

Assessing social accountability in health professions education: bridging the gap between interest and implementation

Amy Clithero-Eridon¹, Arshia Chhabra², Brian Zamora³, and Yeojin Park³

¹PhD, MBA, Principal Lecturer, University of New Mexico School of Medicine, Department of Family & Community Medicine, Albuquerque, New Mexico, United States

²BA, Medical Student, University of New Mexico School of Medicine, Albuquerque, New Mexico, United States

³BS, Medical Student, University of New Mexico School of Medicine, Albuquerque, New Mexico, United States

Abstract

Social accountability (SA), defined as aligning health professional education, research, and service with community needs, remains inconsistently implemented across institutions. The Individualized Social Accountability Tool (ISAT) provides a structured framework for assessing and benchmarking SA across institutions. However, low adoption rates limit its full potential, and barriers to implementation remain poorly understood. We conducted a cross-sectional study using two surveys distributed via REDCap to current ISAT users (N=50) and interested adopters (N=62). Descriptive statistics were used to characterize responses. Open-ended responses were analyzed using a thematic qualitative approach with frequency counts to contextualize key themes. Response rates were 24% for both surveys (12/50 users; 15/62 interested). Respondents represented diverse global regions, including North America, Sub-Saharan Africa, and the Middle East. While 79% (N=11) agreed that SA is

important, only 40% reported it as a high institutional priority. Faculty development was limited: 43% reported no SA training, and 29% offered training only upon request. Despite this, 86% of institutions expressed interest in using ISAT. Identified barriers included limited resources, unfamiliarity with the tool, and financial constraints. There is a clear gap between the perceived importance of SA and institutional prioritization and implementation. ISAT use appears promising in increasing awareness, particularly in identifying discrepancies between perceived and actual SA performance. However, structural and resource-related barriers limit adoption. Addressing these gaps may require shifts in institutional culture, targeted faculty development, policy adjustments, and stronger evidence demonstrating ISAT's impact to fully realize its potential.

Keywords: Social Accountability, assessment, Health Professional School

Date submitted: 17-April-2026

Email: Amy Clithero-Eridon (aclithero@salud.unm.edu)

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-Non Commercial-Share Alike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

BACKGROUND

Social Accountability (SA) has been defined by the World Health Organization as the responsibility of health professional organizations to align their education, research, and service activities with the health needs of the communities they serve.¹ SA extends beyond social responsibility (implicit commitment to societal welfare) and social responsiveness (directing activities toward explicitly identified health priorities): socially accountable schools collaborate with local communities and demonstrate impact (Table 1).² Health professional schools, especially publicly

Citation: Clithero-Eridon A, Chhabra A, Zamora B, and Park Y. Assessing social accountability in health professions education: bridging the gap between interest and implementation. *Educ Health* 2026;39:272- 281

Online access: www.educationforhealthjournal.org
DOI: 10.62694/efh.2026.682

Published by The Network: Towards Unity for Health

funded ones, have an ethical responsibility to their communities and are increasingly expected to demonstrate impact on individual and community well-being. There is also movement to embed SA as an accreditation mandate beyond Canada, where it is already embedded.³⁻⁶

Tools that support institutions in measuring and improving accountability are therefore essential. The Training for Health Equity Network (THEnet) framework allows schools to select context-appropriate indicators and has been validated across settings.⁷ The REVOLUTIONS framework

