnership.
- Authentic mutual trust, respect, and commitment characterize the relationship.
- Relationships build on identified strengths and assets, and address areas needing improvement.
- Power is balanced among partners. This approach enables sharing of resources.
- Clear, open, and accessible communication occurs among partners that stresses listening, development of common language, and constant clarification of terms.
- All partners jointly establish roles, norms, and processes in a manner that reflects input and agreement of all members.
- Interaction occurs among all partners to improve the partnership and its outcomes.
- Partners share credit for accomplishments.
- Partnerships evolve and thus require time to develop.

For this case study, Polvika's conceptual framework[5] was modified to reflect how the nine principles of partnership provide guidance in implementing a new partnership (Figure 1). Specific prepartnership conditions were met before the partnership could begin. The campus-community principles provided guidance during development of the partnership. The outcome is a program of *service* for public school students in an alternative school and other community schools, and *learning* for university nursing students and both service and learning for health department school nurses.

PREPARTNERSHIP CONDITIONS

A collaborative campus-community partnership was established in 1999 among a school of nursing at a southeastern university, a county health department, and a large public school system, specifically an alternative school. Environment and situational factors (Figure 1) facilitated the collaboration. All organizations were losing financial and human resources. The local county governing body contracted with a private not-for-profit hospital and medical care system that privatized many traditional health department clinical services for uninsured and low-income clients. The health department was restructured, some public health nursing positions were lost, and some services were reorganized with new supervisors and new policies and procedures. Simultaneously, local clinical learning experiences for community health nursing students disappeared, the health department hired a new director of school nursing, and the university hired new nursing faculty.

As part of privatization, a school-based prenatal clinic for pregnant teen-agers was discontinued. Teens who previously received prenatal care at school now received care from designated community clinics. Consequently, students missed more days at school, and had less access to health care and health education resources. The principal of the alternative school initiated the collaborative process by inviting faculty in the school of nursing to explore ways they could partner to restore health care resources she believed helped keep teen moms in school.

Before entering into the partnership, several important factors were assessed. Although domain similarity existed between the school of nursing and the health department's school nursing, no overlap occurred in goals and functions. School nursing, a community health nursing subspecialty, has evolved from a sole focus on halting spread of communicable diseases in school children to a comprehensive approach of promoting and protecting the health of all children and adolescents in school. School nurses: a) provide direct nursing care, crisis intervention, emergency responses, and consultation about management of a wide range of health problems and disabilities; b) teach individuals and groups about specific health issues; and c) help students obtain health care so students can focus on learning rather than coping with illnesses.[15] Because school nurses foster health for better learning, domain similarity existed between the alternative school and school nurses, but no domain similarity existed between educators at the alternative school and the school of nursing. Discrete roles of all three organizations and their employees were clear: school nurses provided health care services, public school staff provided classroom instruction, and university faculty provided professional higher education.

The first task in developing the new partnership called for representatives to build trusting relationships with their respective administrators and with representatives of partnering organizations. Each organization developed legal parameters and processes to allow nursing students to function in the school system and gain access to targeted groups. Nursing student scope of practice issues were translated into service activities, and those issues were communicated among organizational representatives so legal parameters would be accurate and comprehensive. Specific concerns included: a) relative cost for school nurse involvement, b) need to not disrupt academic class time, and c) high-quality learning experiences for nursing students. All participants wanted a mutually beneficial program and expressed commitment to a partnership, but they recognized the complexity of bringing together individuals and programs from three institutions with unique perspectives and goals.

ESTABLISHING THE PARTNERSHIP

Principle One. Partners share mission, values, goals, and measurable outcomes for the partnership. All three organizations recognized that healthy children achieve better learning outcomes than children with unmet health needs. The principal and counselors at the alternative school wanted fewer absentee days for teen moms and more case management for selected students. The director of school nurses and the faculty member from the university wanted to promote high-quality nursing practice. The stress and cost in time of supervising a nursing student must be weighed against the benefits of access to current nursing knowledge from nursing students and the potential for additional services to children. Outcomes must ensure that institutional goals were met, resources were available and allocated for activities generated by the partnership,

and collaborative arrangements met all legal requirements.

Principle Two. Authentic mutual trust, respect, and commitment characterize the relationship. Each organization designated a person responsible for activities in the partnership. Those individuals established veracity and authenticity in their developing relationships. The director of school nursing and the faculty member responsible for the community health nursing course were new and did not know each other. The alternative school principal had no experience with university nursing faculty or the new director of school nursing. Key school and university administrators had a long relationship characterized by mutual trust. This history facilitated establishment of a collaborative relationship between school and university administrators.

