

**TRANSFORMING A MEDICAL STUDENT RUN TUTORING
PROGRAM INTO A COMMUNITY-CENTERED ORGANIZATION IN
LINE WITH BIOETHICAL PRINCIPLES**

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Abstract

In this paper, I explore the relationship between academic medical centers and the local school districts in which they are situated within the context of what I experienced as a medical student working in an education non-profit. This analysis is intended to arrive at actionable recommendations for the non-profit, RISE, with the end goal of transforming the organization into one in line with the principles of urban bioethics. The hope is that applying what I learned in the classroom, in the Urban Bioethics master's degree program, will improve the success of RISE in its adaptation by the community and result in greater impact on education and mentorship of our students.

First, in the introduction, I will describe the general healthcare landscape in the United States and how education is viewed by the healthcare system. I will also discuss in the introduction my personal experience as a medical student at Temple in Philadelphia and my exposure to the school district that led me to be involved with the education non-profit. Second, I demonstrate that education is a key social determinant of health by exploring the literature and research that supports this notion. Third, I explore the economic and political context that I believe foreshadows greater investment in education from academic health centers. Fourth, I describe the Philadelphia RISE educational organization and its current status of operations. Fifth, I consider Temple's strategy in community engagement as a veteran role model for the fledgling non-profit. Sixth, I discuss the role of urban bioethics in shaping my ultimate recommendations to the non-profit. Seventh (and finally), I articulate the recommendations, which will most notably alter the leadership structure to incorporate community stakeholders.

Dedication

In solidarity with the public school students of Philadelphia. We medical students see you. We want you to succeed. We want to help.

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This work could not have been completed without support from the Temple Center for Urban Bioethics (CUB). Didactics within the program gave me the tools to analyze and background to understand community engagement, which led me to conceive and bring to fruition this project. My professors, specifically Dr. Nora Jones, enlightened me on a breadth of topics, including social determinants of health, the interaction of academic institutions and the communities, community advisory boards, and so forth. Professor Strand guided me and mentored me through project development and the writing process. I would also like to thank Dr. Reeves, Jerome Wright, and Mary Beth Hays for sharing the history of collaboration between CUB and the school district.

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Chapter 1: Introduction

Background

Will patients' health outcomes improve if schools in their communities enhance the educations they deliver to their students? I assert that hospitals are operating under the premise that the answer to this question is yes. In this paper, I explore the relationship between academic medical centers and local school districts in which they are situated as the backdrop for what I experienced as a medical student working in an education non-profit.

The social determinants of health are a modern phenomenon in public health, which states that most of someone's ability to be healthy relies upon factors outside of the traditional medical institution. Therefore, medical centers are increasingly integrating projects that incorporate the social determinants of health. One of these determinants is education.

In this paper, I intend to explore how one non-profit made up of medical students interacts with its local school district and how future directions of these relationships may benefit from examination through an urban bioethical lens. The exploration of the relationships occurred through personal observation and semi-structured interviews with multiple stakeholders. These stakeholders included the founding director and associate director of the Center for Urban Bioethics (CUB) at Temple University, core faculty of CUB, a senior coordinator at CUB, a teacher from one of local school district's schools, and the co-founders of a local non-profit that connects the schools' students with medical student tutors. My ultimate objective in this paper is to outline recommendations to the

non-profit for how to optimize its interaction with the community, drawing on lessons learned from the courses I took in the master's degree program in urban bioethics.

Personal Experience

Temple University Hospital is an academic medical center, situated in the urban American neighborhood of North Philadelphia, Pennsylvania. The medical center also has an attached medical school. I define this academic medical center to include the hospital and the medical school. The people that make up this entity include medical doctors, nurses, residents, PhD researchers, professors, health science students (medical dental, podiatry, pharmacy), and the hospital's board of directors.

As a medical student at Temple, I was instructed on the type of relationship I ought to have with the surrounding community – i.e the patient population I encountered at Temple University Hospital. As early as in orientation, Temple's faculty stressed the importance of listening to and addressing the specific needs of the community. Through trainings in cultural sensitivity, implicit bias, systemic racism, and learning about the history of the Black community's mistrust of the medical system, we were being prepared to not only be learners from but also servants to the community.

