

## **THE SCHOLARSHIP OF COMMUNITY ENGAGEMENT: USING PROMOTION AND TENURE GUIDELINES TO SUPPORT FACULTY WORK IN COMMUNITIES**

NOVEMBER 11, 2002 AGENDA AND FOCUS GROUP NOTES FROM THE ANNUAL CONFERENCE OF THE ASSOCIATION OF AMERICAN MEDICAL COLLEGES

In his widely cited book, *Scholarship Reconsidered* (1990), Ernest Boyer contends that in addition to valuing the generation of knowledge (traditional scholarship), higher education should also support the application of knowledge through faculty engagement in community-based research, teaching and service. Boyer and other leaders believe that institutions should encourage faculty to use their expertise in new and creative ways to work with communities. While Boyer's work has received much attention in the last decade, roles and rewards policies continue to serve as a key structural constraint to health professions school faculty who want to be actively involved in communities and to develop their scholarship focused on community engagement. This barrier has firm footing within the academy, yet health professions faculty are finding that they can overcome it by working creatively and persistently within the current system.

**Community-Campus Partnership for Health** invites you in your role as faculty member or administrator to participate in a focus group **at the AAMC meeting in San Francisco on November 11, 2002 from 1:00-2:30pm at the Hilton Union Square 14**. In this session, led by CCPH Fellow Diane Calleson, PhD, we will discuss how you have integrated your community-based work into your academic scholarship, and share best practices and strategies for developing a portfolio for promotion and tenure that highlights innovative community-based research, teaching, clinical care and service.

### **Agenda for the Discussion:**

15 minutes: The Scholarship of Community Engagement Project: Proposed Goals and Outcomes

10 minutes: Introductions

40 minutes: Discussion Topics

1. Defining the Scholarship of Community Engagement
2. Framing Community Scholarship in the Scope of Faculty Work
3. Portfolio Development and the Review Process
4. Assessment of Community Scholarship
5. Effect of Institutional Culture and Structure
6. Strategies for Promotion and Tenure Using a Scholarship of Community Engagement

10 minutes: Next steps for moving this discussion forward

## Focus Group Discussion

Part One: Diane Calleson's presentation – see powerpoint slides at <http://futurehealth.ucsf.edu/ccph/2002fellows-calleson.html>

*Question posed to the audience—what makes sense about community scholarship?*

- ◆ What happens at the community level is as important as what is happening at the patient care level
- ◆ It makes sense from the standpoint of students applying skills in a public health setting
- ◆ Land grant institutions theoretically have service in their mission. Realistically this often goes un-noticed. Value is not perceived **unless** it is linked to the curriculum. It is often not validated as a legitimate form of scholarship.
- ◆ Examples abound of health education/health intervention models in the community. It takes a lot of time to build relationships with the community, but this time is not valued. Unless you can write about the work you are doing (and publish) it is not valued. One question is, how do you assess your work in the community?

\*\*Idea of a committee to revise clinician educator criteria. Intrigued with the idea of how one might make these revisions. Maybe there is a way to include criteria for community-based scholarship. Perhaps an analogous methodology to teaching portfolios, a delineated value for developing partnerships?

Mission of higher education always involves the triumvirate (Research, Teaching, and Service). Community based participatory research can be an excellent method for fulfilling all of these components of the mission.

*What evidence can faculty show that this type of research is contributing to the mission of the university?*

One example is the Duke project, focused on researching a specific intervention related to asthma in a community-based participatory way. This project may have been a bit easier because it is so well defined.

What are the drivers people/institutions really care about? 1) CDC/Center Health Disparities—grant money available, more and more seeking the community voice in grant applications. 2)

Increased requirements to include minority subjects in clinical research. This will not happen through traditional research routes.

*Other evidence of impact? Particularly around teaching and service*

- ◆ A lot of community members would like to have students engaged in service-learning. But is faculty promotion going to come from it? The driver is students, if students demand it; rewards may begin to be tied to it.
- ◆ If we could find compelling evidence that by participating students will remain involved in public service/health, the argument would be stronger.
- ◆ Track—how does community involvement/opportunity affect student career choices?
- ◆ The models can be inconsistent, i.e. the medical model and public health models are fundamentally at odds. Engaging medical students in public health focused service-learning

may never be a strong argument, may be perceived as asking medical schools to move curriculum in direction of community/public health.