Table 1: Social Obligation Scale²

	Category	Item	Value	Unit
Category 1	Item 1	100	kg	
	Item 2	200	kg	
	Item 3	300	kg	
	Item 4	400	kg	
	Item 5	500	kg	
	Item 6	600	kg	
	Item 7	700	kg	
	Item 8	800	kg	
	Item 9	900	kg	
	Item 10	1000	kg	
Category 2	Item 11	1100	kg	
	Item 12	1200	kg	
	Item 13	1300	kg	
	Item 14	1400	kg	
	Item 15	1500	kg	
	Item 16	1600	kg	
	Item 17	1700	kg	
	Item 18	1800	kg	
	Item 19	1900	kg	
	Item 20	2000	kg	
Category 3	Item 21	2100	kg	
	Item 22	2200	kg	
	Item 23	2300	kg	
	Item 24	2400	kg	
	Item 25	2500	kg	
	Item 26	2600	kg	
	Item 27	2700	kg	
	Item 28	2800	kg	
	Item 29	2900	kg	
	Item 30	3000	kg	
Category 4	Item 31	3100	kg	
	Item 32	3200	kg	
	Item 33	3300	kg	
	Item 34	3400	kg	
	Item 35	3500	kg	
	Item 36	3600	kg	
	Item 37	3700	kg	
	Item 38	3800	kg	
	Item 39	3900	kg	
	Item 40	4000	kg	
Category 5	Item 41	4100	kg	
	Item 42	4200	kg	
	Item 43	4300	kg	
	Item 44	4400	kg	
	Item 45	4500	kg	
	Item 46	4600	kg	
	Item 47	4700	kg	
	Item 48	4800	kg	
	Item 49	4900	kg	
	Item 50	5000	kg	
Category 6	Item 51	5100	kg	
	Item 52	5200	kg	
	Item 53	5300	kg	
	Item 54	5400	kg	
	Item 55	5500	kg	
	Item 56	5600	kg	
	Item 57	5700	kg	
	Item 58	5800	kg	
	Item 59	5900	kg	
	Item 60	6000	kg	
Category 7	Item 61	6100	kg	
	Item 62	6200	kg	
	Item 63	6300	kg	
	Item 64	6400	kg	
	Item 65	6500	kg	
	Item 66	6600	kg	
	Item 67	6700	kg	
	Item 68	6800	kg	
	Item 69	6900	kg	
	Item 70	7000	kg	
Category 8	Item 71	7100	kg	
	Item 72	7200	kg	
	Item 73	7300	kg	
	Item 74	7400	kg	
	Item 75	7500	kg	
	Item 76	7600	kg	
	Item 77	7700	kg	
	Item 78	7800	kg	
	Item 79	7900	kg	
	Item 80	8000	kg	
Category 9	Item 81	8100	kg	
	Item 82	8200	kg	
	Item 83	8300	kg	
	Item 84	8400	kg	
	Item 85	8500	kg	
	Item 86	8600	kg	
	Item 87	8700	kg	
	Item 88	8800	kg	
	Item 89	8900	kg	
	Item 90	9000	kg	
Category 10	Item 91	9100	kg	
	Item 92	9200	kg	
	Item 93	9300	kg	
	Item 94	9400	kg	
	Item 95	9500	kg	
	Item 96	9600	kg	
	Item 97	9700	kg	
	Item 98	9800	kg	
	Item 99	9900	kg	
	Item 100	10000	kg	

describes attributes of socially accountable medical education but not how to assess progress.⁸ The Indicators for Social Accountability Tool (ISAT) offers a structured way to evaluate SA efforts and enables benchmarking across institutions.⁹ Early adopters report using ISAT to strengthen community partnerships and target research toward population needs, yet programs often express interest while lacking guidance, clarity, or capacity for uptake.^{10,11} We do not fully understand the barriers institutions face when implementing a whole-institution review, or why some programs express interest but never adopt a free, expert-supported tool like ISAT. This study investigates both implementation and non-implementation to assess effectiveness, identify barriers, and increase the tool's accessibility, usability, and global integration.

METHODS

Design

We used a cross-sectional, observational design to evaluate ISAT utilization experiences, institutional readiness, and barriers to uptake.

