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## **Los Angeles County Department of Public Health Institutional Review Board (IRB) Policy Regarding Health Equity, Diversity and Inclusion in Research or Related Activities Reviewed by the Institutional Review Board**

### **PURPOSE:**

To raise awareness about and enable the collection of data on health equity, diversity, and inclusion, and to establish guidelines for addressing health equity, diversity, and inclusion in research and related activities reviewed by the Los Angeles County Department of Public Health (DPH) Institutional Review Board (IRB).<sup>1,2</sup>

### **SCOPE:**

This Standard of Practice (SOP) applies to research and related activities that are reviewed by the DPH IRB including those originating from the Department of Health Services Ambulatory Care Network, Health Services Administration, and Integrative Correctional Health Services, as well as the community-based organizations for whom this IRB serves as IRB of record.

### **DEFINITIONS:**

“Research” is (1) a systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge, or (2) a systematic collection or analysis of data with the intent to generate new knowledge (Protection of Human Subjects, 45 CFR § 46.102[1], 2019).

“Related activities” means any process that involves collecting data from or about individuals other than that related to provision of clinical care or conducting statutorily mandated activities and surveillance, including but not limited to: activities that may be considered “practice” or otherwise not research,

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<sup>1</sup>The “Los Angeles County Department of Public Health Institutional Review Board (IRB) Policy Regarding IRB Review of Research and Related Activities Involving Human Subjects” has previously set forth the procedures through which the IRB reviews research and related activities that involve human subjects.

<sup>2</sup> For projects involving, sponsored by, or otherwise originating from DPH, please refer to CSO-SOP 008, available on request for DPH-affiliated persons only.

program evaluation, quality assurance and improvement, certain non-legally-mandated surveillance<sup>3</sup>, and needs assessments.

A “principal investigator” or “PI,” is the person responsible for all aspects of research and related activities, including methodology, recruitment, data collection, data analysis and ethical conduct and compliance with all state and federal regulations as well as the policies of this IRB. For related activities, the term “project lead” can be used to refer to the person with the same responsibilities as a PI.

“Health equity” is “when everyone has a fair and just opportunity to attain their optimal health and well-being” (Los Angeles County Department of Public Health [LACDPH], 2023, p.2).<sup>4</sup>

“Diversity” is “the presence of different and multiple characteristics that make up individual and collective identities, including race, gender, age, religion, sexual orientation, ethnicity, national origin, socioeconomic status, language, and physical ability” (Nakintu, 2021, p.2).<sup>5</sup>

“Inclusion” is “creating environments in which any individual or group can be and feel welcomed, respected, supported and valued to participate fully” (Nakintu, 2021, p.2).

“Health inequity” refers to “avoidable gaps between social groups that are caused by systems that limit the availability and ability for certain groups to get resources, such as a good education, safe and supportive neighborhoods, and a job that pays a living wage.”<sup>6</sup>

“Social determinants of health” are “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks” (Office of Disease Prevention and Health Promotion, 2020, para. 1).

“Community engagement” is the process of working collaboratively with a community to address and prioritize the issues that most affect their well-being. Community engagement ensures that communities who are most impacted by challenges and inequities have an equal voice in designing and implementing solutions to these issues in order to accelerate change. It often involves partnerships and coalitions that help mobilize resources and influence systems, changes relationships among partners, and serves as catalysts for changing policies, programs, and practices to advance health equity and foster lasting collaboration to improve health across the whole community.<sup>7</sup>

## **THE IMPORTANCE OF ADDRESSING HEALTH EQUITY, DIVERSITY AND INCLUSION IN PUBLIC HEALTH RESEARCH AND RELATED ACTIVITIES:**

As the public health impacts of structural racism have come to the forefront, the National Institutes of Health (NIH) recently discussed addressing structural racism and outlined the importance of establishing a framework for its funded research to address and develop “robust health disparities/equity research”

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<sup>3</sup> This may include expanded surveillance or those activities which utilize surveillance data for a purpose other than originally intended.

<sup>4</sup> This definition is from the DPH Center for Health Equity’s “Health Equity Framework”. Although definitions of “health equity” vary by source, many share the goal of achieving optimal health across multiple domains of health by addressing structural barriers and social determinants of health (e.g., discrimination, systemic racism, neighborhoods, violence, food insecurity, poverty).

