Abstract

COVID-19 presented challenges to the Health Coaches Program at the University of Arkansas. This undergraduate pre-professional health careers service-learning program has operated for over six years with success for improved patient health outcomes in Fayetteville, Arkansas through a partnership with Washington Regional Medical Center. This program partners students with vulnerable patients and a medical team for weekly patient visits and a reporting session with medical providers with the aim to further patient-centered goals within our local community population. With precautions for health safety during a pandemic, not only did the traditional classroom pedagogy shift, but our protocols in the field with our community partners, practices with remote technologies and patient relationships had to adapt quickly and have continued to evolve over the past nine months. The focus continues to be on strong communications, relationships and adaptive training through shared values for continued patient success.

Moving Forward in Protocols for an Undergraduate Pre-Medical Careers Service-Learning Program during COVID19

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Lady Gaga and COVID19

My aunt is dying of an early onset form of dementia. At my last visit, I reached out to touch her hair and she recoiled. In that instant in her eyes, I saw that she no longer knew who I was. It was the first time this experience has happened for me, loving someone you have known all your life who is going away. Before her illness, she was known for her quick wit, stories and practical jokes. She loved to laugh and make everyone around her laugh. A natural entertainer, in charades, her rendition of Lady Gaga wearing a meat dress killed (Her grandkids had put that entertainer's name in the bowl hoping to stump her). First, that anyone could accomplish translating such an image in a remarkably short time was phenomena, but also, that she was the kind of middle-aged person aware of personalities like the singer, and in the meat suit, and willing to take the risks to get all that into miming on the spot and accomplish it. She was surprising and fun.

University of Arkansas Health Coaches

This matters to the story I am about to tell about teaching undergraduate pre-med students in a service-learning community program because we, as practitioners in experiential learning, already bridge spaces in understandings and build on "soft skills" for students in the work, but now, in this "New Norm," we are often doing so at deeper levels and across technologies and traumas, some obvious and some not. Just how we make the

curriculum and programs adaptive, useful and evolving, and how do we know if we are on the right track? I am losing my aunt slowly, over many years. In my more traditional classes, I could teach literature and can talk at a distance through characters or scenes, metaphor, with small understanding about what loss might mean. It is largely theoretical. But, out in the world where our actual programs and partners occur, there are less easy answers or solutions for the adjustments, the protocols, and in a program dealing with elderly patients, death. Over the phone, this is tough to face.

The Health Coaches program at the University of Arkansas pairs teams of undergraduates who are medical humanities or pre-health professionals majors with vulnerable patients in our community who, pre-COVID19, went out to visit these patients weekly in their homes to assess and work toward wellness goals. They accompanied these patients to doctors' visits, at the patients' requests, to help in better understanding instructions and next steps. They often met and talked with family members and helped with community resources when needs arose. We operate in a team with medical professionals to accomplish this. My co-lead from the University, Dr. Fran Hagstrom, is a speech pathologist and comes from the College of Education and Health Professions; I teach English courses and come from the Fulbright College of Arts and Sciences, as the humanities and service-learning side of our partnership since I have worked in experiential and service-based projects both internationally and here in the US for over 15 years. Much of my work was in long term study abroad sites in villages in the developing world and with national programming to support local communities. Those international projects limited the kinds of students who could often afford to join them. I very much wanted to focus service-learning curriculum toward academically meaningful experiences alongside local community development and partners, and that was how I found my way into this medical humanities program. The students in this project come who want to pursue healthcare careers in diverse paths from nursing to general medical practice to occupational therapy, and it helps them learn more about their career choices and skillsets toward those. The program offers a series of three courses alongside field service that gives students something the classroom alone cannot—the chance to be with real patients and medical professionals to see how our healthcare system works to affect lives. It helps students better understand how lives are affected by many factors, individual and collective. Our lead doctors, Dr. Mark Thomas and Dr. David Ratcliff, are both skilled physicians, teachers and administrators; our nurses, Brooke Billingsley and Karen McIntosh, are dedicated and amazing communicators. We invite guest lecturers from many academic areas across campus to lend knowledge and guidance. Our patients say they are helping students in their career paths and callings.