The historical medical education model entailed students learning how to deliver care through witnessing and practicing on patients and in that interaction, they were *takers* from patients who were not privileged enough or wealthy enough to seek care where they would not be guinea pigs. Temple stressed the moral imperative to be *givers* as well – to give back to the community that we were learning from. As stated in Wilkins and Alberti (2019), “community engagement requires *bidirectional relationships* and

interactions that are built on trust, mutual respect, cultural humility, and mutual benefit...AHC leadership should drive the narrative beyond seeing community engagement as a social responsibility and emphasize the value of engaging communities in training a culturally sensitive and diverse workforce.”

One opportunity that we had to give back to the community was through a program called “service learning.” The idea was for us as medical students to help out in the schools and also to learn about the culture of our community through this interaction so that we could better serve the patients in the hospital. Jerome Wright, the senior coordinator at Temple, stated that “it is not necessarily about those two hours a week changing the world, but giving folks an opportunity to experience a different context.” Service learning involved first and second year medical students going into local schools and doing various activities with the kids there. This was not unique to Temple. Wilkins and Alberti (2019) point out that “The 2015 revision to the Medical College Admissions Test assesses aspirants on the sociocultural contributors to health. The Liaison Committee on Medical Education (LCME), the accrediting body for undergraduate medical education, requires medical schools to “make available sufficient opportunities for medical students to participate in service–learning activities and ... encourage and support medical student participation”.

During my first few months of school, I signed up to go biweekly to a school I will refer to as X High School out of respect to the school and its dedicated staff. X High School is a technical school (formerly referred to as a vocational school) with tracks for careers in beautician, HVAC systems repairs, digital design, food services/culinary arts,

car mechanics, and so forth. The school is trying to increase interest from its student body in applying to college. One track that emphasizes this route is the biotechnology cohort.

At X, I pushed into two classes – a freshman algebra class and a sophomore biotechnology class. The phrase “pushing in” refers to a teaching role where an individual walks around the room to support students in the class one on one, while the main teacher delivers the primary lesson simultaneously. Our goal was to work on classwork with the students to help in classrooms that have very high student-teacher ratios, sometimes exceeding 1:30. In math class, we walked through the steps of the problems, and I was looking over their shoulders to guide them back on course as they rehearsed these skills in practice. In the science class, we sat with our student partners and discussed an experiment where the students were using increasing concentrations of bleach and measuring the effect the various solutions had on pairs of denim jeans.

When the COVID pandemic struck in March of that first year, all of service learning was put on hold; but another opportunity arose to work with the kids that a group of medical students were facilitating outside of the official channels of Temple. This group was called RISE – Remote Interpersonal Student Education. The goal was to reconnect with our students who were struggling to adapt to the online learning environment through video conferenced tutoring and mentorship sessions.

I was eager to get involved and, as a second-year medical student, signed up to be the coordinator for the Temple chapter. That role entailed handling the logistics and operations for the medical student tutors as well as the mentored students at X. We met with the leadership at the school to discuss our plan for the year, recruited tutors, conducted trainings and collected required clearance documentation, and met with

teachers to recruit students. We then paired them up and collected regular feedback from the tutors in the forms of post-session surveys and in regular monthly chapter meetings. We then reported that feedback back to the schools and came up with measures to tweak our operations to help run the sessions more smoothly.

Concurrently, during the first two years of medical school, I was also attending didactic seminars for a master's degree in urban bioethics. One of the courses was called "Community Engagement" where we learned about how to ethically and effectively initiate partnerships with communities. These partnerships often intend to administer some type of intervention and measure response. This theoretical work fit very nicely with what we were trying to do through RISE as medical students.

Now, as a fourth-year medical student, I am writing this report to draw from that coursework and make recommendations to the RISE student-led organization, which is now an official nonprofit. Throughout the paper, I will incorporate quotes and excerpts from articles that we read in the master's degree in urban bioethics coursework. I will also incorporate points from articles that I read in independent research for this paper.

Chapter 2: Education As A Social Determinant Of Health

An individual's health is dependent on a multitude of variables. According to current research in epidemiology and population health, 80-90% of an individual's health is accounted for by factors outside of the traditional medical institution of doctors and medications. These factors have come to be known as the social determinants of health. As defined by the Centers for Disease Control, these determinants are the "conditions in the places where people live, learn, work, and play (which) affect a wide range of health risks and outcomes."

In 1848, Horace Mann identified education as the "balance wheel of the social machinery." His point was that education is a predictor of future socioeconomic status and can serve as an avenue to rise out of poverty. Groups that are afflicted by social inequality are often concomitantly subject to health inequity as well. Thus, education may serve as a vehicle to overcome health inequity as well.

