In Our Own Words: Baccalaureate Nursing Students Describe Academic Service Learning Experiences

SAGE Open Nursing
Volume 7: 1–8
© The Author(s) 2021
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/23779608211010960
journals.sagepub.com/home/son

Lora Humphrey Beebe, PhD, PMHMP-BC, FAAN,
Lizanne M. Elliott, DNP, RN FNP-BC,
Helen Whitaker, BSN Student, and Colby Gladson, BSN Student

Abstract

Introduction: Service learning integrates community service, didactic and student self-reflection while at the same time striving to identify and meet needs of the community partnership agencies involved. Project Descriptions. In this manuscript, two baccalaureate nursing students describe their service learning experiences while embedded in an integrated primary care community partner site for two years. In project one, students designed and conducted an educational group for mental health clients in a rural day treatment program. In project two, the student revised a diabetic clinic educational form to reduce client burden.

Project management and outcomes: Projects were designed in collaboration with community partners and faculty. Project one resulted in increased knowledge of coping mechanisms in a majority of group participants. Three months after implementation of the revised form designed in project two, a majority of diabetic clients served in the clinic had A1c reductions.

Discussion: Lessons learned by students during the experiences include communication skills such as developing rapport with specific client groups, steps of change management, professional team interactions and increased civic engagement.

Conclusion: To our knowledge, this is the first manuscript wherein baccalaureate nursing students add their voice to the literature describing the benefits of academic service learning. Our next step is an online follow up 9 months post-graduation, to examine whether benefits and skills are maintained.

Keywords

nursing students, community partnership, academic service learning

Received 8 June 2020; Revised 23 November 2020; accepted 26 March 2021

Introduction

Nursing has been a service profession since its inception. With roots in the Christian mandate to care for widows, children, the poor and the sick (Hood & Leddy, 2003), the earliest nurses met community needs not only by providing direct care, but by relaying messages, conducting home visits (Nutting & Dock, 1935) and founding some of the first hospitals (Kelly & Joel, 1999). The originator of modern nursing, Florence Nightingale, is most famous for her service to wounded veterans during the Crimean war (Dossey, 2000). After the Civil War, forward-thinking persons in the United States came to believe that nurse training schools were needed; an apprenticeship model was established (Hood & Leddy, 2003) in which students served as a hospital labor force while gaining knowledge for practice. Recently, the processes and localities of nursing care delivery have shifted again as care moves into the community (Beebe, 2007). This shift underscores the importance of a student educational process that accounts for community needs.

College of Nursing, University of Tennessee, Knoxville, United States

Corresponding Author:
Lora Humphrey Beebe, College of Nursing, University of Tennessee, 1200 Volunteer Blvd, Knoxville, TN 37996, United States.
Email: lbeebe1@utk.edu

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (https://creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).

According to the American Association of Colleges of Nursing, the goal of nursing education is to "meet current, emerging, and future healthcare needs of populations through purposeful integration with the higher education institution, health systems, and communities of interest." (AACN, 2017, p.2). The Institute of Medicine (2011) has been highlighting the need for collaborations between educational and health care systems since 2010 and last year, the Higher Learning Commission (2020) addressed academic service learning as an accreditation standard by adding service learning as an example of a cocurricular activity under accreditation core component 4.B.1 (The institution has effective processes for . . . achievement of learning goals in academic and cocurricular settings).

Seifer (1998) defined Academic Service Learning (ASL) as a "structured learning experience that combines community service with explicit learning objectives, preparation and reflection"(p. 274). ASL integrates community service, didactic instruction and self-reflection to enhance learning while fostering relationships between learners, community members and clients in a process of shared skills, experiences and perspectives (Alexander-Ruff & Kinion, 2019).

In this paper, two undergraduate BSN students describe their ASL projects during a 2 year primary care immersion. Of the 300 hour clinical immersion, at least 100 hours were devoted to the ASL project. To our knowledge, this is the first manuscript to include students' descriptions of the entire ASL process.