One added note: Time in curriculum is key, but also need to show activity that is sustained over time—represents larger support from the institution.

*What is community service for faculty? How is it defined and how/why should it be valued?*

- ◆ Professionalism—if we are trying to impress importance of professionalism to students, service to the community represents professionalism. Faculty I know of/work with have been involved in community service for 20 years. But it is not valued and often not stated. This diminishes interest on the part of other faculty. Often we have to seek out community-based physicians to volunteer at university events because the interest is so low.
- ◆ A key question is “what is the definition of community service?” People have different definitions; some say that simply being a physician is a community service.

*Some examples and free form discussion*

1. General Clinical Research Center at UM. If you receive GCRC money, you had to interact with the community. Before you could even mention your research, you had to attend meetings and listen to the community. Any physician who used GCRC money agrees to report back to the community regarding the results of the research, to not simply collect data and disappear.
2. In Boyer’s work—discussions of criteria for quality. Do all of the work in the continuum, but you have to do it with a certain level of quality. Submit to peer review, evaluation, etc. Should quality of educational standards meet standards of the community?
3. Weaving public health into the medical education curriculum. Duke has developed a standardized way of teaching faculty how to work with the community.
4. Healthy Futures—created between hospitals and/or programs. Coalition that works together, Diabetes clinic, dental health, etc. 475 Volunteer Community physicians—Migrant Farm Clinic, Downtown Clinic...great opportunities. Faculty has to want to be involved, you can lead a horse to water but you can’t make the horse drink. Faculty need to want to be involved independent of recognition.
  - a. True—but there also needs to not be dis-incentives for involvement. Faculty decide they want to be involved and have an interest in it, recognize there is no direct compensation for it...but often now faculty are discouraged from becoming involved.

An idea mentioned by Diane Calleson

1. At institutional level—where clinical dollars mean a lot, faculty need a presence in the community to draw in patients.

*As tenure track positions decrease in quantity, where do you see faculty getting involved in this work? Tenure track or not? Women/Men? Minority faculty? Who is getting involved?*

- ◆ The most notable at UM are on tenure track
- ◆ There are a number in the clinical tracks who would like to do this type of work, but the pressure to see patients in an income generating setting is strong. Most who are engaged are engaged in spite of this pressure, the usual context is being told to “tone down the service.”

- ◆ A wild idea—if the state tied funding to “improving the health of the community” instead of numbers of patients seen, there would be an incentive for this type of work.
- ◆ If you can show the work makes sense financially...
- ◆ At our institution, those involved are already tenured. Had one young female faculty member who tried to get involved, and found she had no time. Young faculty are not at all getting involved.
- ◆ UCLA—If you are going to be a clinical instructor, you must generate \$\$\$\$\$. My goal is to work with the homeless, I recruit from a pool of volunteer faculty to serve on Saturday. Always returning to the same small pool to get faculty involved. This takes away big chunks of time; I am lower on the totem pole because I want to do this kind of work.
- ◆ Discussion of impact—how can you assess, prove the impact of your work for promotion and tenure.
  - It is ironic to be having a discussion of impact, and how to measure and prove impact of community-based work for promotion and tenure...when in reality, the current yardstick for promotion and tenure (publication) has next to no impact at all!
- ◆ AHEC’s—We are hearing that it is not so much a matter of not being rewarded, as it is a reality of being punished for engaging in this type of work.

*The cultural shift is clearly critical—how do we move from disincentive to incentive for this kind of work?*

- ◆ People who have modeled how to do this work, are not motivated by advancement. If the goal is to move up the ladder you will not be engaged in this.
- ◆ BUT—We lose faculty because there is no place for them on the ladder. We don’t create a place for them.
- ◆ It is critically important to get faculty engaged with mentors—create relationships with faculty who model this type of involvement.
- ◆ The mentors I have found as a young faculty member engaged in this type of work, are still ingrained in the traditional publish or perish model. Their creative solution is to get advancement based on community-based work by publishing about it...
- ◆ Cultural change/shift will come from medical students/residents who are inspired by this type of work and begin to demand it.

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