On a more direct level, formal education equips individuals with useful skills like literacy and arithmetic, as well as knowledge about health topics such as nutrition and exercise. The ability to follow recommendations of doctors and national public health agencies often depends on the consumption of print media. Taking medications appropriately, especially in the context of our complex pharmacological culture, may depend on a decent skillset in arithmetic. Aside from this direct logical argument, other complimentary arguments add weight to this truth. For example, attaining higher education is correlated with having a higher salary, which improves access to healthcare resources. Thus, it follows that achieving adequate education may enhance a patient's ability to achieve favorable health outcomes.

The link between education and health has been studied extensively and the literature is rife with investigations that describe this relationship. Eide and Showalter (2011) reviewed recent literature studying whether the relationship between education and health is causal. Cutler and Lleras-Muney (2008) found that education was positively correlated with several health data points. Fletcher and Frisvold (2009) recorded a correlation between attending college and preventative care usage. Others have looked at social services' impact and specific educational policies that correlate with better health outcomes.

Eide and Showalter (2011) describe three primary (competing) theories. One, that achieving higher education causes the attainment of better health. Two, that poor health causes poor educational achievement. Three, that education and health are not causally linked but correlated by other, confounding variables. They review the existing literature on this topic and discuss several efforts to analyze the effects of compulsory school age laws. These statewide (and sometimes nationwide) studies find modest declines in mortality from one additional year of compulsory education. Additional findings include decreased rates of disability and decreases in BMI. The studies they review were conducted both within the United States as well as outside - in the UK and Australia - showing that this phenomenon is consistent across the globe.

Cutler and Lleras-Muney (2008) focused on the big picture, correlating socioeconomic status and health. One component of their analysis zoomed in on education as one aspect of socioeconomic status. They reported several positive correlations between education and health outcomes such as mortality, heart disease, diabetes, smoking, and alcohol consumption.

Fletcher and Frisvold (2009) found that attending college was correlated with a 5-15 percent increase in likelihood of using preventative health services. These services included obtaining flu shots, getting routine physical exams, dental care, and cholesterol monitoring. They emphasize that the government subsidizes these services for the population because they are known to help maintain health and avoid future catastrophic care, which is very costly to the system. Therefore, it appears to be a helpful for the government to invest in education as well, as this increases compliance with preventative care.

Taylor et al. (2016) laments about the voluminous research documenting the existence of disparities in the social determinants of health without actionable recommendations and focuses on the utility of social services. Interventions in housing and nutrition were shown to improve health outcomes. As for education, they found three interventions aimed at reducing childhood obesity.

Cohen and Syme (2013) sought to identify which specific policy interventions within education reform would be most impactful in improving healthcare outcomes. Their review highlights early child education and quality education to be the most significant predictors of good outcomes. They refute that sheer quantity of years spent in school is a reliable predictor of meaningful education that would have an impact on health.

In summary, education is a thoroughly studied modifiable variable that can influence a person's health outcomes. Therefore, in communities with poor measures of both, it seems reasonable to believe that improving education of its youth may have downstream effects in improving health as well. Such is the case in Philadelphia where

data is published documenting a twenty year difference in life expectancy between rich and poor neighborhoods of Philadelphia, situated just five miles from one another (Center On Society And Health at Virginia Commonwealth University, 2016). With mortality as the crudest measure of healthcare, this disparity is in urgent need of address. No entity is better incentivized to manifest better healthcare outcomes than the hospitals that take care of the patients. If the outcomes largely depend on the social determinants (and education is one of them), then the determinants might become the focus of the hospital's mission.

Chapter 3: The Incentives

While most reimbursement schedules in the United States are still volume-based, there are existing accountable care organizations (ACOs) that reimburse based on value. Many healthcare economists agree that volume-based reimbursement incentivizes high-volume, but not necessarily high-quality healthcare. This leads to marked strain on the US healthcare system. By contrast, ACOs are conceptual remedies and organizations like the Mayo Clinic, Kaiser Permanente, and Geisinger Health have emerged as leaders in the arena of population health, producing high quality care and often at a lower cost. Even if many academic medical centers nation-wide are not appropriately financially incentivized to address social needs and preventative care, I infer that some are adopting this community-centered culture modeled after industry leaders. In that spirit, they are motivated to find creative ways to facilitate health improvements in the populations they care for.