Over the past 20 years, the nursing education literature has documented the many benefits of ASL to students, clinical partners, clients, communities and faculty (Bailey et al., 2002; Clark, 2008; Stallwood & Groh, 2011; Community Practice Partnerships for Health (2013). ASL projects meet student learning needs while providing resources for clinics to offer additional services or programs to meet community needs (Nash et al., 2018).

ASL offers unique benefits in fostering the practice readiness of participating students. Students participating in ASL directly engage in problem solving, critical thinking (Brown & Schmidt, 2016), ethical decision making and change management (AACN, 2008; Stallwood & Groh, 2011). Numerous authors have reported positive changes in civic responsibility, along with increased awareness of health disparities, social justice and health policy (Brown & Schmidt, 2016; Groh et al., 2011; Murray, 2013; Yancey, 2016). In addition, literature documents increased cultural proficiency (Cupelli, 2016; Stone et al., 2019), including enhancement of the perceived value of rapport and assessment in working with vulnerable populations (Nash et al., 2018; Stone et al., 2019). Two studies documented that increases in cultural competence were sustained for one year after international ASL projects ranging from 1–4 weeks in length (Gower et al., 2019). Recently, Franzese and colleagues highlighted the importance of ASL in reducing the stigmatization of mental health clients (Franzese et al., 2020).

This body of literature is limited by small sample sizes, limited generalizability and short time frames (most projects occurred over a period of days to weeks). While several publications referenced written student reflections or focus groups (Alexander-Ruff & Kinion, 2019; Brown & Schmidt, 2016; Cupelli, 2016; Main et al., 2013), contributions to the literature from students participating in ASL over time are notably absent.

The ASL projects described herein were part of the clinical activities of students participating in a funded study (Transforming Rn Roles in Primary Care – TRIP, Award # 1UK1HP31710-01-00) implementing community partnership enhancement across didactic, simulation and clinical settings. TRIP data were collected from students and faculty by our independent evaluation team and the project was approved by the University of Tennessee Institutional Review Board (IRB). Details of the TRIP curriculum have been published elsewhere (Beebe et al., 2019). In brief, TRIP incorporated didactic, clinical and simulation over 4 semesters (2 years). Didactic content emphasized chronic disease and recovery based care. Clinical activities included ASL, interprofessional team conferences and simulation. The entire TRIP curriculum emphasized population health and team based care.

The ASL projects described took the form of quality improvement activities, and varied according to clinical site and community need. Projects were completed for credit in the Primary Care Clinical Immersion (PCCI) course during the first semester, senior year (spring 2020). The PCCI course provides students the opportunity to practice health promotion, health restoration, and health maintenance with Primary Care populations/settings including adult, adult behavioral, pediatric, and pediatric behavioral, building on the foundation of nursing knowledge, communication skills, and critical reasoning to address unique needs of the specialty population. The course includes the following objectives: 1) Communicate effectively (for example Instructs *Primary Care clients*(s)/families utilizing health education materials); 2) Reason Critically (for example Implements the nursing process in the care of *Primary Care* specialty client); 3) Practice Safely (for example Applies appropriate infection control measures (hand hygiene, equipment cleanliness, PPE); 4) Act Professionally (for example Describes processes required to affect change in organization or the political system); and 5) Lead Effectively (for example Identifies areas of quality improvement initiatives).