Sample and Recruitment

The sampling frame consisted of contact lists supplied by the ISAT host organization, The Network: Towards Unity for Health (TUFH).^{12,13} The first group comprised healthcare leaders who expressed interest in ISAT after a May 2025 informational email but did not follow through; respondents who did not recall receiving this information were exited from the survey. The

second group comprised organizational leaders who had completed, or were completing, the ISAT. All individuals on each list were invited by email; no additional selection criteria were applied. Because the frame included only institutions already connected to the TUFH network, respondents cannot be considered representative of all higher-education institutions in their regions.

Data Collection

Both groups completed an electronic survey administered via REDCap, a database hosted at the University of New Mexico.¹⁴ Surveys were distributed between December 2025 and January 2026, with three weekly reminders.

Instrument Development

The two instruments (Appendices 1 and 2) were developed by the research team. Interest-survey items characterizing institutional SA (student recruitment, faculty development, learning-site location, community-targeted research, and community representation in governance) were derived from a validated SA framework.⁷ User-survey items mapped to each ISAT process stage, probing usefulness, successes, and barriers, with open-ended items eliciting advice for future adopters. Instruments were reviewed for face and content validity by the research team and TUFH ISAT leadership, but were not formally piloted.

Data Analysis

REDCap provided descriptive statistics.¹⁴ Given small group sizes, no between-group statistical

comparisons were attempted. Open-ended responses were thematically analyzed by A.C.E., A.C., and B.Z. using a concise approach, with frequency counts for context.¹⁵

Reflexivity

The research team is affiliated with a TUFH member institution, and A.C.E. has a role within the TUFH network; findings are reported in TUFH's official journal. No author developed the ISAT or holds a financial interest in it. To mitigate favorable-interpretation bias, authors coded independently before consensus, negative findings (non-adoption, difficulty, low prioritization) are reported in full, and implications for TUFH are addressed in the Discussion.

Ethics

The University of New Mexico Human Research and Review Committee approved this study (HRRC#25-425).

RESULTS

We achieved a 24% response rate for both surveys: 12 of 50 ISAT users and 15 of 62 interested adopters responded. One respondent did not recall learning about ISAT, leaving 14 responses to post-demographic questions.

Interested, but did not adopt ISAT

Medical schools accounted for most respondents (N=11, 73%); nursing, allied health, and pharmacy each had one response; and one respondent represented an entire health science center. Regions represented were North America (33%), Sub-Saharan Africa (27%), the Middle East (20%), and Asia, Europe, and South America (7% each). Most reviewed the tool (N=9, 64%) and were very familiar with the term “social accountability” (N=9, 64%). Institutional SA parameters are shown in Table 2. Faculty development was limited: six schools (43%) never trained faculty on community-engaged teaching or SA principles, and four (29%) offered training only upon request. Research projects targeting priority community health needs are shown in Figure 1.

Most respondents (N=11, 79%) agreed on SA importance, citing ethical obligations to the communities that fund them, health equity, and

institutional prestige. However, only six schools (40%) rated progress toward SA as an essential or high priority. Institutions reported external requirements shaping assessment activities: accreditation, government mandates, funding, and professional guidelines.

Although 14 institutions (86%) remain interested in using ISAT, respondents reported unfamiliarity with the platform, resource constraints, particularly the lack of “financial support,” and the “extensive amount of human resource and time” required. One respondent described the instrument as “alien” at their institution. Respondents also wanted demonstrated value, such as evidence that the tool can “enhance funding structures to advance our work and impact.”

Current ISAT Users

One-half of the user respondents had completed the ISAT process, one-third were working toward completion, and the remainder had gathered core teams and initiated planning. Time to completion ranged from one month to over six months. Core team composition and the difficulty of engaging each cohort are shown in Table 3, and barriers are listed in Table 4. Successes to date are captured in Table 5; 42% (N=5) indicated that the process positively changed community perception of the organization. More than one-half (67%) of users found discrepancies between institutional self-perception and actual assessment results, and all agreed the process raised awareness and sparked new conversations or initiatives.