Value based care reimbursement directly financially incentivizes healthcare systems to achieve better outcomes, and one way of doing this is through community interventions that tackle the social determinants. While value based care currently only represents a fraction of reimbursements, healthcare policy and research experts are advocating for its expansion. In that ideal future where financial incentives align with this policy incentive, insurance companies will shift to a system where the hospital will be paid a fixed amount for a service, regardless of how many resources it takes to deliver that service safely and care for the patient afterwards. Let's take a surgery as an example. In a community of patients who have high rates of chronic conditions like hypertension and diabetes, the post-operative period has higher rates of complications requiring

expensive care and management. That decreases the net profit that the hospital can take home to the bank. However, if the hospital can go into the community and encourage exercise and healthy nutrition, then the rates of diabetes and hypertension go down and they get to keep more of the reimbursement from the surgery. In this light, the hospital's financial interest to engage the community becomes clear. If the patients are healthier, so too is the hospital's bottom line.

In *Shifting academic health centers from a culture of community service to community engagement and integration*, Wilkins and Alberti (2019) eloquently described the “prestige of academic health centers...caring for the most complex and vulnerable populations. Given the “intractability of health inequities,” and the shift to value-based care reimbursement, there is incentive on the part of AHCs to engage more strategically with communities to improve health outcomes. They assert that,

This will require commitments from institutional leaders, infrastructure to support engagement, and changes in policies to fuel innovative partnerships, facilitate community partner integration, and reward community-engaged scholarship... Recent Internal Revenue Service regulations strengthen nonprofit hospitals' obligations to invest in their communities' health as a condition of their tax-exempt status. Every three years, hospitals must conduct a community health needs assessment, which engages local communities and public health experts.

Indeed, this practice of community engagement has been federally formalized for safety net hospitals. However, its current requirements are minimal and thus compliance is not always effective at generating the outcomes of its hopeful charter.

What should this engagement look like? Wilkins and Alberti (2019) describe this as well: “Broadly defined, community engagement is the application of institutional resources (e.g., knowledge and expertise of faculty and students, technical infrastructure, and physical space) to address and solve challenges facing communities through collaboration with these communities. Approaches to community engagement are wide-ranging and include community-based service–learning, community-engaged research, and community-driven health services delivery. Community engagement is distinct both from outreach, which is unidirectional, and recruitment into research, in which the ultimate goal of interactions is to enroll individuals in a study. In contrast, community engagement requires bidirectional relationships and interactions that are built on trust, mutual respect, cultural humility, and mutual benefit.”

Thus, given the financial incentives for better outcomes, it follows logically that hospitals would be invested in improving the health of the populations for which they care. As I previously illustrated, education is a tool that has been shown to improve health outcomes. Therefore, hospitals have a vested interest in improving education as a vehicle for improving health outcomes.

Chapter 4: The Status Of RISE Program In Philadelphia

History Of The Organization

The objective of this section is to describe the RISE Philadelphia organization. I will do this by drawing on personal experience as well as interviews I conducted with core RISE leadership. I interviewed Justine Garfinkle and Hayoung Youn, the two medical students who founded RISE. I also interviewed a teacher from X. High School who I will refer to as Ms. Y out of respect for her privacy.

As mentioned in the introduction, RISE began during the COVID pandemic in 2020 to address the needs of students forced into remote learning for extended periods of time. RISE is truly a cooperative of Philadelphia-based medical students who banded together to make a difference in the lives of Philadelphia inner city youth. We have all been influenced by our affiliations to our respective academic medical centers in our thinking and actions. Chapters developed initially at PCOM (Philadelphia College of Medicine), Temple, Jefferson, and Drexel. We later expanded to University of Pennsylvania and Rowan, which is located just a few minutes' drive across the river from Philadelphia in Camden, New Jersey.

Each chapter (each medical school) was assigned to different schools with each chapter variably organized depending on how their school oversaw club activities. For the most part, each chapter has a president, vice president, coordinator, and ethics chair. The chapter is responsible for recruiting medical student tutors, coordinating with the school to pair them with students, and reporting any issues to the central leadership team. These responsibilities are divided amongst the chapter leadership team. The ethics chair

is part of an ethics committee with the representatives from the other chapters to deliberate on ethical issues that may arise during tutoring.

To become a tutor, medical students must attend cultural humility training, implicit bias training, volunteer training specifically designed by the school district and submit required background check documents. These documents are maintained on a secure database. Only once they are cleared can tutors begin interacting with students.