There are significant health disparities, poor health status indicators, and challenging social determinants of health in the communities where the ASL clinical sites were located. The ASL clinical sites included one clinic in Hamblen and one in Union county Tennessee. Union county is designated a Geographic High Needs and Medically Underserved Area (U.S. Department of Health and Human Services Health Resources and Services, 2018). The socioeconomic status of persons served in these clinics is lower than the other Tennessee counties and leads to disparities in health and limited access to care. Many persons are either uninsured, underinsured or have limited resources which negatively impacts their ability to acquire health insurance or to meet the basic needs of the family. For example, in the counties where the clinics are located:

- The median household income ranges from $36,600–$47, 543 and over one third of all residents fall below the 200% poverty line (U.S. Census Bureau, 2018).
- At least 20% of persons are covered by TennCare (Medicaid Waiver Program), compared to an average of 12% for all counties in Tennessee (Tennessee Division of TennCare, 2016).
- On average 38% of persons are uninsured compared to 13% for all counties in Tennessee (U.S. Census Bureau, 2018).

In Hamblen County, Hispanics (including a large number of Migrant and Seasonal Farm Workers) constitute 10.9% of the population compared to 4.8% Tennessee-wide. According to the National Center for Farmworker Health (2018), 69% speak Spanish and 38% are functionally illiterate with less than a 6th grade education. Residents in Union County are the most rural, poorest, lowest educated, and under/uninsured of any Tennessee county (U.S. Census Bureau, 2018).

Student Project I: Management and Outcome

My assigned clinical site provided physical and mental health services in a very rural area with a population of about two thousand people. Twenty-six percent of the population lived below the poverty line and about seventy percent had at least one chronic disease (i.e. diabetes, hypertension, and hyperlipidemia). I spent time assisting in other areas (hypertension and prenatal clinics) before deciding to conduct my ASL with the day treatment group. I wanted to work more closely with the day treatment group for two reasons: to enhance my knowledge of mental health/recovery and to help group members learn about health promotion. I saw an opportunity to learn while at the same time helping meet health-disparity related needs amongst the group members. For example, I saw persons with diabetes mellitus who did not understand the importance of carbohydrates; some persons were unkempt and lacking basic hygiene while others had low health literacy regarding physical and mental health. I saw an opportunity to help group members learn health promotion activities and the nurses' role in health promotion. My nursing student peer made similar observations, so we decided to collaborate on the day treatment ASL project.

After receiving approval from our faculty and nurse manager, we spoke to the day treatment group leader about conducting our ASL project with the day treatment group members. At first, the leader was concerned about outsider involvement in the day treatment group. She was inquisitive about what we would do and how we would interact with the group members. We explained that we thought there was a lot to learn by developing relationships with the group, and that we wanted to focus our ASL project on the needs of persons attending the day treatment group. It took a while to develop relationships with the group members. We knew relationships were progressing when we conducted a successful meeting with the group at the end of the day to discuss the day's events and our goals for the next day. Assisting group members with activities like meal preparation, games and group discussions over the first two semesters helped us develop rapport with participants and assess their needs. We identified three main foci: 1) general information about mental and physical health, 2) the effect of illness on daily life, and 3) effective coping mechanisms.

We decided to offer an educational program after observing that group participants enjoyed educational discussions. First, we talked to participants to assess their willingness to participate and level of interest. We assessed learning needs of the group members by querying their interest in mental health topics and preferred learning styles. Every group member expressed interest in information about mental health diagnoses and coping mechanisms. They were very excited and wanted to attend our group. For our ASL project, we designed and implemented an educational group for day treatment participants. Topics included depression, anxiety, and schizophrenia. Our goals were to expand participant knowledge, enhance their coping skills, and educate them on the role of the nurse in health promotion and illness management. We began with a literature review on educational techniques in psychosocial rehabilitation.

We reviewed 4 studies conducted over the past 15 years (Corrigan & O'Shaughnessy, 2007; Casanas et al., 2012; Mowbray et al., 2005; Shuan et al., 2012) and one seminal work addressing educational principles

in psychosocial rehabilitation programs like day treatment (Cnaan et al, 1988). Mowbray et al (2005) documented that day treatment participants were interested in learning about their illness and its management. Two studies assessed the effectiveness of educational groups in day treatment programs; both documented knowledge improvements regarding disorders and coping skills (Casanas et al., 2012; Shuan et al., 2012). Finally, we reviewed a study documenting the effect of education in reducing the self-stigmatization of persons with mental health disorders (Franzese et al., 2020). With this in mind, we included a discussion of stigma in our education plan.