User advice for future adopters converged on three themes: build a culture of social accountability first, including a structured orientation phase; assemble a passionate, diverse team representing “faculty or academic leaders, institutional staff, students, and community partners,” with roles defined early; and sustain engagement longitudinally, using ISAT to “strengthen partnerships and organizational culture, not just to produce a report.”

DISCUSSION

No universal indicator determines an ideal level of SA for all contexts, but this should not prevent introspection. ISAT provides a customizable

Table 2: Social Accountability Parameters for Health Professional Schools

Parameter	Value	Unit	Frequency
1. Academic Performance	85%	Percentage	Annual
2. Research Output	10	Projects	Biennial
3. Community Engagement	50%	Percentage	Annual
4. Financial Transparency	90%	Percentage	Annual
5. Student Satisfaction	80%	Percentage	Annual
6. Faculty Satisfaction	75%	Percentage	Annual
7. Alumni Satisfaction	70%	Percentage	Annual
8. Public Health Impact	15	Projects	Biennial
9. Environmental Sustainability	85%	Percentage	Annual
10. Social Responsibility	80%	Percentage	Annual

Table 3: Core Team Composition

Team	Chair	Members	Advisors	Observers
1. Academic Council	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
2. Research Committee	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
3. Community Engagement	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
4. Financial Transparency	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
5. Student Satisfaction	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
6. Faculty Satisfaction	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
7. Alumni Satisfaction	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
8. Public Health Impact	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
9. Environmental Sustainability	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray
10. Social Responsibility	Dr. John Doe	Dr. Jane Smith, Dr. Michael Brown	Dr. Emily White, Dr. David Green	Dr. Robert Black, Dr. Lisa Gray

Figure 1: Research projects that target priority community health needs



Table 4: Barriers to ISAT

Barrier	Frequency
Lack of resources	10
Lack of training	8
Lack of time	7
Lack of buy-in	6
Lack of data	5
Lack of communication	4
Lack of leadership	3
Lack of support	2
Lack of knowledge	1
Lack of motivation	1

Table 5: Domains with the most significant changes within organizations using the ISAT tool

Domain	Change
Leadership	10
Communication	8
Training	7
Resources	6
Time	5
Data	4
Buy-in	3
Support	2
Knowledge	1
Motivation	1

baseline; without one, there can be no targeted reform.

Our findings reveal a disconnect between the perceived importance of SA (79%) and institutional prioritization (40%). Barriers to adoption were multifactorial: competing priorities, time and resources, leadership inertia, unfamiliarity, and the need for evidence of long-term impact. When schools must choose between accreditation metrics and SA, SA becomes aspirational rather than essential.

Although not designed a priori around an implementation framework, the barriers and facilitators we identified map readily onto the

Consolidated Framework for Implementation Research (CFIR) domains: innovation characteristics (unfamiliarity, adaptability, evidence strength), inner setting (culture, leadership, resources), outer setting (accreditation and funding policy), individuals (champions, including students), and implementation process (orientation, team formation, sustained engagement) (Figure 2).¹⁶ Future evaluations should apply CFIR prospectively, or RE-AIM, whose maintenance dimension aligns with users' call for longitudinal engagement.¹⁷

For TUFH, as custodian of the ISAT, these findings have implications: interest alone does not translate into adoption. Structured onboarding materials,

Figure 2: Barriers and Facilitators to ISAT Adoption, Organized by CFIR Domain

Outer Setting	Inner Setting	Individuals	Implementation Process	Innovation Characteristics
Barriers: - Accreditation metrics vs. SA - Competing priorities - Time and resources - Leadership inertia - Unfamiliarity - Need for evidence of long-term impact Facilitators: - Accreditation metrics - SA as aspirational	Barriers: - Culture - Leadership - Resources Facilitators: - Culture - Leadership - Resources	Barriers: - Champions - Students Facilitators: - Champions - Students	Barriers: - Orientation - Team formation - Sustained engagement Facilitators: - Orientation - Team formation - Sustained engagement	Barriers: - Unfamiliarity - Adaptability - Evidence strength Facilitators: - Unfamiliarity - Adaptability - Evidence strength

worked case examples, dedicated implementation support, and a published evidence base demonstrating ISAT's impact will likely determine whether the tool achieves its benchmarking potential.