According to RISE founder Jusine, the Fall of the 2022-2023 school year had 35 active student-tutor pairings across chapters. There are about 40 students on the waitlist. Many of the students are recruited directly from officially partnered schools and are often facilitated with teacher recommendation and principal support. Additionally, some students get in touch with the RISE program through the website where they can sign up directly for tutoring regardless of what school they attend. The students are all K-12 and are mostly interested in help with reading and math. Majority are English speaking, but a few are Spanish speaking and we have been able to accommodate them with Spanish-speaking medical student tutors through the Latino Medical Student Association.

Success In Innovation

The leadership team at RISE has done a great job in partnering with the schools and with the tutors. They have formed a curriculum committee whose sole responsibility is to support the learning by curating and developing tutoring resources. They have built a library of resources, such as math worksheets, on a google drive and distributed this to the tutors to use with their students. The leadership team is continuously responsive to tutors' evolving needs by collecting feedback at regular intervals and modifying

operations accordingly. This feedback is sometimes through verbal communication at meetings and sometimes through formal google surveys. The chapters are also frequently in touch with the partnered schools – meeting with guidance counselors, teachers, and principals. That communication ensures that RISE is consistently checking in and finding out if its efforts are supporting the school in the way it needs.

The RISE team also investigates how it can modify operations to better serve the community. This community consists of mostly economically disadvantaged, inner city, multi-racial families, whose children attend under-resourced public schools. RISE collects feedback from the community through end of year and semester surveys of the students. These are often filled out by parents as well. Additionally, email from parents and families are recorded by the leadership team.

Challenges

To be expected for a new organization, some structural problems have arisen along the way. One issue is that as COVID became normalized, educators were interested in live (rather than virtual) tutoring, citing superior trust and rapport building in person. However, the tutors were very hesitant to agree to those terms because the organization had already pitched the program to the medical student tutors as online/virtual, which appealed to that group because scarce time would be wasted traveling to and from sessions. This preconception might potentially be remedied by reframing the program to future tutors as a hybrid in-person and remote model.

Another issue has been the imbalance of tutors and students. In the first year of the program, we had many eager tutors sign up but lack of coordination with schools to

supply the students. In the next year, the problem was flipped – the coordination with schools was improved and we had a greater supply of students but not enough tutor recruitment. The key here is planning early, with both schools and tutors, and communicating often about the numbers.

Lastly, there were challenges in communication between tutor and student and with the student's family. Texts and emails go unanswered and planning breaks down when people do not show up to sessions. It is imperative that both tutor and student attend because they are truly and genuinely interested and not because they are being forced by a teacher or parent.

Chapter 5: Community Engagement At Temple

To best inform RISE in its community engagement, I want to draw on lessons learned from seasoned role models in Temple's Center for Urban Bioethics (CUB) who has been conducting community engagement for over a decade. To understand CUB's strategy with community engagement, I interviewed several key folks from their office, including the founding director, Dr. Reeves; the associate director, Dr. Jones; faculty member Mary Beth Hays; and senior coordinator Jerome Wright.

One theme that came up in the readings and in my interviews was that building trust is a slow, gradual process. Wilkins and Alberti (2019) comment that, "There is often a critical window of partnership building during which common goals are agreed on and expectations are set. This is vital to the stability and sustainability of partnerships. The pace of initial partnership building can be slow, especially true 'in communities where there is a history of being undervalued or disrespected by academia. Thus, [Academic Health Centers] must be committed to developing long term relationships.'" Those sentiments were echoed by Mary Beth Hays and Dr. Reeves. In their experience, it takes time to build trust, but you can lose it instantaneously. For that reason, it was crucial to build slowly and strategically in a sustainable way.

Another theme that recurred in my research was the importance of developing community around a common goal. Dr. Reeves described a program called PHASES, which brought trauma informed counselors into schools to train teachers on how to respond to kids acting out, often displacing anger or fear triggered by an experience outside of school. The program met resistance because a key stakeholder was left out of the initial discussion – the school district itself. LeChasseur (2014) reflects on the

importance of partnerships between schools and outside organizations discovering a shared sense of community as well.