Keeping our literature review results in mind, we designed an educational program for day treatment participants that incorporated kinetic, auditory and visual learning about depression, anxiety, and schizophrenia as well as coping mechanisms. We incorporated kinetic learning using a symptom circle. Group participants stood in a circle and members were directed to remain facing forward if they experienced the symptom described, and to turn around (face the opposite direction) if they had not. For example, when we announced "sadness to the point that you are unable to accomplish daily tasks in the past week" participants who had dealt with this feeling remained facing forward while those who had not turned around. In order to normalize the feelings described, my peer and I also participated. Our goal was to demonstrate that many people experience various feelings and thoughts throughout their life. Participating ourselves also showed group members that many of their friends and support persons may have faced similar struggles. After the activity we provided time to discuss feelings and reactions.

The next step of our educational program was a one-hour group discussion using visual aids to accommodate auditory/visual learners. We presented information about anxiety, depression and schizophrenia including: symptoms, coping mechanisms, and statistics on numbers of people affected. Our auditory component included a discussion, and we highlighted content presented by writing it on a poster board for the visual learners. We divided the board into three sections labeled depression, anxiety, and schizophrenia. As we covered each, we listed the coping mechanisms, sometimes listing the same coping mechanism for different disorders. This provided a visual representation of coping mechanisms, and the opportunity to notice that the same coping mechanisms could be used for different disorders. For example, listening to calming music could help cope with both schizophrenia and anxiety. We concluded our presentation by playing Jeopardy (question and answer with points for correct answers). Questions were based on the information presented. Our goals were to reinforce learning, keep the participants engaged, and build their confidence by highlighting knowledge gained.

Ten day treatment group members participated in our educational group. To provide quality improvement information to our clinical partner, we developed and administered a ten question Likert scale that each participant completed before and after the educational program. Questions focused on participant confidence regarding knowledge of: various mental health disorders, stigma, and coping mechanisms. We used ten statements relative to the group content to gather quality improvement information. Participants answered according to a Likert type scale from 1 = strongly disagree to 5 = strongly agree. Examples of statements included: "I know the signs and symptoms of depression", "I feel as though nurses are very knowledgeable about mental health" and "I am confident in my ability to implement coping skills". Individual participant changes from pre to posttest were compared by hand for each item. Seventy percent of the participants (n = 7) had an increased score on the item "I am confident in my ability to implement coping skills" from pre to posttest. Participants' view of nurses was another area of growth; after our educational program eighty percent of participants (n = 8) strongly agreed with "I feel as though nurses are very knowledgeable about mental health".

Lessons Learned

Although I was unsure how ASL would enhance my learning at first, participating in this project taught me several things I will carry forward in my career. First, I learned through personal experience the importance of building respectful and caring relationships with all clients. The rapport between a nurse and client is essential to holistic care. Additionally, I had a great opportunity to develop my therapeutic communication skills over the course of the two years. My constant interaction with participants provided an abundance of opportunities to communicate therapeutically regarding their diagnosis and coping mechanisms. I also learned how cultural differences impact health. For example, the comfort food of the south (something many clients were accustomed to) includes vegetables cooked in fat and fried proteins which can negatively impact health. Having this cultural awareness as a nurse helps me tailor health promotion education while respecting cultural mores.

Student Project 2: Management and Outcome

I was fortunate enough to be offered the opportunity to complete my ASL in the Diabetic Education Program (DEP). I was interested in this clinic because I have

family members with diabetes, and I wanted to learn more about treatment and management options. The site serves mainly urban clients (many are homeless and 25% live below the poverty line), as well as refugees from Africa, Central/South America, and the Middle East.