At five years into the Health Coaches program, which was two years ago, and before COVID19, we saw the need to grow and adapt the materials from its beginnings with much technical and clinical information—necessary lectures like "Medicaid Versus Medicare: Understanding the Socio-Economic Gaps and Politics" and "Metabolic Syndrome"—to build out into the less tangible aspects of patient care, adding content such as strategies to develop more meaningful communications through motivational

interviewing, how to navigate professional interpersonal relationships (both the intimacies and distances necessary in this work), and how to shift and disrupt health narratives to empower an even fuller patient-centered goal setting process, among other things. Our hospital team took the initiative to ask for those kinds of instructions for the students. These lessons were occurring, of course, but there was a need for more targeted learning strategies as our program became stronger and the roles the students played in the patients' lives grew more vital to directly address the humanities issues. We were planning the curriculum adjustments to guide this work more formally and had begun to pilot some of these lesson plans and guest speakers with success.

Health Coaches has been one of our strongest service-learning models on campus, and it has been an effective tool to support improving individual health outcomes for the patients of our community partner, Washington Regional Medical Center, our largest hospital system in the city of Fayetteville, Arkansas. WRMC saw emergency room visits decrease from the population served and increased health literacies. So, we were gearing up to adapt our curriculum and to increase our student enrollment and patients to serve even larger populations, based on the strong foundation. Then, in year six, amid these adaptations in process, a pandemic hit. It changed everything.

Economics

In higher education, the benefits of a program like ours are undeniable toward intangible things like student personal growth successes, educational benefits and community outreach; but, we cannot escape the material, that budgets are based in student numbers in classes, majors and programs and ratios and outcomes. To be responsible and successful, service-learning programs, especially those working closely with vulnerable patients like ours, need dedicated and experienced oversight and guidance, and often, smaller numbers, which is how we began. Our program began enrolling around 15 students for the initial course. The intangible costs like faculty who work with community partners to manage the system gets added to the teaching and curriculum development mix, and, as practitioners know, this often lowers research output and publications. So, there is actually incentive built-in to not evolve and grow and increase numbers or curriculum change. In times of non-crisis, this ratio is often left outside monetary equations. These programs can be top-heavy, financially speaking, as well as in workload. Our university development offices promote these kinds of programs to our donors, and these are the same programs that alumni offices and admissions offices share with those on the outside to show how the academy reaches across the divide to forward meaningful intellectual exchanges into real world training, support and solutions for our communities. In shrinking economies' do-more-with-less principles, academic budgets must meet the needs for as many as they can. So, we were not unlike so many other service-learning programs in Health Coaches at year six, in early spring 2020, when the before-unimagined happened.

"We're due for a pandemic," Dr. Mark Thomas, Director of Population Health at Washington Regional Medical Center, prophetically said to the class last fall in the first series of our classroom training before students go out into the field. He added this as hyperbole to a lecture about the ways socio-economic factors affect medical choices disproportionately for those most disadvantaged and only to emphasize that tipping the balance for the public even in small ways has devastating effects, pointing at what could happen if a real unknown event occurred. He posed the question for students to imagine the implications for systems and what that could then mean in a worst-case scenario future. How could any of us have known then? The topics in that class had already looked on the strain building in current healthcare markets and the shrinking profit margins for hospitals, the regulations on those margins and the issues unfolding to provide adequate care for the most vulnerable. He highlighted the emergencies in rural areas for even the most basic services and providers. He explained to students how systemic insurance policies affect individuals in Arkansas, our state--how national and state politics made Patient X unable to receive specific care services or medications, and how that might arise in the day to day for our program work. The complexities are a lot for students to imagine.

