A Community Development Approach in Physical Therapist Education

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Authors/Affiliation:
Kimberly Varnado, PT, DPT, DHSc\(^1\); Anne Mejia-Downs, PT, MPH, PhD\(^1\); Alexander Scharmann, PT, DPT\(^1\); Shannon Richardson, PT, DPT, EdD\(^1\)

\(^1\) Doctor of Physical Therapy Program, College of Saint Mary, Omaha, NE
Address all correspondence to Dr Varnado at: kvarnado@csm.edu.

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Abstract

Physical therapists should be able to screen patients for social determinants that impact health and refer to community resources as appropriate. To make appropriate referrals, physical therapists must equip themselves with skills to connect patients and clients to community resources outside the walls of their respective institutions, starting with developing these practices in physical therapist education programs.

Experienced community builders recommend a community development approach where residents initiate and agree upon decisions, and outside stakeholders work as partners to elevate the community. The community should be supported to determine the desired outcomes in ways that enhance equity, inclusion, and social justice. Communities play a substantial role in health outcomes. Studies indicate that 85% of one's health is connected to community and economic resources, while only 15% is affected by medical interventions. Connected communities are potent tools to enhance health. Connected communities are places where residents nurture neighborhood relationships that enable them to work together to create a good life supporting their collective well-being.

The community-builder approach recenters people and their communities as fundamental health leaders; institutions can use their resources to elevate communities by relocating authority back to communities. Communities have assets and resources largely unrecognized, disconnected, and not mobilized by residents. Institutions are positioned to support citizens and their associations in discovering, connecting, and mobilizing these assets. This asset-based community development (ABCD) approach focuses on 5 principles: place-based, citizen-led, relationship-oriented, asset-based, and inclusion-focused.
This perspective paper will describe ways institutions can elevate communities; the benefits of community development practices in physical therapist education programs; and explore examples of community partnerships and best practices to develop equitable alliances with residents in the community.

**Impact**

A large part of one's health is directly related to where one lives. Physical therapists and physical therapist assistants can play a vital role in improving the health of society by engaging in their local communities through community development. Community development is a practice where community members and outside stakeholders, such as physical therapists, come together to meet the needs of a community.
"Real education means to inspire people to live more abundantly, to learn to begin with life as they find it and make it better..." Carter G. Woodson.1(p17)

**Historical Underpinnings**

In 1933, Carter G. Woodson\(^1\) underscored the connection between sociopolitical-economic and environmental causes of ill health in his revolutionary novel, *The Mis-Education of the Negro*. Woodson cautioned against pathologizing race and reframed the discussion to focus on the perils of segregation that forced Black Americans to live in deplorable conditions. He identified illnesses affecting Black Americans as related to social determinants of health (SDOH) and directly asked healthcare practitioners for assistance. It has been ninety years since Woodson's publication, and unfortunately, little progress has been made to address health disparities in historically marginalized and excluded groups.\(^2\)

**Introduction**

In recent years, the physical therapist community has begun to discuss the impact of SDOH on health behavior as it relates to musculoskeletal recovery.\(^3\) Rethorn et al\(^3\) encouraged clinicians to screen for SDOH because it can reveal adverse conditions beyond the scope of clinical care. But they also highlight that screening for SDOH without appropriate referrals to community resources is ineffective and potentially unethical.\(^3\) To make appropriate referrals, faculty, students, and clinicians must equip themselves with skills to connect citizens to community resources outside the walls of their respective institutions and clinics.\(^3\) However, do physical therapist education programs or continuing education courses prepare providers with the necessary skills to promote collective action within their communities to connect people to resources to help support their health journey? Do physical therapists and physical therapist assistants believe it's their role to serve the profession in this capacity? This perspective paper
describes ways institutions can use an asset versus a deficit-based approach to elevate communities. It explores the benefits of community development practices in physical therapist education programs. It also provides examples of community partnerships and best practices to develop equitable alliances with residents in the community.

