

Lessons Learned in Implementing a Community Development Model **Joyce Splann Krothe, DNS, RN**

Lessons learned in using a community development model to establish a nurse-managed clinic are described in this summary. A full article has been developed and is being reviewed by appropriate journals in the fields of service-learning, nursing, and public health. These lessons have potential for interdisciplinary application in service-learning projects and can guide the formation of community-campus partnerships.

The case: In 1996 a nurse-managed clinic was established in a rural county designated as a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA). The dual mission of the clinic is to provide healthcare, disease prevention, and health promotion services to county residents who lack access to care; and, to serve as a service-learning project for Indiana University nursing students. All clients are uninsured or under-insured. Clinic operations are guided by a Community Advisory Board comprised of lifelong community residents, including clients. The county is adjacent to the community that is home to Indiana University. A community development model was used to plan the clinic and implement the service-learning objectives.

A community development model focuses on the achievement of community goals and includes a true partnership in which power and decision-making are shared by community members and the academic community (Krothe, Flynn, Ray & Goodwin, 2000). It assumes that positive community change occurs as a result of full participation of community members. Faculty and students engaged in service-learning projects using a community development model must understand the important distinction between *working with* the community and simply *working in* the community.

Reflection is the key to distinguishing a service-learning experience from regular academic requirements and faculty play an important role in structuring reflective experiences. Incorporating reflection in formative and summative evaluation and engaging the community with students in the process of reflecting on the service-learning experience is essential. The involvement of community partners in reflection is often overlooked by academic partners.

Implementing a community development model means that a true partnership is established between the academic institution and the community. One of the key principles identified by Community-Campus Partnerships for Health is that partnerships take time to develop and evolve over time. The term partnership is often used prematurely or loosely to denote an arrangement of placing students in a community to meet a specified academic need. In this case the term was used on the part of the academic partner from the inception of the project, while the community used partnership language only after several years of working together.

Lessons learned over the past seven years of clinic operation have implications for interdisciplinary application to service-learning projects. Examples from the clinic case are provided for each of the lessons learned.

- ❑ People's cultural backgrounds and life experiences affect the way they respond to outsiders and their ideas.

- As outsiders academic partners may be tested to see if they will follow through with projects; in this case negative past experiences with university projects affected the community's initial willingness to commit resources to development of the nurse-managed clinic. Such misperceptions affect both partners; if they are not acknowledged they risk impeding the formation of a partnership.
- ❑ Faculty practice in communities occurs within dynamic settings and situations that are political.
 - Academic partners need to understand the community dynamics which affect decisions. For example, in this case the community blocked initial submission of a grant application to become a Community Health Center (CHC); while acknowledging the need for a CHC they were unwilling to alienate local physicians who opposed it. The role of lay individuals in the community, in this case community health workers, became vital to moving the community to acceptance of a CHC.
- ❑ Community priorities do not always match quantitative data about the community's needs.
 - The community did not perceive hypertension to be a problem, although the geographic area was designated the state's stroke belt. The academic health professionals addressed this issue by involving students in service-learning activities associated with mandatory hypertension screening of school children in 4th, 7th, and 11th grades, which helped the community understand the extent of the problem.
- ❑ Clear communication and negotiation skills are required.
 - In this case the community partner needed to understand the need for the academic partner to be accountable and responsible for clinic management to the funding entities. The skill of listening is as essential as effective verbal skills in communication. Students gained a new appreciation of the importance of communication in the context of community.
- ❑ Progress and successes need to be shared in timely and appropriate ways with various audiences.
 - The same data were presented in different formats to students, to funding agencies, in community forums (graphs, pie charts), at professional meetings, and in the professional literature.
- ❑ The various systems in which faculty work often have conflicting expectations.

- Issues of workload and flexibility between academic and practice schedules had to be addressed. Tenure and promotion criteria often do not reflect the scholarship of practice nor do they adequately reward service-learning activities.
- ❑ Students need to be accountable to the community for service and research.
 - Community members had often been involved in the past in student projects and had committed time and energy for which they had seen limited returns for their community. This created initial reluctance to partner for the nurse-managed clinic endeavor.
- ❑ Consumer representation in decision-making requires perseverance and deliberate strategies to ensure inclusion.
 - Recruiting and retaining client representation on the Community Advisory Board has been difficult; success in partnering with all of the community requires perseverance. Efforts must be directed toward helping community members understand their role and play a meaningful part in decisions.
- ❑ The community development model does not always match funding requirements and academic time frames.
 - Implementation of sustainable partnerships usually takes longer than planned. In this case the goal for self sufficiency of clinic operations has taken seven years; the funding entity initially required that this point be reached in three years. Furthermore, communities do not live by the semesters and deadlines imposed by academia.

Reference

Krothe, J.S., Flynn, B., Ray, D. & Goodwin, S. (2000). Community development through faculty practice in a rural nurse-managed clinic. Public Health Nursing, 17, 264-272.