Students in this program come from across two colleges, Arts and Sciences and Health Professions, and from disciplines like nursing and pre-professional health to psychology, medical humanities, biology and chemistry, and they do so to begin to apply the information they are learning in those paths toward deeper understandings of what those things mean for their future dreams to serve others as health care providers. For one example that occurs more often than not, when their patients, in homes that usually look very different from the ones they grew up in, do not exactly say that they are not filling certain prescriptions because doing so would mean choosing to not be able to pay the heating bill or their granddaughter's gas money or food or another sometime mounting medical expense (etc. etc.) for that month, Health Coaches undergrads have learned it takes time to learn the landscapes of these intersections, and they have learned how to ask sensitive questions about the patients' priorities, the costs, insurance issues and to take a note of all the medications prescribed at the latest visits (and on record through the hospital) to check with pharmacies and our nurses about other options that might be available that can help the patient better navigate the intricacies. They learn to keep building trust so that we are there to support patients' wellness in any and all the ways we can because many things are not directly said, or at least not easily or right up front. Relationships take time and continuity to build. One of the first ways the program was directly affected by the pandemic was economically; our summer funding was by necessity not possible after COVID19 hit. This program has operated year-round since its inception to support and follow patients for that established contact and trust, and though we do operate with less than our full student team, we have provided services and check-ins for all patients, even in summer previously. Cutting summer costs this past summer allowed us to operate into the unknown economies of what is now this next year.

Colleges and universities across the country face this health and economic crisis with no easy options. The University of Arkansas is the flagship higher education institute for the state, and here is what the pandemic meant more immediately for our support, from information shared from our Chancellor, Dr. Joseph Steinmetz: at first, last spring, it was reported that the State Legislature suggested cuts of around $8.2 million from the remaining overall budget of 2020. Cuts for this next year, approved on April 15, 2020, were for an additional $6 million, so that meant university-wide, we would operate at $116 million planned for 2021, away from the past projected $122 million. There was a Board of Trustees ruling supporting no tuition or fees increases for students during this crisis at the onset, so we are very dependent during a pandemic on holding enrollment and housing numbers, which at this writing, have been steady based off predicative indicators like orientation and housing agreements. And, since last spring, we have had some good news on our campus that COVID19 numbers are declining as of the end of September, most likely due to increased testing and quarantine spaces and isolation for students infected or exposed, which could mean the ability to stay on campus through the term safely, though with many classes in remote learning. And, from an update on September 30, 2020, these numbers reflected a more accurate picture for how the funding has evolved on our campus moving forward: the State Legislature actually cut $8.3 million from last year's budget but then restored all of that on the last day of the fiscal year. This academic year, University of Arkansas leadership budgeted for a $15.7 million reduction in state appropriations. Some or all of this may come back to us, as was possible this past year. We will know more in coming spring when state leaders have a better idea of actual state revenue. Tuition was kept flat. There have been an additional $6.3 million in losses through August 3, 2020, in COVID19-related expenses (for example, our campus has programs in summer that generate revenue like the Walmart Shareholders meeting that rents space for housing and meetings that did not happen this past summer; there were tuition cuts for summer classes which created the need to cut faculty summer teaching and programming, like ours). The COVID19 expenses/losses to campus revenue will likely be much higher when they are updated over the next several months. These are additional, unexpected expenses, and in this unknown, administrators often have to plan very conservatively. What we know for programs with a small faculty to student ratio in times of uncertainty and the need to generate tuition income, small programs are expensive and can therefore be vulnerable.

Shifting Program Protocols

Fast forward to the middle of New Norm where many of us find ourselves today and what this means for students and the work: Sally Barnes, a senior pre-med student was entering a medical program this fall and was an experienced Health Coach, who had been through the three-course training series and was volunteering her time because she loved the work. She was serving on a team to mentor younger students who were rising in our program, and it was April. Campus had shifted to remote learning last spring, beginning March 12.