The Role Community Plays in Health

In the United States, health outcomes and life expectancy are connected to where one lives. It is estimated that up to 60% of a person's health is determined by their zip code rather than their genetic code. Additional factors impacting lifespan include personal behaviors, social relationships, neighborhood safety, income, and access to quality education, food, and housing. Poverty is the most reliable predictor of poor health outcomes. Studies indicate that 85% of one's health is connected to community and economic resources, while only 15% is affected by medical interventions. Putman reports that community connections between neighbors and local associations are powerful, underutilized tools that can reduce the risk of premature death by 50%; therefore, living in disconnected communities is harmful. In disconnected communities, neighbors are separate from one another, and there is a focus on individual survival over community health. Russell and McKnight define connected communities as places where residents nurture neighborhood relationships that enable them to work together to create a good life supporting their collective well-being.

Paradigm Shift

In researching this topic, the authors encountered different paradigms and vocabulary used by community builders to empower populations. For example, many community engagement efforts leverage a deficit-based approach whereby individuals external to the community, such as paid professionals, solicit community stakeholders, identify problems,
suggest agency-driven solutions, and place community members in a passive role. Therefore, community engagement is not the preferred approach of community builders because the following traits often characterize it:

- Decision-making power rests with those least impacted by the decisions.
- Those outside communities assume the authority to define problems and solutions unilaterally.
- Outcomes are set by those external to the community who are least affected by the efforts.

Thus, community builders recommend using an asset-based community development approach that includes the following:

- Openly and routinely review power relations between community members and outside actors.
- Start in the community and branch out to support and provide resources to help residents build power.
- Let citizens identify their concerns and possibilities.
- Enable the community to agree on solutions and responses to community issues before external actors are leveraged.
- Support the community to determine the desired outcomes in ways that enhance equity, inclusion, and social justice.

In addition, some of these paradigms highlight the unintended harm caused by "helping healthcare professionals" who label people as patients and clients to sell services that create dependency. For example, in the traditional medical model, providers are often viewed as the unilateral producers of health and well-being. In contrast, community builders propose a
different approach where healthcare professionals intentionally co-create health with citizens by recognizing that communities, when connected, have innate health-producing capacities. "Most medical leaders advocate nonmedical community health initiatives because they recognize that their medical systems have reached the limits of their health-giving power." 6(p88)

**Elevating Communities Using an Asset-Based Community Development Approach**

An alternative to traditional narratives where clinicians and institutions are the primary producers of health and wellness, the community-builder approach re-centers people and their communities as the fundamental health leaders. Institutions can use their resources to elevate by relocating authority back to communities. 6 However, to uplift communities, institutions must understand that communities' gifts, talents, and resources are present. Communities have assets and resources largely unrecognized, disconnected, and not mobilized by residents. Institutions are positioned to support citizens and their associations in discovering, connecting, and mobilizing these assets. 7 Thus, the community development process starts with a paradigm shift from a deficit-based to an asset-based perspective. See the Table for a comparison of these approaches. Institutions identify what is present (i.e., the capacity of the residents), not what is absent or problematic. In the community development literature, this process starts with identifying what's strong and not what's wrong. 6

Institutions can co-create health with citizens using an asset-based community development (ABCD) approach. ABCD focuses on how local residents grow collective efficacy through their assets, gifts, skills, passions, networks, associations, resources, physical spaces, and shared cultural experiences. 10 The five core principles of ABCD are place-based, citizen-led, relationship-oriented, asset-based, and inclusion-focused. 11 Place-based refers to seeing the neighborhood as the primary unit of change to address socio-economic challenges. Citizen-led
involves creating solutions from the inside out. Residents in the community begin forming solutions, and outside partners are secondarily engaged if needed. In ABCD, every person has irreplaceable gifts, skills, and talents. Therefore, communities that are relationship-oriented tend to rely on the power of collective effort. Asset-based refers to starting with what is strong within a community and not what's wrong. The inclusion-focused core principle highlights the importance of belonging and inviting people on the margins socially, politically, economically, and culturally to the center. The primary goal of ABCD is to amplify collective citizen visioning and production through a process that uses all four essential elements of the ABCD process, including resources, methods, functions, and evaluation.