<sup>5</sup>We acknowledge that many definitions of “diversity” exist; however, we have cited one that we think closely aligns with DPH values.

<sup>6</sup> This definition was provided by the DPH Center for Health Equity on February 12, 2024.

<sup>7</sup> This definition is from an internal DPH policy on community engagement.

(Collins et al., 2021, p. 3075) and be accountable for such commitments to health equity, diversity, and inclusion. DPH has similarly committed to working towards achieving health equity to reduce health inequities such as disproportionately poor birth outcomes among African Americans, disproportionate rates of sexually transmitted infections among transgender persons, and lack of cultural and linguistic inclusion in access to healthcare (LACDPH, n.d.). DPH research and related activities inform program planning and policy to improve the health and everyday lives of LA County's residents. These activities should likewise align with DPH's values and be conducted with a health equity lens.

### **THE ETHICAL PRINCIPLES ON WHICH THE IRB'S COMMITMENT TO HEALTH EQUITY, DIVERSITY AND INCLUSION IS BASED:**

The following ethical principles form the basis of the IRB's commitment to address health equity, diversity and inclusion in research and related activities. These principles align with the letter and spirit of the federal regulations that pertain to human subjects research (Protection of Human Subjects, 45 CFR § 46, 2019; Protection of Human Subjects, 21 CFR § 50, 2019).

- 1) *Accountability* – DPH should demonstrate its commitment to health equity, diversity and inclusion in research and related activities through data collection and analysis to demonstrate the inequities and identify the barriers to achieving health equity (World Health Organization [WHO], 2023; American Medical Association [AMA], 2001).<sup>8</sup>
- 2) *Beneficence* - The benefits of research and related activities should be maximized and the risks - including group harms to the community minimized (Protection of Human Subjects, 45 CFR § 46.111[2], 2019).
- 3) *Caring/Compassion* - DPH should care for LA County residents and be aware of their needs and wishes (WHO, 2023; AMA, 2001).<sup>9</sup>
- 4) *Justice* – Los Angeles County residents should not be denied the opportunity to be healthy based on their belonging to a group that has been economically/socially disadvantaged (Protection of Human Subjects, 45 CFR § 46.111[3], 2019).
- 5) *Respect for persons* - DPH should be considerate of participants' autonomy and voluntary participation, and should ensure that health equity, diversity and inclusion in research and related activities are addressed with fully informed consent of participants (Protection of Human Subjects, 45 CFR § 46.116[a], 2019).
- 6) *Responsibility* - DPH is responsible for promoting the health and well-being of LA County's residents (WHO, 2023; AMA, 2001).<sup>10</sup>

### **RESPONSIBILITIES OF THE PRINCIPAL INVESTIGATORS/PROJECT LEADS:**

PIs/project leads will make reasonable attempts to address health equity, diversity and inclusion across all phases of a project including, but not limited to: research questions being asked; methodology; recruitment; data collection; data analysis; debriefing of participants; dissemination of findings; and application of findings to policy decisions at varying levels. Please see attachments B and C for health equity in research resources.

PIs/project leads will make reasonable attempts to start developing relationships and building trust with the community as early as possible. PIs/project leads will prioritize inclusion of appropriate community and/or stakeholder engagement and consultation tactics across all aspects of the project, including but

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<sup>8</sup> This ethical principle is adapted from WHO "Code of Ethics" and AMA "Principles of Medical Ethics" to apply to healthcare delivery.

<sup>9</sup> See footnote 8 above.

<sup>10</sup> See footnote 8 above.

not limited to: research questions being asked; research design; recruitment; data collection; data analysis; and dissemination of findings to the community. Community engagement is an essential and intentional means to get input, buy-in, and learn about the complexities of communities to help contextualize the research and provide meaningful and impactful programs and services.

PIs/project leads will ensure equitable participant inclusion criteria based on social determinants of health such as race/ethnicity, socioeconomic and cultural attributes, and differential access to the benefits of public health research, either historically or current. This may include provisions for translations of any data-gathering activities into the language(s) primarily spoken by a significant proportion of the source or target population and at appropriate reading level(s); adequate staff to conduct the project activities in the aforementioned primary language(s); and implementation of a project in appropriate neighborhoods or locations, with compensation for childcare, time spent, transportation and parking as appropriate.