Our hospital also regulated that we shift from in-person visits to remote phone check-ins for patient safety. This brought many challenges both for students and for patients. What had been at minimum an easy hour spent with students and patients who had come to know and like each other very much, was now sometimes awkwardness and silence over the phone. The average calls lasted about fifteen minutes. Patients expressed that they missed seeing the student teams and some could not understand or keep up with the phone calls to answer them. Our hospital partners remained dedicated to support the program while they shifted focus to additional work directly related to COVID19, so they still were available for texts and calls if students ran into immediate medical issues that needed to be reported; but, our hospital team could not be with us for our weekly sessions as before. The patients had adjustments to the loss of the socialization that they had come to expect with the students, and most became more isolated from family and friends not stopping by and visiting and offering the supports they had received before. Life and its health issues went on however. The students and I shifted to our online learning platform for anonymous reporting and talking on our personal cell phones when questions arose.

I am in my kitchen. Zoom is not yet the norm on our campus two weeks into campus shifting to remote learning that it later would become for us by this fall. It's midday, I'm wearing sweats. It's a Sunday. Sally, the student Health Coach, and I were processing the impending death of her patient who was in the final days of her life. What we would have done before was to be able to coordinate with Hospice care and to visit at our patient's bedside. To be physically present with a smile, a hand hold, an offer to the family to support them with community resources or guidance, while not easy, is often done in a way that so many words are not necessary. The gesture of showing up speaks volumes of understanding in these situations. Over the course of our program, our population is elderly with complex medical health issues, patients have passed. And for some deaths, we have known very clearly they were coming and been able to prepare for the losses together, sitting with doctors and nurses, faculty and classmates to process and plan for the experiences.

I remember distinctly looking out the window at times as Sally talked. The woman who was dying liked to garden, and I studied the new bed of oak leaf hydrangea just installed in the increased time at home to keep focused off a global epidemic. The new plants were getting cropped by deer in the evenings. Though I had not met this patient personally, in the circles I sat with the students and medical team each week, I knew intimately about her garden, her life, her health, just as I knew about another's grandson, one's extended tumultuous family lives, as well as the personalities and strengths of the students, and felt deep kinship and care to them. I knew that there were things not spoken by this student now, how in her calling and the day, that she simply wanted to have something to say or know to make better the gaps made even more uncrossable over the phone and in this shift between her and the patient dying, things that there was no way to convey before and made more difficult in this new medium and without much time to adjust to it. So, Sally and I talked very openly awhile about more simple things: how to have meaningful presence in a moment and exactly

what she could say, how she might be able to express her care over the phone. It was a moment we had planned for in class with a Hospice director who comes to present slides. That is a theory of death, and it is abstract. But death is an individual practice. We only get one. This student seemed worried that she might fail in this task somehow because the patient she had come to know so well was distant on their last call together. In our program, the shift to using phones rather than our regular face-to-face appointments had come so abruptly and by necessity for the physical well-being of our patients within one day, and it was only within a few weeks of this turn in this particular relationship that this moment had arrived. It was also my own shift from the classroom setting to the phone with the students. We were all feeling it out, but there was not time for much of a learning curve, and that was what I understood coming from Sally, on top of the usual terribleness of loss in death. Death, it seemed, she could have handled easier, had it been pre-COVID, where she could have seen her patient, held her hand one last time to assure her she was there and cared for her. But death, like life, does not happen clinically. So, I shared with her about the visit with my aunt that did not involve words because my aunt was beyond making sense of those or even of me anymore. I teach English which mostly means dealing in writing, reading and words. I shared with her what I knew of being in a moment, how moments will not be what we expect them to be, no matter how much looking or talking about them ahead of time we do. How the ability to be in those moments deeply comes and goes, takes experience and willingness and capacity to go beyond where we start—that these moments are felt more than thought out ahead. I am sure my words did not matter. The experience with my aunt only helped me to understand that plans change and some gaps cannot be crossed. Talking about those things on that day was not exactly metaphor and not exactly a direct translation for what this student was trying to make sense of and going through or for her next steps that would be her final contact with her patient. But, our talking like that was not meant to be. It was what was left of our classroom after it moved into fragmented, individual spaces via phone where we were all looking for ways to make things work. We talked for about an hour. Moments like that are the ones I return to as most important in my professional life. These are also essential for service learning work, being available and willing to find solutions and build our relationships and now, more than ever, as we have to shift with compassion and lean into uncertainty to adapt in mostly people-programs with the changes made necessary by social-distancing and technologies for that that works against all our usual people skills.