Limitations include a low response rate (24%), although nearly all world regions were represented. The TUFH-derived sampling frame cannot be considered representative of higher-education institutions in these regions, and self-selection by respondents with strong views on SA is possible. In addition, the instruments were not formally piloted. Finally, respondents were institutional leaders; the

perspectives of students and junior faculty were not captured.

KEY RECOMMENDATIONS

Institutional level: Build a culture of SA before assessment; provide structured orientation and faculty development; assemble diverse teams with defined roles that include students and junior faculty, who often champion SA where leadership is hesitant, and embed ISAT longitudinally rather than as a one-time report.

National level: Accreditors, governments, and funders should incentivize SA assessment through

accreditation and funding requirements to counter competing institutional priorities.

Regional and global levels: TUFH and partner networks should provide onboarding resources, implementation support, and peer mentoring across institutions, and build the evidence base for ISAT's impact.

the practical implementation of the ISAT. Although interest is high, adoption remains limited by resource constraints, unfamiliarity, and perceived lack of evidence. Importantly, engaging with ISAT increased SA awareness and revealed discrepancies between perceived and actual performance, demonstrating this tool works as intended.

CONCLUSION

This study highlights a disconnect between the perceived importance of social accountability and

References

1. Boelen C, Heck J. Defining and measuring the social accountability of medical schools. *World Health Organization* 1995. <https://www.who.int/publications/i/item/defining-and-measuring-the-social-accountability-of-medical-schools>
2. Boelen C, Dharamsi S, Gibbs T. The social accountability of medical schools and its indicators. *Education for Health* 2012; 25: 180. <https://doi.org/10.4103/1357-6283.109785>
3. Lindgren S, Karle H. Social accountability of medical education: Aspects on global accreditation. *Medical Teacher* 2011; 33: 667–672. <https://doi.org/10.3109/0142159X.2011.590246>
4. Kaufman A, Scott M, Andazola J, Fitzsimmons-Pattisen, D, Parajon L. Social accountability and graduate medical education. *Family Medicine* 2021; 53: 632–637. <https://doi.org/10.22454/FamMed.2021.160888>
5. About CACMS. *CACMS | CAFMC*, <https://cacms-cafmc.ca/about-cacms/> (Accessed 15 July 2026).
6. Boelen C, Woollard B. Social accountability and accreditation: a new frontier for educational institutions. *Medical Education* 2009; 43: 887–894. <https://doi.org/10.1111/j.1365-2923.2009.03413.x>
7. Ross SJ, Preston R, Lindemann IC, Matte M, Samson R, Tandico F, Larkins S, Palsdottier B, Neusy AJ. . The training for health equity network evaluation framework: a pilot study at five health professional schools. *Education for Health* 2014; 27: 116. <https://doi.org/10.4103/1357-6283.143727>
8. Ventres W, Dharamsi S. Socially accountable medical education—the REVOLUTIONS Framework. *Academic Medicine* 2015;90:1728. <https://doi.org/10.1097/ACM.0000000000000872>
9. Social Accountability Health, <https://socialaccountabilityhealth.org/> (Accessed 15 July 2026).
10. Barber C, van der Vleuten C, Leppink J, Chahine S. Social accountability frameworks and their implications for medical education and program evaluation: a narrative review. *Academic Medicine* 2020; 95: 1945–1954. <https://doi.org/10.1002/lrh2.10277>
11. Wood B, Fitzgerald M, Kendall C, Cameron E. Integrating socially accountable health professional education and learning health systems to transform community health and health systems. *Learning Health Systems* 2021; 5: e10277. <https://doi.org/10.1002/lrh2.10277>
12. Home. *The Network: TUFH*, <https://thenetworktufh.org/> (Accessed 15 July 2026).