Another issue brought up by several people was the tension between genuine well-meaning offers of service and logistical constraints that make the desire to help look performative. Mr. Wright summarized this concern as a problem of transience. Medical students often come to new geographic areas for four years of school. They are well-intentioned and want to make a difference and get involved with the community but they also feel pressured to build resumes that will make them competitive in residency applications. The problem is students come in and then they disappear. Sometimes in that process, students are determined to solve some problem for the sake of their CV that they may manufacture problems where there are none, which ends up causing net harm. Ms. Y underscored this issue, reflecting that students need more consistent presence and commitment from volunteers to build trust and relationships.

Chapter 6: Framing In Terms Of Bioethical Principles

The core bioethical principle of autonomy is emphasized as key to successful community engagement. Hotze (2011) believes that the school and the academic medical center should both have active roles in shaping the tutoring programming. We are outsiders from medical schools – large institutions with people who come from all over the country and world – and it is our responsibility to engage with the community on their terms. In metaphorical terms, we need to let them drive the bus and we supply the fuel to propel them forward. Wilkins and Alberti (2019) frame this shared decision making as essential to “ensure that the actual needs of the community are taken into account.” LeChausser (2014) describes this as a dichotomy between community-driven and community-based.

Urban bioethics urges us to take one step further, moving from honoring autonomy to facilitating agency. Autonomy means that the community has the right to decide which (if any) intervention it receives. Agency elevates the onus of the researcher and the academician to ensure that the community is making an informed decision. This practice involves assessing the way the community best ascertains new information and packaging the materials accordingly. Facilitating agency also entails gathering the appropriate stakeholders so that the group deciding represents the whole community’s interests.

Consequentially, it is important to define community to elicit feedback and input from the right people. LeChausser (2014) identifies three concepts within a community reading initiative that they analyzed:

Parents as community, racial/ethnic groups as community, and businesses as community... What do individuals involved in partnership mean when they talk about ‘the community?’ What is the position of those meanings in relation to power and privilege? If community-district partnerships are about systems building and improving the education of children, can its goals be accomplished if decision making is not shared with those most adversely affected? The question of who is best equipped to radically improve failing systems is at the heart of such partnerships—and yet was barely, if ever, discussed by the [community reading partnership] governance council. The way that members of community-district partnerships attempt to engage the community—or ignore them—has deep implications for the social justice of their work.

One lesson they learned was that parents who are “economically underprivileged or otherwise disenfranchised might bring new and useful perspectives to addressing gaps in the system.” Thus, RISE must ask the question of who is the community that we are trying to help and engage directly with those stakeholderst to develop its programing.

One challenge posed by bringing parents onto the board is overcoming the perceived power differential between academics and community members. These individuals from both groups are gathered under one umbrella, working as a team to accomplish the educational intervention goals. However, they need to recognize that

people coming from backgrounds of immense privilege (academic medical centers) and from socioeconomically disadvantaged positions need to be carefully melded for this to be successful. To overcome this, there needs to be sensitivity towards the “complexities of bringing disenfranchised individuals into a mostly privileged arena” (LeChausser, 2014). One suggestion is to create “groups that could focus on empowering new recruits who might otherwise be intimidated by the existing governance council members... investing in programming or restructuring the existing governance council in ways that might deconstruct power differentials” (LeChausser, 2014).

How specifically to deploy the parents to maximize utility is discussed by LeChausser as well. “The problem with placing parents in a strictly advisory role is that advisors are not handed any authority within the group—the governing body of the [community reading partnership] could consistently choose to disregard advice given through a parent advisory group, diminishing their influence on the work that is implemented. Creating a parallel structure with less authority would be more empowering for disenfranchised members to participate in [community reading partnership] than to make the governance council more accommodating to others.” Therefore, it is imperative for RISE to create a parallel board of community stakeholders that works in harmony with the existing leadership board. This can be thought of as analogous to the senate and house of representatives within the United States congress.

Chapter 7: Summarizing Concrete Suggestions for RISE

Dr. Youn, one of RISE's founders, summarized it well. "The best way to do community service is to get community buy in. That is the only way to make it sustainable. We must get community leaders involved. We are outsiders. We are transient. We do not know all the ins and outs of the community. We are all dedicated, but to know how to make the biggest impact we need to be in contact with the community."

Based on Temple's experience with the school district and the literature's recommendations for community partnership, agency seems central to RISE growing in a positive manner. RISE has beneficence in its mission and non-maleficence with its safety checks and ethics committees actively engaged in avoiding harmful scenarios, but there is room for growth in developing the agency of the community in this project. Having a parent, educator, or even a student on the board of RISE would facilitate more direct and continuous communication. Another possibility is for clergy involvement. Oftentimes, the priests and pastors are most intimately aware of the community's struggles and needs. Partnering with the clergy may offer another avenue to integrate with the community and connect the resources with those who need it.