So, the parameters of how our service-learning program worked changed overnight, and the program is continuing to evolve to meet the patients' needs. Our plans for growth in our student numbers have been on hold, and we have not completed the curriculum adjustments planned for that growth, as yet because we await decisions on the long term support of the program, though we are working towards grants for funding at several levels and across two colleges. I could tell you generally that the program moved to a telehealth model over the medium of telephone, and it is successful. Both things are true. With each student team's individual accommodations and adjustments for their patient situations and relationships, the phone visits times are

increasing; we are moving up this fall from shorter calls in the spring to much longer ones, with an average of at least a half hour per call. Patients are getting used to the phone check-ins, but some have had a harder time remembering when these are and some do not answer the calls as regularly as they received the in-home visits. The regularly say that they miss seeing the students. One patient struggles to speak loudly enough over the phone for communication to be easy and clear. During this, we increased our patient load to accommodate another program eliminated by the pandemic; we have ten new patients, and these are patients that will only know Health Coaches through the phone visits. The phone visits will continue into Spring. Most of our patients do not have the technology for video conferences so those patients have remained in contact with our teams only via phone. Our classroom by this Fall regrouped into a Zoom virtual class, and our medical team rotates in one representative in and out of those because they are still in great demand at their work. With our hospital partner serving a college town, they have been operating at or near capacity for their COVID unit for the month of October, and we expect this number to increase as the months get colder, so we may shift again to not having as much contact with our medical team partners. There were challenges such as overcoming the summer months' lapse for the time that we did not meet in the lack of our summer school program: our patients were slow to respond and to set up schedules at first to the phone call visits, and the calls were shorter in time length, which means the information and relationships will likely be greatly reduced as well, which likely affected health outcomes over what we were able to do before. But, with each week, we see adaptations improving. The virtual classroom work has evolved to focus more on how to work with not only the patients over technologies but with a partner you can no longer see to get social cues from, mostly on three-way calls so that the conversations are smooth and not adding an additional layer of awkwardness or confusion for the elderly patients.

I share these stories because as we all move into realms of the unknown (in planning, teaching and executing), the solutions we find are human ones without clear answers sometimes. It can feel like fumbling between what we imagine and what is. We do not know how long we will be working remotely for our main campus classes or this program. We phased out bringing new students on board this term, in favor of focusing on our trained students and volunteers this year. As we take away connections and structures, funding and classrooms, and for our program, the very visit settings where we could sit with patients in their homes or appointments, we still find means to learn and support one another, though the planning and future may be very different from our shared vision pre-COVID-19. Our virtual classroom has been adaptable to the patient issues that arise each week. How do we operate and adapt when the unthinkable occurs, and ultimately, what do the people we are serving need as we move forward in the best ways we can? For us, so many of the visual, physical, informational and social cues in a medical support program are simply not there right now, and using a phone or even a screen just do not come close to our old ways of operating. Simply being near another, in a home or the classroom, was taken for granted—so much that we exchanged. But we are finding our ways.

About the author

Laura Gray has taught in the English Department at the University of Arkansas for the past twenty years. She became involved with service learning projects in Central America, Vietnam and Kazakhstan over 15 years ago. Her work toward local community engagement is in medical humanities and general studies with technical and professional writing student service projects. Her email contact: lgray@uark.edu