In communities, institutions can identify resources, including the six assets used to enhance local well-being (i.e., resident contributions, associations, local institutions, local places, exchanging tangibles, and local culture). After residents discover community resources, institutions can focus on methods to make those resources accessible in a collective sense. Seven community functions must be performed to create greater community well-being, including enabling health, assuring security, stewarding ecology, shaping local economies, contributing to food production, raising children, and co-creating care.

The seven foundational functions of communities to create well-being:

1. Enabling health: neighborhoods are the primary source of health; life expectancy is determined by personal behaviors, social relationships, physical environment, and income.
2. Ensuring security: residents' safety is largely related to how many neighbors they know by name and how often they are present and associated within their community.
3. Stewarding ecology: being good stewards of the environment.
4. Shaping local economies: within local communities, residents have the power to build an economy that is less dependent on outside systems.

5. Contributing to local food production: communities should be competent in local food production to sustain the economy and environment.

6. Raising our children: local people should raise their children instead of solely relying on outside institutions.

7. Co-create care: hospitable communities are the best places to receive care because institutions are in the business of providing services and not care.

The last element involves evaluating the ABCD process to assess citizen contributions in the community, the growth of associations, the strength of connections, and the use of evaluations to make improvements.\textsuperscript{11}

\textbf{Examples of ABCD in Practice}

Institutions can start community development by engaging with residents and finding community connectors familiar with people across the neighborhood. Institutions can also create community asset maps instead of needs assessments to determine skills and gifts at the resident, association, and institution levels. In addition, institutions can host community discovery conversations to learn more about what residents care about and assess their desire to commit collectively. Another example includes institutions creating social space for residents to interact and share their gifts.\textsuperscript{10}

\textbf{The Benefits of Community Development Practices in Physical Therapist Education}

While some students have experience working with community organizations or participating in service-learning activities, many learners do not enter physical therapist education with the knowledge and skills to work alongside communities in a partnership role.
During clinical experiences, students can focus on identifying community resources for their patients, even if their clinical placement is transient. Students should be encouraged to experience the community where they practice and investigate available resources. What are the community's assets? Do clinical sites host activities to help patients connect with those resources?

Physical therapists and physical therapist assistants can participate in community development with appropriate training. Community development, as described above, is a team approach to developing equitable alliances between an institution and the residents of a community. The institution must take the time to learn from the residents and let them lead in creating their desired health outcomes. At the College of Saint Mary (CSM), preparing Doctor of Physical Therapy (DPT) students to partner with residents starts with coursework in the first semester. Students have two courses that lay the foundation for professional formation, including a review of the American Physical Therapy Association Core Values and Codes of Ethics, an analysis of global healthcare systems, discussions concerning SDOH, and biopsychosocial elements contributing to citizens' well-being. In the second and subsequent semesters, students learn how to collaborate with community members to identify ways to share knowledge and clinical skills and connect residents to local resources as needed.

Since the inception of the CSM DPT Program, there has been a unifying goal to create a culture to produce practitioners to help meet the healthcare needs of society. As previously discussed, the health of society is directly linked to the health of local communities. As described above, an ABCD approach is preferred for institutions to co-create health with community residents. The following two examples highlight campus-community partnership that
depict the five core principles of ABCD: place-based, citizen-led, relationship-oriented, asset-based, and inclusion-focused.¹¹

**Example 1 (Health Promotion)**

*Relationship-Oriented*

A relationship was established between the course director of a Health Promotion course and the resident advisor of a government-subsidized housing development near the university. The course director sought partnerships to enhance student learning while benefiting the community. It was also crucial that this effort be sustained year after year so that the relationship with the community could continue to be strengthened. Before any commitments were made or projects agreed upon, the course director toured the community, talked with residents, and endeavored to understand the culture and priorities of the residents.

*Citizen-Led*

Rather than starting with what the students could offer the community, the residents were asked what was important to them and what their hopes were for their community. This conversation occurred during a monthly resident meeting that the course director attended and had asked to be included on the agenda. After several ideas were brought forward and discussed, the residents requested health information on topics they felt were significant. When a health fair event was proposed, the idea was welcomed. It was essential that the community members felt heard and appreciated while right sizing the project for size and scope for the students to be successful.