After approval by the site manager, my nurse mentor provided me with an email introduction to the DEP pharmacist. Getting started with ASL was difficult; working alone challenged me to take initiative and reach out to strangers to set up meeting times to discuss clinic needs, project ideas and scheduling. It was an opportunity to learn how to communicate effectively and professionally. As I spent time observing and learning about the DEP clinic over the first two semesters, the potential ASL opportunities there became clearer to both the DEP pharmacist and myself.

While observing and learning the DEP clinic routine, I also learned the functions of the Diabetic Educator: medication management, client education and supporting lifestyle changes. Diabetes can be a life changing diagnosis for this population consisting of underserved, poor, adult men and women. Every client visit covers a multitude of topics: medication education, blood glucose results, A1c results, and diet adherence (assessed by 24 hour recall). In addition, new clients get basic dietary education including the effect of food on blood glucose. The pharmacist performs a knowledge assessment to determine new clients' baseline understanding of diabetes. Finally, new clients are provided handouts on medication education, diet, exercise, and blood glucose monitoring.

One thing I noticed was the client burden of keeping track with paperwork. Every new DEP client received 3–4 documents during their very first visit (blood glucose log, action plan, and at least one dietary handout). All this information is provided immediately after diagnosis, when clients were processing information about multiple required lifestyle changes. I wanted to reduce the emotional burden of these individuals who were, in my opinion, being bombarded with information. Another ASL option was the formation of groups for new clients diabetes, what the diagnosis meant to them, and diabetes management options. A group would potentially be more efficient than providing the same information to every new client individually.

My next step was to choose which ASL option to implement. First, I met with the pharmacist to discuss the specifics, advantages and disadvantages of reducing paperwork burden or providing group information sessions. Since the DEP was a long standing program, many forms and routines were familiar to staff and clients, making it harder to initiate change. However, reducing paperwork burden had advantages to both clients and staff: It was time efficient and would simplify the follow up process. The disadvantages of providing group information sessions centered around barriers such as a lack of reliable transportation and scheduling – it would be problematic to find a time a majority of the group members could meet.

I also gathered feedback from clients to help decide between ASL projects. I talked informally with over a dozen clients to ask what they perceived as their biggest hurdle when dealing with their new diagnosis. I also spoke to several health care providers at the clinic about their struggles providing care to persons newly diagnosed with diabetes. Barriers such as low heath literacy about diabetes and low adherence to medications and diet were mentioned over and over by both clients and providers. Considering the results of the needs assessment and the difficulty of group scheduling, I chose to conduct an ASL project to reduce the burden of client paperwork.

For my ASL project I condensed two one page forms (Diabetic Action Plan and Blood Glucose Log) into a single sheet called a Condensed Action Plan (CAP). After reviewing the literature on diabetic handouts (McCay et al., 2019), the role of diabetic educators (Ruggiero et al., 2010), and the benefits of handouts and self-education (Powers et al., 2016), I sought guidance from the DEP pharmacist on the required information for the Condensed Action Plan (CAP). DEP clinic policy specifically required the form to include: The client's goal A1c, their current A1c, their goal blood glucose level, and a place to record their next scheduled appointment. Once these elements were included, I was given permission to incorporate other content I deemed necessary.

I designed the CAP with 2 charts. On the left are 31 spaces to record daily blood glucose for one month. On the right are 4 boxes for the provider to record educational information about Diet, Exercise, Monitoring, and Medication. Once my revisions were complete, I generated an electronic copy of the CAP, which is now in its sixth month of implementation. Quality improvement information about the usefulness of the CAP was gathered by clinical partner chart review. Data included the date they received the CAP, their most recent A1c before receiving the CAP, and their A1c 3 months after receiving the CAP. Of sixteen clients who received the CAP over six months, 14 showed a decrease in their A1c level.