PIs/project leads will use existing and/or collect new data related to health equity, diversity, and inclusion such as social determinants of health, and other participant characteristics defined socially, economically, demographically and/or geographically. These data may include, but are not limited to: the primary language(s) spoken by participants; distribution of participants by race/ethnicity; income/poverty level; neighborhood (e.g., zip codes, Service Planning Areas, names of LA County unincorporated areas and/or incorporated areas); sexual orientation and gender identity; and disability status.

A description of progress toward meeting these health equity-related responsibilities will be included with annual IRB progress reports, including reasonable justifications for being unable to meet these responsibilities.<sup>11</sup> Specifically, the annual progress report will ask: 1) whether project materials are available in appropriate languages and reading levels; 2) the degree to which the recruitment sample reflects the target population; 3) the methods in place for collection of health equity data; 4) how the community was engaged; 5) the methods used to disseminate project findings (e.g., town hall, local newspaper/newsletter, radio in primary language of participants). Please refer to Attachment A for a more detailed look at the questions that have been added to the progress reporting form.

#### **RESPONSIBILITIES OF THE IRB:**

The IRB will track health equity, diversity and inclusion metrics collected by the PIs/project leads through responses to Attachment A questions, project annual status reports and final closeout reports, which are submitted to the IRB through IRBManager. Using IRBManager, the IRB will generate reports that summarize the data on an annual basis and report aggregate findings to PIs/project leads.<sup>12</sup>

The IRB will complete an equity review to ensure projects are meeting the health equity responsibilities outlined above. A report summarizing results of the equity review will be shared with the project team.

When requested, the IRB will provide technical assistance virtually, by phone, or email, regarding procedures that address health equity and promote diversity and inclusion such as best practices for engaging the community and collecting metrics. The IRB will provide annual or bi-annual virtual or in-person trainings on community engagement in research, evaluation and related activities. Training slides will be made available on the IRB website: <http://www.publichealth.lacounty.gov/IRB/Training.htm>

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<sup>11</sup> This can be extraction of data already being collected.

<sup>12</sup> Annual progress reports must be submitted for all projects; failure to submit annual progress reports results in automatic closure of projects.

Contact:

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## Health Equity in Research and Related Activities: Links and Resources

### DO

#### **Toolkits including ways to measure progress towards addressing health equity**

Engagement for Equity ([click here](#))

Urban Institute Community Engagement Resource Center ([click here](#))

### TRAIN

#### **Free courses and webinars on community engagement and health equity**

Community Engagement: Collaborating for Change | University of Michigan ([click here](#))

Community Engagement in Research and Population Health | Coursera/University of Rochester ([click here](#))

CDC TRAIN (series of free courses) ([click here](#))

### LEARN

#### **Case studies where local government health departments have engaged communities to address health equity**

Lessons (Re)Learned from COVID-19 ([click here](#))

Case studies across diverse communities and with community organizations; tribes; state and local health departments; hospitals; and universities highlight the opportunity to apply lessons from COVID-19 for sustained changes in how public health and its partners work collectively to prevent disease and promote health, especially with vulnerable communities.

### READ

#### **Select articles about health equity and community-engaged work**

**Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health (National Academy of Medicine)** ([click here](#))

Describes the development of a conceptual model to achieve “meaningful community engagement” including strengthened partnerships and alliances; expanded knowledge; improved health and health care programs and policies; and thriving communities. The model relies on the concepts of drivers of health; drivers of change; and social, political, racial, economic, historical, and environmental context.

**Commentary on Community-Based Participatory Research for Journal of Participatory Research Methods** ([click here](#))

Provides backdrop of history and theoretical underpinnings of community engaged and community-based participatory research.

**Engage for Equity: Development of Community-Based Participatory Research Tools (Health Education and Behavior)** ([click here](#))

Outlines a set of four community-based participatory research (CBPR) partnership tools aimed at supporting community–academic research partnerships in strengthening their research processes, with the ultimate goal of improving research outcomes. The four tools are: The River of Life Exercise; a Partnership Visioning Exercise; a personalized Partnership Data Report of data from academic and community research partners; and a Promising Practices Guide (see Engage for Equity toolbox above).