Principle Three. The relationship builds on strengths and assets, but also addresses areas needing improvement. Each organization clearly reported organizational strengths, need for services, and resources they could offer. The preexisting relationship between school and university administrators added a strength that contributed to the partnership's success. All organizations identified areas needing improvement. For example, while the state and local school nurse-to-student ratio improved from 1:2400 to 1:2000 in 2001-2002, the national standard is 1:750. The director of school nurses had been trying to justify an increase in the number of school nurses. A graduate student discovered that, in a sample of schools, fewer children were sent home for health reasons when a nurse was available to assess and intervene when students had health problems.[16] For the graduate student, this project met course requirements and provided valuable experience. For the health department, the data supported continued requests for additional school nurses.

Principle Four. Power is balanced among partners. This approach enables resources to be shared. At initial meetings, partners stated their goals, needs, and resources in time, space, and personnel. All explored and clarified advantages and limitations of developing a partnership. Formal lines of communication were established. Because agency representatives held decision-making positions in their organizations, they could explore approaches to meet goals within agency parameters or change resources and modify usual practices to accommodate needs of other partners. For example, the alternative school wanted additional health promotion services for teen mothers. To provide these services, nursing students and their instructor needed work space. Some school staff relocated temporarily to provide space. Because space was limited, additional student placements with school nurses at other schools were sought. Community health nursing students were thus paired with selected school nurses for one-half their clinic time, easing space problems at the school and fostering closer ties between some school nurses and university faculty.

Principle Five. Clear, open, and accessible communication occurs among partners that stresses listening, common language, and constant clarification of terms. All partners knew that only by working together could they achieve institutional goals. Representatives listened to perceptions and needs of other partners and kept an open mind about agency limits. They freely exchanged ideas, clarified terms specific to each organization, and explored ways to organize learning and service experiences. From this exchange of ideas, representatives validated action plans with administrators in their own institution. Agency attorneys reviewed plans and policies to ensure that terms used in agreements reflected agency goals. Obtaining parental permission for nursing students to provide services

Table 1
Partnership Outcomes: One, Five-Day Rotation of Undergraduate Students

Outcomes Reported by School Nurse	n of Nurses	Mean	Time Value of Student Services	Estimated Cost @ $22.00 per hour
Extra projects completed by student nurse in five days (@ four hours per project)*	22	1.23	4.9 hours	$107.80
Extra classes taught in five days by student nurse (@ two hours)*	23	1.65	3.3 hours	$72.60
Extra services to children in five days by student nurse (@ one and one-half hours)**	23	4.61	6.6 hours	$14.52
Added value of student nurse services				$194.92
Perceived number of minutes student saved school nurse each day at school***	21	24.86	2.1 hours	$46.20
Perceived number of minutes student cost school nurse each day at school***	21	42.62	-3.6 hours	-$79.20
Perceived cost of student nurse services				$-33.00
Actual Net Gain per student for five-day rotation				$161.92

* - estimates of time include time to plan, prepare, and evaluate project or class.
** - estimates of time include time needed to record findings and make appropriate referrals.
*** - for total of five days.

to students at the alternative school, and confidentiality issues, received close attention by administrators and attorneys.

Principle Six. All partners jointly establish roles, norms, and processes in a manner that reflects input and agreement of all members. Frequent discussion occurred between university faculty and staff at the alternative school to develop a process to guide social workers, counselors, career guidance counselors, school nurses, teachers, nursery workers, and administrators at the alternative school in working with nursing students. For nursing students to become part of the education team, they learned each person's roles, tasks, and processes for accessing and interacting with teen moms. Time with teens was scheduled as educational support services. In addition, nursing students worked with selected teachers to plan and teach health education classes. The director of school nursing and faculty member from the university determined specific roles and functions for nursing students assigned to school nurse preceptors. To pilot the school nurses' placements, students initially were paired with the strongest school nurses.

Principle Seven. Interaction occurs among all partners to improve the partnership and its outcomes. University faculty meet with alternative school staff each year to evaluate experiences and develop future plans. The nature of nursing student assignments changed between year one and two because the alternative school class schedule changed to a 90-minute block schedule. This change required modifications in the process developed for student nurses to meet with their assigned teens. University faculty and the director of school nursing communicate regularly about services students deliver, problems reported by school nurses, and learning needs of the nursing students. From these conversations, university faculty developed a workshop for school nurses who work with nursing students. Participants share methods for students to learn while contributing to the nursing program.

Principle Eight. Partners share credit for accomplishments. At the end of year one, the director of school nursing and the original university faculty member presented preliminary results from the partnership at a regional conference for school nursing. Other publications and presentations about the collaborative process continue to recognize activities and achievements of the partners.