One limitation of my project was that the CAP was limited to one month of daily blood glucose information. This was a problem because clients who were not seen monthly would likely have missing information. Ideally, the CAP needs space to accommodate blood glucose information for three months. This is an area where a revision to the form may be indicated. I also believe my work could have been more inclusive. For instance,

20–25% of the clients seen in the DEP are Spanish speaking, so there is a need for a translated Spanish document to increase their access to this information and facilitate their use of the form.

In contrast to most of my peers, I worked on my ASL project independently due to space limitations in the DEP. Working alone on this project had its pros and cons. Scheduling was facilitated as I was not required to accommodate a peer's schedule. I enjoyed the opportunity to build one on one rapport with the clients and pharmacist. I think the main disadvantage of working alone was lack of a peer discuss and refine ideas. In hindsight, specific things I would change would have been to add more days to the blood glucose log, or utilize a different configuration for the tool.

Over the past 2 years, the DEP pharmacist showed me what it means to be a professional in your field, and what it means to be a topical expert. He was extremely knowledgeable about every aspect of diabetes, but more importantly he knew how to establish rapport with the clients. Overall, I learned that clients in the DEP greatly appreciated anyone who was willing to help them. A client who was being released from the program (A1c < 7.0 for two consecutive months) stated, "I just want to thank you guys for helping me out, I appreciate everything you've done for me."

Lessons Learned

Overall, the things I learned and the benefits I gained from ASL have been numerous. I greatly benefited from this opportunity to work on my problem solving skills. It was fulfilling to identify a problem (paperwork burden) and develop a solution(condensing forms). ASL taught me that there are so many ways that I can be a contributing and caring member of society. ASL also opened my eyes to the depth of the health disparities in impoverished communities, and poor health literacy in my community, and how I can have a positive impact in my community. Finally, ASL has changed how I look at the poor (25% of residents in the county living below the poverty line) and underserved persons that I served during these past two years. I will be forever grateful for the opportunities and benefits ASL provided, that I will take into my practice for years to come.

Discussion

These case exemplars highlight and extend the literature on ASL benefits. As the literature indicates, the benefits of ASL to clinical sites include students functioning as resources to offer additional services or programs to meet community needs (Nash et al., 2018). Both of the projects highlighted herein enabled clinics to implement changes they otherwise would have lacked resources to provide. In addition, both students cited practice readiness skills, specifically enhancements in problem solving and therapeutic communication noted by other authors (AACN, 2008; Nash et al., 2018; Stallwood & Groh, 2011; Stone et al., 2019). Increased awareness of the contributions of cultural differences (Cupelli, 2016; Stone et al., 2019) and health disparities to client outcomes also were expressed by our student authors (Brown & Schmidt, 2016; Groh et al., 2011; Murray, 2013; Yancey, 2016).

Our student ASL project descriptions indirectly address additional ASL benefits such as critical thinking (Brown & Schmidt, 2016) and change management (AACN, 2008; Stallwood & Groh, 2011). Descriptions of the time required to be accepted into established clinics exemplifies the initial steps of the successful change management process. The reported reductions in self stigma after the educational group described herein echo the results of one other study reporting that education reduced self-stigmatization in persons with mental health needs (Franzese et al., 2020).

These ASL projects were not directly related to policy, but health policy implications may be derived. For example, project one could be shared with the local chapter of the National Alliance on Mental Illness (2020): the student group goes hand in hand with that organization's priority to strengthen behavioral health infrastructure. Similarly, project two meets the American Diabetes Association's priority of reducing diabetes burden, improving nutrition and increasing physical activity in this group (American Diabetes Association, 2020).

To our knowledge, this is the first publication to include student voices speaking directly about their ASL experiences outside of course assignments. Some of the benefits highlighted by our student authors are directly traceable to the length of this ASL experience, which continued for two years, enabling not only skill acquisition, but growth over time. Our next step is an online follow up 9 months post-graduation, to examine whether benefits and skills are maintained.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This project/publication is supported by Grant Number UK1HP31710 from the Health Resources and Services Administration (HRSA), of the U.S. Department of Health and Human Services as part of an award totaling $2,659,027.