*Asset-Based*

To identify the focus of health information to provide at the health fair, students were tasked with talking with resident volunteers about health in general for a course assignment.
They made appointments with the residents and met in their community space to complete a paper about their health priorities, the community's resources, and what they felt the students could provide. This assessment needed to be completed with an asset approach instead of a needs-based method, so this topic was presented to the students before this assignment. This asset-based paper was used as the basis for the health fair topics.

*Place-Based*

It is vital for community members to feel comfortable in the place(s) where they interact with others to feel more equal with institutional stakeholders. Therefore, it was imperative that the students travel to the community to learn about it and talk with residents before the health fair. To truly get to know a community, it is important to become familiar with it in person, not only to drive by but to have experiences in the place. The best location for the health fair was decided to be the community room because it was accessible to all residents and known as a gathering space. The booths for the health fair were placed around the room, with a check-in booth in the entryway to record and educate community members about vital signs before entering the exhibits. Booths for young children were placed in a separate, secure room with child-sized furniture, and displays for adolescents were located outdoors, near the community room, to allow tweens and adolescents to come and go while they were separate from the adults and felt more emboldened to ask questions.

*Inclusion-Focused*

Students were encouraged to plan the booths and activities from the residents' perspective. Eighty percent of the residents were Black, female, single head of household, with children. Therefore, students needed to understand the importance of using inclusive language, referring to examples from the lives of the residents, and using messages that would be
understood from the cultural vantage point of the community. Children and adolescent-focused booths were added to be more inclusive. The students also scoured the internet to find graphics and photos that looked like the residents to use in the booths. Also, the exhibits were not merely displays of information; the students were required to include the community members in a learning activity to teach health concepts.

This partnership resulted in an annual health fair for the housing complex that lasted 12 years. The students applied their knowledge of health promotion in a real-world situation and learned how to communicate more effectively with others different from themselves. The residents accumulated knowledge about health over the years, grew empowered to engage in discussions concerning their well-being with future healthcare providers, and reported that they felt "seen" as a result of this partnership.

**Example 2 (The Stephen Center)**

*Relationship-Oriented*

The CSM DPT Program consistently seeks to identify community assets at the individual, local, association, and institutional levels. In the early development phase of the CSM DPT program, the program director (PD) and director of clinical education (DCE) established relationships with church leaders, residents, clinicians, free clinic owners, and community housing facilities to assess available resources. Different parties' missions, visions, and strengths were mutually exchanged to understand each other’s goals better and create a unifying partnership.

One early partnership that developed was with the Stephens Center, a temporary housing facility in Omaha, Nebraska. The PD and DCE met with organization leaders to learn how they impact the local community. Since 1984, the Stephen Center has served the Omaha community.
by providing temporary assistance with housing and helping individuals and families return to the community. Once successfully connected back to the community, many of the Stephen Center’s former residents return to the center as employees to show gratitude and support residents in their recovery journey.

Citizen-Led

Following meetings with community leaders, the PD and DCE coordinated with DPT faculty to create learning objectives and experiences in their courses to support community health initiatives. The CSM DPT program worked closely with the organization’s leaders to create an integrated clinical experience to screen individuals with pain and balance deficits. Over the years, the CSM DPT Program, under the direction of the Stephen Center, has created programming and delivered physical therapist services to support the organization’s goal of partnering with individuals, families, and the community to overcome homelessness, substance abuse, and mental health challenges.

Asset-Based

One of the Stephen Center’s primary strengths is assisting residents in returning and fully integrating into their communities. The center works directly with social workers and other healthcare professionals to help determine the best resources to support residents. It was identified that some residents had significant medical challenges that limited their ability to fully participate in the resources and programs provided by the Stephen Center. Some of these challenges included difficulties with mobility, balance, or musculoskeletal impairments.