## Attachment C

### Health Equity in Research and Related Activities: Relevant Articles

1. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health (National Academy of Medicine)
2. Commentary on Community-Based Participatory Research for Journal of Participatory Research Methods



# Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health

## Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies

February 14, 2022

*“Knowing is not enough; we must apply. Willing is not enough; we must do.”—Goethe*

### Introduction

People and the communities they are a part of—defined as “groups of people affiliated by geographic proximity . . . or similar situations to address issues affecting the well-being of those people”—are deeply impacted by the systems that drive and influence their health; however, they are often not included in the process to create or restructure programs and policies designed to benefit them (CDC, 2011). When health and health care policies and programs designed to improve outcomes are not driven by community interests, concerns, assets, and needs, these efforts remain disconnected from the people they intend to serve. This disconnect ultimately limits the influence and effectiveness of interventions, policies, and programs.

Over the last several years, health and health care entities, including advocacy organizations, philanthropic and funding agencies, care systems and hospitals, and academic and research organizations, among others, are recognizing the need to engage the communities they serve. Yet, many entities only conduct superficial engagement—the community is denied access to the decision-making process, and interactions tend toward tokenism and marginalization, or the community is simply informed of plans or consulted to provide limited perspectives on select activities (Carman and Workman, 2017; Facilitating Power, 2020). True, **meaningful community engagement** requires working collaboratively with and through those who share similar situations, concerns, or challenges. Their engagement serves as “a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. [It] often involves partnerships and coalitions that help

mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices” (CDC, 2011). Shifting toward meaningful community engagement often requires decision makers to defer to communities and move to power sharing and equitable transformation—necessary elements to ensure sustainable change that improves health and well-being (Facilitating Power, 2020). It is important to note that meaningful community engagement requires working closely with communities to understand their preferences on how, when, and to what level and degree they want to be engaged in efforts. Some communities may prefer to only provide input or be consulted at certain times, while others may prefer shared power and decision-making authority.

Tools and resources are available to provide practical guidance on and support for community engagement (CDC, 2011). Yet, the intention to engage does not always translate to or ensure effective engagement (Carman and Workman, 2017; Facilitating Power, 2020). In other words, the fundamental question is not whether entities think they are engaging communities but whether communities feel engaged. Bridging this gap requires the ability to define meaningful community engagement and assess its impact—especially related to specific health and health care programs, policies, and outcomes.

With these realities in mind, the National Academy of Medicine’s Leadership Consortium: Collaboration for a Value & Science-Driven Health System, with funding from the Robert Wood Johnson Foundation and guidance from an Organizing Committee, is advancing a project to identify concepts and metrics that can best assess the extent, process, and impact of community engagement. The Organizing Committee comprises experts in community engagement—community lead-

ers, researchers, and policy advisors—who are diverse in many ways, including geographic location, race and ethnicity, nationality, disability, sexual orientation, and gender identity (see *Box 1*). This effort aims to provide community-engaged, effective, and evidence-based tools to those who want to measure engagement to ensure that it is meaningful and impactful, emphasizing equity as a critical input and outcome. As work began on the project, the Organizing Committee realized the need for a conceptual model illustrating the dynamic relationship between community engagement and improved health and health care outcomes. This commentary will describe how the Organizing Committee arrived at the conceptual model, the critical content that the model contains and expresses, and how the model can be used to assess meaningful community engagement.

### Background on the Development of the Conceptual Model

The Organizing Committee identified the need for a new conceptual model that could be used by a range of stakeholders, including federal, state, and local agencies; tribal communities; advocacy and community-based groups; funders, philanthropists and financiers; academic institutions; care systems, health centers, and hospitals; and payers, plans, and industry. The Organizing Committee additionally highlighted important considerations for the conceptual model design and development process.

#### The Need for a New Conceptual Model

An analysis of the peer-reviewed literature and organizational websites for frameworks and conceptual models of engagement identified over 20 examples. Several models explicitly focused on partnership processes and levels of engagement. Other models connected engagement to factors influencing health, interventions, policy making, community-based participatory research (CBPR), and patient-centered comparative effectiveness research. Only a few models associated engagement to outcomes, indicators, or metrics. One model, drawing from CBPR evaluation, connected partnership characteristics, partnership function, partnership synergy, community/policy-level outcomes, and personal-level outcomes (Khodyakov et al., 2011). However, this model did not identify the role of diversity, inclusion, and health equity as core components of partnership characteristics and functioning, did not include health equity as a key outcome or goal of partnerships, and was developed to support research partnerships.