ORCID iD

Lora Humphrey Beebe https://orcid.org/0000-0002-1774-5231

References

American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education for professional nursing practice*. http://www.aacn.nche.edu/education-resources/baccessentials08.pdf2008

American Association of Colleges of Nursing. (2017). *The preferred vision of the professoriate in baccalaureate and graduate nursing programs, Oct 2017*. https://www.aacnnursing.org/news-information/position-statements-white-papers/professoriate

American Diabetes Association. (2020). *2020 state and federal legislative and regulatory priorities*. https://www.diabetes.org/advocacy/advocacy-priorities

Alexander-Ruff, J. H., & Kinion, E.S. (2019). Developing a cultural immersion service-learning experience for undergraduate nursing students. *Journal of Nursing Education*, *58*(2), 117–120.

Bailey, P. A., Carpenter, D. R. & Harrington, P. (2002). Theoretical foundations of service learning in nursing education. *Journal of Nursing Education*, *41*, 433–436.

Beebe, L. H. (2007). History and evolution of nursing. In: K. Polifko (ed.). *Concepts of the nursing profession* (pp. 16–29). Thomson Delmar Learning.

Beebe, L. H., Mixer, S. J., Thompson, K., Davis, S., Elliot, L., Lakin, B., Bullard, T., Hurt, M., & Niederhauser, V. (2019). Transforming RN roles in community-based integrated primary care (TRIP): Background and content. *Issues in Mental Health Nursing*, *40*(4), 347–353.

Brown, J. M., & Schmidt, N. A. (2016). Service learning in undergraduate nursing education: Where is the reflection? *Journal of Professional Nursing*, *32*(1), 48–52.

Casanas, R., Catalán, R., & del Val, J. L. (2012). Effectiveness of a psycho-educational group program for major depression in primary care: A randomized controlled trial. *BMC Psychiatry*, *12*(230), 147–163.

Clark, L. (2008) Partners in practice, *Nursing Management*, *15*(3), 12–13.

Cnaan, R. A., Blankertz, L., Messinger, K. W., & Gardner, J. R. (1988). Psychosocial rehabilitation: Toward a definition. *Psychosocial Rehabilitation Journal*, *11*(4), 61–77.

Community Practice Partnerships for Health. (2013). *Guiding principles of partnerships, position statement on authentic partnerships*. https://ccph.memberclicks.net/principles-of-partnership

Corrigan, P., & O'Shaughnessy, J. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, *42*(2), 90–97.

Cupelli, L. (2016). An innovative service-learning project to develop cultural competency in undergraduate nursing students. *Teaching and Learning in Nursing*, *11*, 113–117.

Dossey, B. M. (2000). *Florence Nightingale: Mystic, visionary, healer*. Springhouse Corporation.

Franzese, J., Pecinka, J., & Schwenk, J. (2020). Alternative clinical experience through academic service-learning develops into partnership for mental health rotation. *Teaching and Learning in Nursing*, 2020, *15*(1), 1557–3087.

Gower, S., Duggan, R., Dantas, J. A. R., & Boldy, D. (2019). One year on: Cultural competence of Australian nursing students following international service learning. *Journal of Nursing Education*, *58*(1), 17–26.

Groh, C. J., Stallwood, L. G., & Daniels, J. J. (2011). Service learning in nursing education: Its impact on leadership and social justice. *Nursing Education Perspectives*, *12*, 400–405.

Higher Learning Commission. (2020). *Criteria for accreditation policy*. https://www.hlcommission.org/Policies/criteria-and-core-components.html?highlight=WyJzZXJ2aWNlI iwibGVhcm5pbmciLCJzZXJ2aWNlIGxlYXJuaW5nIl0=

Hood, L. J., & Leddy, S. K. (2003). *Conceptual bases of professional nursing* (5th ed.). Lippincott, Williams & Williams.