Place-Based

To address these challenges, the CSM DPT Program co-created an integrated clinical experience with residents at the Stephen Center. First and second year DPT students traveled to
the Stephen Center to meet the residents at their facility. DPT students screened and assessed residents' neuromuscular, integumentary, cardiovascular, pulmonary, and musculoskeletal systems and identified impairments. Under the supervision of core DPT faculty, students provided interventions, education, recommendations, and follow-up documentation to the Stephen Center staff, community physicians, and the CSM occupational therapy onsite team.

*Inclusion-Based*

As the Stephen Center and CSM partnership develops, more residents' health interests are communicated to the DPT program. Most recently, the DPT program has been working closely with the Stephen Center to find ways to support their residents who are not engaging in physical activity and have complained of pain. Using asynchronous and synchronous exercise videos with CSM DPT students and faculty to address these needs is being explored with the Stephen Center staff. The CSM DPT Program seeks to increase access and resources for underserved, historically excluded, and economically marginalized residents.

The Stephen Center partnership has positively impacted the residents and the CSM DPT students and faculty. After each community event, CSM DPT students and faculty reflect upon their experiences working with residents. In addition, residents have also participated in reflection time to communicate their expectations and future ideas to support their health journey. The mission of CSM's DPT program is to prepare competent, compassionate, and professional physical therapists who demonstrate excellence in physical therapist practice to diverse and medically underserved communities. DPT students leave their experience at the Stephen Center with valuable exposure to those impacted by significant social and health disparities. In turn, the hope is that students will learn to work within their communities to connect residents to available resources.
Conclusion

Community development is a paradigm shift from thinking about residents as patients or clients who need services to viewing them as leaders who co-create solutions to address needs in their community. It allows individuals in the community to voice concerns and provide possible solutions. Physical therapists and physical therapist assistants can develop partnerships that significantly impact the health of individuals from their local community. An individual's health is most influenced not by genetics but by where they live. Physical therapists and physical therapist assistants must find ways to participate in community development with individuals, families, and other organizations within their local communities. A DPT program can help students participate in community development by seeking opportunities to partner with community members. Students involved in community-building in their DPT programs can learn firsthand the value of developing partnerships. With this valuable exposure, students can learn to build partnerships during their clinical education experiences and following graduation as licensed professionals.

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References


10. Russell C. We don’t have a health problem, we have a village problem. *Community Medicine*. 2020;1(1):1-12.


Table. Asset-Based Versus Deficit-Based Approach of Community Engagement

<table>
<thead>
<tr>
<th>Principles of Each Approach</th>
<th>Asset-Based Approach</th>
<th>Deficit-Based Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perspective</td>
<td>Considering the positive aspects and strengths of the community — What assets are available?</td>
<td>Considering what is needed in the community — What is wrong? What are the problems?</td>
</tr>
<tr>
<td>Goals</td>
<td>The community establishes its own goals.</td>
<td>Outside stakeholders determine the goals.</td>
</tr>
<tr>
<td>Identifying resources/assets</td>
<td>A variety of factors are considered resources or assets — informal leaders, community traditions, social networks, skills of community residents.</td>
<td>Conventional items are considered resources or assets — people in positions of power, financial resources, formal social organizations, external experts.</td>
</tr>
<tr>
<td>Agents of change</td>
<td>Sustainable change occurs when community decides to change</td>
<td>Change comes from outside stakeholders.</td>
</tr>
<tr>
<td>Role of outsiders</td>
<td>Working with and alongside the community to create change.</td>
<td>Working for and outside the community to create change.</td>
</tr>
<tr>
<td>Who does the work</td>
<td>Community residents mobilize assets</td>
<td>Outside experts provide services in paid roles.</td>
</tr>
<tr>
<td>Labels for residents of community</td>
<td>Resilient, gifted, citizens.</td>
<td>Vulnerable, needy.</td>
</tr>
<tr>
<td>Measurement of success</td>
<td>Measured by capacity of community to effect change, make connections, and improve relationships.</td>
<td>Measured by outcomes established by external stakeholders.</td>
</tr>
</tbody>
</table>