Principle Nine. Partnerships evolve and thus require time to develop. Over a three-year period, the partnership grew to include other university faculty, nursing students in other courses, school nurses in private schools, public school nurses in a neighboring county, and regional and state school nursing consultants. One state and one federal grant application were funded as a result of the service-learning partnership. All partners expanded the number of individuals directly involved in the education of students in public schools and the education of nursing students. Key representatives continue to meet regularly and evaluate processes and outcomes of the partnership.

Table 2
Services Reported by Nursing Students During One, Five-Day Rotation*

Type and Number of Services Provided Per Day Per Nursing Student	
Screening	
Weight / Height	2.57
Vision	2.00
Blood Pressure	1.50
Review of immunization record and case management	2.93
Screening for lice with student/parent education	3.46
Direct care of children/adolescents	
Assessment of health problems with supervised interventions	7.10
Personal health counseling/health education	2.57

Type and Number of Services Provided Per Rotation Per Nursing Student	
Health Education classes	3.50
Investigation of community and cultural resources	7.90
Infant development assessment (at home under supervision)	3.00

* = Figures include activities nursing students completed at the alternative school plus activities completed with school nurse preceptor.

PARTNERSHIP OUTCOMES

Currently in year five, the partnership meets the three criteria for success outlined in Polvika's modified model (Figure 1). The organizational structure and process for matching preceptors and student nurses are in place. One-half the school nurses completed a training class for preceptors. While some school nurses report that having students with them does not save time, added value accrues in the extra projects and services nursing students provide (Table 1). Formal interagency agreements facilitate high-quality learning experiences for community health nursing students in schools.

Students spend five to six full days with a school nurse preceptor completing extra projects, teaching health education classes, and providing personal health services to children. Preceptors report that having nursing students work with them saves time but requires additional supervisory time when students are on site. When additional time for class preparation and project planning is considered, student nurses add considerably to school nurse productivity (Table 1).

Students spend additional days at the alternative school, so the total number of services they report is greater than the number their preceptors noted (Table 2). Specific services for teen moms at the alternative school change each year as the educational context changes. Their participation has evolved into a close working relationship with teachers, counselors, and social workers and other nursing staff as they provide teen moms with health education, health counseling, parenting, and referral services to community agencies.

The second outcome measure is the degree of responsiveness by partners to program changes. Throughout the partnership, education programs at the alternative school, changes in university curricula, and changes in the school nursing program challenged the partnership. For example, when enrollment at the alternative school expanded to require use of all available space, the principal allocated the

stage for student use and arranged tables, chairs, and privacy during the two days student nurses were present. A change to working directly with parent-life teachers has proved beneficial for student nurses to plan and present health education topics in parent-life classes. Extended participation with teens from those classes enhances their understanding of learning needs and other issues the young women face.

The third measure is degree of satisfaction by participants. The university now offers a popular clinical rotation for undergraduate community health nursing students. School nurses eagerly request student placements before the school year begins. Alternative school students look forward to participating in learning activities with nursing students. One young mother wrote that the student nurse "gave me courage to come to school," while several reported that student nurses helped them identify and receive community services. Nursing students reported that working with experienced school nurses was a significant and rewarding learning experience. They report increased awareness of how health status determines students' ability to learn, and the wide-ranging nature of students' health needs. At the end of the rotation, they practice as part of an interdisciplinary team. Comments from journals often refer to increased awareness of the connection between learning and health for children. Many express wonder that students who cope with major environmental and family challenges can function in school at all. Some students became so excited about school nursing, that they chose school nursing as a career goal.

CONCLUSION

In times of diminishing resources for public schools, higher education, and public health, partnerships are essential to meeting goals and societal obligations. Partnerships offer a way to extend scarce resources in a way that affirms each partner's strengths and contributions. When students see educators and service providers model collaboration, they will value partnerships with communities[15] and incorporate those behaviors in their future practice.

While documented evidence confirms the successes of this partnership, there were key components without which success might not have been possible. First, timing of the needs was important. Without a simultaneous need for education placement of university nursing students and a need for health care and health education for teen parents, the project might never have been initiated. Flexibility was equally important to the partnership. When the participating organization's point persons modeled flexibility, the outcomes were creative planning, responsiveness to changing needs of the organization, and ongoing development of the partnership. With flexibility, a sense of fair play or fair partnership was crucial to momentum and enthusiasm. This sense of fairness led to partners accepting and respecting each other's expertise and limitations. All trusted each other because all three primary organizations in the partnership shared the goal of optimizing the health of children in schools, and they were committed to sharing power equally. The principal of the alternative school summarized the success this way: "This collaborative community-campus partnership is working because [all] want to make a difference." ■

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