13. De Maeseneer J, Clithero-Eridon A, DeKempeneer A, Kaufman A, Bor D, Cameron I, Woollard R, Strasser R, Burdick W, Torres N. A network of networks: education for health. *Education for Health* 2019; 32: 36–40. https://doi.org/10.4103/efh.EfH_203_19
14. Harris PA, Taylor R, Thielke R, Payne J, Gonzalez N, Conde J. Research electronic data capture (REDCap)—A metadata-driven methodology and workflow process for providing translational research informatics support. *Journal of Biomedical Informatics* 2009; 42: 377–381. <https://doi.org/10.1016/j.jbi.2008.08.010>
15. Qualitative Methods in Health Research - qualitative research in health care - Wiley Online Library, <https://onlinelibrary.wiley.com/doi/10.1002/9780470750841.ch1> (Accessed 15 July 2026).
16. Damschroder LJ, Aron DC, Keith RE, Kirsh SR, Alexander J, Lowery J. Fostering implementation of health services research findings into practice: a consolidated framework for advancing implementation science. *Implementation Science* 2009; 4: 50. <https://doi.org/10.1186/1748-5908-4-50>
17. Glasgow RE, Vogt TM, Boles SM. Evaluating the public health impact of health promotion interventions: the RE-AIM framework. *American Journal of Public Health* 1999; 89: 1322–1327. <https://doi.org/10.2105/AJPH.89.9.1322>

Appendix 1: Survey questions for those who were invited to complete the ISAT—but did not

1. As the primary respondent on this survey, what type of health professional school are you answering on behalf of? (Select ONE)
 - a. Allied Health
 - b. Medical School
 - c. Nursing
 - d. Public Health
 - e. Dental
 - f. Other (free text)
2. What country is your academic institution located in? (list the countries for them to select)
3. Do you remember receiving an email in May 2025 from The Network: TUFH regarding the ISAT tool? (need to spell out potentially)
 - a. Yes
 - b. NO...If no - then stop survey
4. Have you reviewed the ISAT tool? Yes/No/Don't remember
5. How familiar are you with the term “social accountability”?

1 = Not at all familiar

2 = Somewhat familiar

3 = Very familiar
6. “Does your institution have specific criteria to recruit students from underserved or marginalized communities?” Yes/No
7. “How frequently does faculty receive training on community-engaged teaching or social accountability principles?” (Never / Annually / Biannually / Quarterly)
8. “Are learning sites situated in underserved communities?” Yes/No
9. “What percentage of research projects at your institution target priority health needs in your community?” (0–25 %, 26–50 %, 51–75 %, 76–100 %, Unknown)
10. “Does your institution include community representatives on its governance or planning board?”
11. Is it important for your school to be recognized as socially accountable?
 - a. Yes
 - i. If yes, why?

- b. No
 - i. If no, why?
- 12. How motivated is your school in progressing towards social accountability?
 - a. Not a priority
 - b. 2 – Low priority
 - c. 3 – Somewhat priority
 - d. 4 – Neutral
 - e. 5 – Moderate priority
 - f. 6 – High priority
 - g. 7 – Essential priority
- 13. If yes to Q12, why are you motivated? (free text)
- 14. How does your school currently measure or evaluate your institution's social responsibility? (free-text)
- 15. What external pressures or requirements influence your institution's assessment activities?
 - a. Accreditation bodies
 - b. Government mandates
 - c. Funding requirements
 - d. Professional associations
- 16. Are you interested in using the ISAT tool to help you progress towards becoming socially accountable? (<https://socialaccountabilityhealth.org/self-assessment/>)
 - a. Yes
 - b. No
 - i. If yes to Q16, then what are the barriers to using the ISAT tool?
 - ii. If no to Q16, why not? (free text)
 - 1. If no to Q16, what outcomes would need to be demonstrated to change your perspective?