Bringing parents on board to help run RISE's operations would allow for organic community input to be incorporated. Lessons learned from the Community Reading Partnership from LeChausser's paper suggest that there is a delicate way to build the leadership infrastructure to incorporate parental input. Recommendations include giving the parents actual authority and having a parallel committee where their input is unconditionally welcomed. Consider the analogy to the US congress having two houses

of authority. One may introduce bills and another must sign the legislation into law. Similarly, a parallel board may be introduced to the RISE leadership structure that is made up of community stakeholders, including parents, clergy, educators, and even students interested in developing leadership skills.

Trust and developing sustainable partnerships are another takeaway from this report, stemming from comments made by Mr. Wright, Dr. Reeves, as well as comments in the literature. Through my conversation with Ms. Y, I learned her perspective on RISE's potential impact as relying on trustful relationship building between mentor and student. She emphasized the value in face-to-face meetings to facilitate this trust developing. Strictly remote operations, as RISE has traditionally operated, makes this difficult to accomplish. She suggests that tutors come to the classroom for a first meeting, and to arranging online meetings going forward.

Making these subtle changes may have a lasting impact in making RISE more community centered. This may have consequences for the longevity and success of the program. This methodology may also serve as a blueprint to other educational initiatives driven by academic medical centers in their communities that may be cropping up across the country as a result of increasing emphasis on the social determinants of health.

Bibliography

1. LeChasseur, K. (2014). Critical race theory and the meaning of “community” in district partnerships. *Equity & Excellence in Education, 47*(3), 305-320.
2. Hotze, T. (2011). Identifying the challenges in community-based participatory research collaboration. *AMA Journal of Ethics, 13*(2), 105-108.
3. Wilkins, C. H., & Alberti, P. M. (2019). Shifting academic health centers from a culture of community service to community engagement and integration. *Academic medicine: journal of the Association of American Medical Colleges, 94*(6), 763.
4. Goldring, E., & Sims, P. (2005). Modeling creative and courageous school leadership through district-community-university partnerships. *Educational Policy, 19*(1), 223-249.
5. Eide, E. R., & Showalter, M. H. (2011). Estimating the relation between health and education: What do we know and what do we need to know?. *Economics of Education Review, 30*(5), 778-791.
6. Cohen AK, Syme SL. Education: a missed opportunity for public health intervention. *Am J Public Health. 2013 Jun;103*(6):997-1001. doi: 10.2105/AJPH.2012.300993. Epub 2013 Apr 18. PMID: 23597373; PMCID: PMC3698749.
7. Taylor LA, Tan AX, Coyle CE, Ndumele C, Rogan E, Canavan M, Curry LA, Bradley EH. Leveraging the Social Determinants of Health: What Works?

PLoS One. 2016 Aug 17;11(8):e0160217. doi: 10.1371/journal.pone.0160217.
PMID: 27532336; PMCID: PMC4988629.

8. Fletcher JM, Frisvold DE. Higher Education and Health Investments: Does More Schooling Affect Preventive Health Care Use? *J Hum Cap.* 2009 Summer;3(2):144-176. doi: 10.1086/645090. PMID: 22368727; PMCID: PMC3285406.

9. Cutler, D. M., Lleras-Muney, A., & Vogl, T. (2008). Socioeconomic status and health: dimensions and mechanisms.

10. Centers for Disease Control and Prevention. *Social Determinants of Health: Know What Affects Health.* 2020. [February 20, 2021]. <https://www.cdc.gov/socialdeterminants/index.htm>.

11. Mann H. Twelfth annual report of Horace Mann as Secretary of Massachusetts State Board of Education. 1848. Available at: http://www.tncrimlaw.com/civil_bible/horace_mann.htm.

12. Barber, S. (2020). Place matters: from health and health care disparities to equity and liberation. *North Carolina Medical Journal*, 81(3), 173-176.

13. Center On Society And Health at Virginia Commonwealth University. (2016, April 6). *Mapping Life Expectancy: Philadelphia.* <https://societyhealth.vcu.edu/work/theprojects/mapsphiladelphia.html#:~:text=20%20years%20in%20Philadelphia&text=In%20this%20case%2C%20babies%20bor,year%20difference%20in%20life%20expectancy>. Accessed March 23, 2023.