Institute of Medicine. (2011). *The future of nursing-leading change, advancing health*. National Academies of Health.

Kelly, L. Y., & Joel, L. A. (1999) *Dimensions of professional nursing* (8th ed.). McGraw Hill.

Main, M. E., Garrett-Wright, D., & Kerby, M. (2013). Nursing student voices: Reflections on an international service learning experience. *Kentucky Nurse*, *61*(1), 10–11.

McCay, D., Hill, A., Coates, V., O'Kane, M., & McGuigan, K. (2019). Structured diabetes education outcomes: Looking beyond HbA1C. A systematic review. *Practical Diabetes*, *36*(3), 86.

Mowbray, C. T., Collins, M. E., & Bellamy, C. D. (2005). Supported education for adults with psychiatric disabilities: An innovation for social work and psychosocial rehabilitation practice. *Social Work*, *50*(1), 7–20.

Murray, B. S. (2013). Service learning in baccalaureate nursing education: A literature review. *Journal of Nursing Education*, *52*, 621–626.

Nash, W., Mixer, S. J., McArthur, P. M.,Mendola, A., Jackson, K., Darlington, C., Spangler, B., Pressley, M., & Conley, E. (2018). Helping persons experiencing homelessness complete advance directives: A model for service learning within a community-academic partnership. *Journal of Community Engagement and Higher Education*, *10*(2), 30–38.

National Alliance on Mental Illness. (2020). *Legislative priorities*. https://namitn.org/advocacy/

National Center for Farmworker Health. (2018). *Farmworker fact sheet*. http://www.ncfh.org/uploads/3/8/6/8/38685499/naws_ncfh_factsheet_demographics_final_revised.pdf

Nutting, M. A., & Dock, L. L. (1935). *A history of nursing*. G. P. Putnam's Sons.

Powers, M. A., Bardsley, J., Cypress, M., Duker, P., Funnell, M. M., Fishcl, A. H., Maryniuk, M., Siminerio, L., & Vivian, E., (2016). Diabetes self-management and support in Type 2 Diabetes: A joint position statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics . . . reprinted with permission from Diabetes Care. *Clinical Diabetes*, *34*(2), 70–80.

Ruggiero, L., Modsiri, A., Butler, P., Oros, S. M., Burbaum, M. L., Whitman, S., & Cintron, D. (2010). Supporting diabetes self-care in underserved populations: A randomized pilot study using medical assistant coaches. *Diabetes Educator*, *36*(1), 127–131.

Seifer, S. D. (1998). Service learning: Community campus partnerships for health professions education. *Academic Medicine*, *73*, 273–277.

Shuan, M. E., Christina, E. N., & Watson, A. C. (2012). Effects of severe mental illness education on MSW student attitudes about schizophrenia. *Journal of Social Work Education*, *48*(3), 425–438.

Stallwood, L. G., & Groh, C. J. (2011). Service learning in the nursing curriculum: Are we at the level of evidence-based practice? *Nursing Education Perspectives*, *32*, 297–301.

Stone, W., Mixer, S. J., & Mendola, A. (2019). Culturally acceptable advance care planning and advance directives for persons experiencing homelessness. *Journal of Hospice and Palliative Nursing*, *21*(5), 350–357.

Tennessee Division of TennCare. (2016). *TennCare bureau enrollment reports for 2016*. https://www.tn.gov/tenncare/information-statistics/enrollment-data.html

U.S. Census Bureau. (2018). Tennessee quick facts. http://quickfacts.census.gov/qfd/states/47000.html

U.S. Department of Health and Human Services Health Resources and Services. (2018). *Administration shortage designation advisor*. https://datawarehouse.hrsa.gov/tools/analyzers/hpsafind.aspx.

Yancey, N. R. (2016). Community centered service learning: A transformative lens for teaching-learning in nursing. *Nursing Science Quarterly*, *29*(2), 116–111.