Appendix 2: Survey questions for those who have completed the ISAT

Have you completed the ISAT tool? (if yes, go to [Q3](#). If no - go to Q2)

- 1. Have you recently started using the ISAT tool and are currently working towards completion?
- 2. Who is on your core project team? (choose all that apply)
 - a. Deans
 - i. Why did you select a Dean?
 - b. CEOs
 - i. Why did you select a CEO?
 - c. Faculty
 - i. Why did you select the faculty?
 - d. Staff
 - i. Why did you select the staff?
 - e. Health Professional Students
 - i. Why did you include health professional students?
 - f. Community Members
 - i. Why did you select community members?
 - g. Other
 - i. Describe (free text)
 - 1. Why did you select these personnel?
- 3. Which stakeholder groups have been the most difficult to engage?
 - a. Deans
 - b. CEOs
 - c. Faculty
 - d. Staff
 - e. Students
 - f. Community members
 - g. Other
 - h. None—all were easy to engage
- 4. If Q5 a–g answered then, Why were they difficult to engage? How did you finally succeed in engaging them? (free text)
- 5. What advice do you have for assembling a strong ISAT project team? (free-text)
- 6. To the best of your knowledge, how long did it take you to complete the ISAT process, including gathering your project team? (If they select “completed ISAT in Q1, they will receive this question)
 - a. Less than one week (7 days)
 - b. 2–4 weeks (one month)
 - c. 1–3 months
 - d. 4–6 months
 - e. More than 6 months

7. What barriers have you encountered with using the ISAT tool? (choose all that apply)
 - a. Time
 - b. Resources
 - i. Personnel
 - ii. Money
 - iii. Space
 - iv. Competing priorities
 - v. Technical capacity or expertise
 - vi. Other (free text)
8. Think about the Action Plan—How useful was it?
 - a. 0 = Not able to determine
 - b. 1 = Not useful
 - c. 2 = Useful
9. If they answered C in Q8, then, what was the most useful part of the ISAT process to your organization (free text)
10. After completing the tool, which domains saw the most significant changes within your organization? (for those who have completed)
Rank the top three:
 - a. Student recruitment, selection, and support
 - b. Faculty recruitment
 - c. Faculty development
 - d. Curriculum content
 - e. Curriculum learning methods
 - f. Curriculum types and locations of educational experiences
 - g. Interprofessional education
 - h. Interprofessional collaborative practice
 - i. Community-based, community-engaged, and socially accountable research
 - j. Governance
 - k. Stakeholder and partner engagement
 - l. School/graduate outcomes
 - m. Societal impact
11. Thinking about how the assessment process has influenced discussions about social accountability at your institution...
 - a. Has it raised awareness about social accountability concepts? Yes/No
 - b. Has it sparked new conversations or initiatives? Yes/No
12. What successes have resulted from using the ISAT tool in your organization?
 - a. Changes to institutional planning documents
 - b. Change in resource allocation
 - c. Strengthened partnerships with community organizations
 - d. Changed how you engage with different stakeholder groups for the better
 - e. Changed the community perception of your organization in a positive way
13. How easy was it to implement changes that resulted from the Action Plan? (Only those who have completed it would get this question.)
 - a. 1 = Very difficult
 - b. 2 = Difficult
 - c. 3 = Neutral
 - d. 4 = Easy
 - e. 5 = Very easy
14. How well does the tool accommodate different institutional types and contexts? (Likert Scale)

1 = Very difficult

2 – Difficult

3 – Neutral

4 – Easy

5 – Very easy
15. Were there significant discrepancies between your self-perception and the assessment results? (Or are they appearing for those currently going through the process) Yes/No
16. What advice would you give an organization interested in implementing ISAT at their organization? (free text)
17. What advice would you give to the project team responsible for implementing the ISAT tool? (free text)