Another model, grounded in academic and community partnerships and CBPR, framed the interplay between contexts, partnership processes, intervention research, and intermediate (e.g., policy environment, sustained partnership, shared power relations in research) and long-term (e.g., community transformation, social justice, health/health equity) outcomes (Wallerstein et al., 2020). While this model includes health equity as an outcome, the inputs and some outcomes are focused on academic-community research partnerships. None of the identified models examined opportunities to assess community engagement and the influence and impact it could have in health and health care policies and programs broadly, incorporating diversity, inclusion, and health equity into the framework. The Organizing Committee felt strongly that an additional model was needed to reinforce existing conceptual models—one that provides a paradigm for the factors needed to assess the quality and impact of meaningful community engagement across various sectors and partnerships and one that simultaneously emphasizes health equity and health system transformation.

#### The Process and Methodology for Designing the Conceptual Model

To guide the design and refinement of the new conceptual model for assessing meaningful community engagement, the Organizing Committee focused on eight foundational standards. An effective conceptual model will:

- **Define what should be measured in meaningful community engagement, not what is currently measured.** On the premise that society “measures what matters most,” and “what is measured gets done,” the Organizing Committee wanted the conceptual model to focus on the outcomes needed to guide the measures and metrics of meaningful community engagement, not being limited by what already exists in the literature. The development of the conceptual model and areas for assessing meaningful community engagement leveraged the wealth of knowledge, expertise, and experience of the Organizing Committee and were not constrained by whether the metrics were available. This conceptual model represents the Organizing Committee’s aspirational ideal of what matters, what should be measured, and what should be done to support meaningful community engagement.

### BOX 1 | Organizing Committee for Meaningful Community Engagement

- **Sergio Aguilar-Gaxiola**, University of California, Davis (co-chair)
- **Syed M. Ahmed**, Medical College of Wisconsin
- **Ayodola Anise**, National Academy of Medicine
- **Atum Azzahir**, Cultural Wellness Center\*
- **Kellan E. Baker**, Whitman-Walker Institute
- **Anna Cupito**, National Academy of Medicine (until July 2021)
- **Milton Eder**, University of Minnesota
- **Tekisha Dwan Everette**, Health Equity Solutions
- **Kim Erwin**, IIT Institute of Design
- **Maret Felzien**, Northeastern Junior College\*
- **Elmer Freeman**, Center for Community Health Education Research and Service
- **David Gibbs**, Community Initiatives
- **Ella Greene-Moton**, University of Michigan School of Public Health
- **Sinsi Hernández-Cancio**, National Partnership for Women & Families (co-chair)
- **Ann Hwang**, Harvard Medical School (co-chair)
- **Felica Jones**, Healthy African American Families II\*
- **Grant Jones**, Center for African American Health\*
- **Marita Jones**, Healthy Native Communities Partnership\*
- **Dmitry Khodyakov**, RAND Corporation and Pardee RAND Graduate School
- **J. Lloyd Michener**, Duke School of Medicine
- **Bobby Milstein**, ReThink Health
- **Debra S. Oto-Kent**, Health Education Council\*
- **Michael Orban**, Orban Foundation for Veterans\*
- **Burt Pusch**, Commonwealth Care Alliance\*
- **Mona Shah**, Robert Wood Johnson Foundation
- **Monique Shaw**, Robert Wood Johnson Foundation
- **Julie Tarrant**, National Academy of Medicine
- **Nina Wallerstein**, University of New Mexico
- **John M. Westfall**, American Academy of Family Physicians
- **Asia Williams**, National Academy of Medicine
- **Richard Zaldivar**, The Wall Las Memorias Project

\*Provided perspectives on the conceptual model through in-depth interviews

- **Be sufficiently flexible to measure engagement in any community.** Community goes beyond geography and represents a group of individuals who share common and unifying traits or interests. Community “can refer to a group that self-identifies by age, ethnicity, gender, sexual orientation . . . faith, life experience, disability, illness, or health condition; it can refer to a common interest or cause, a sense of identification or shared emotional connection, shared values or norms, mutual influence, common interest, or commitment to meeting a shared need” (WHO, n.d.). The Organizing Committee recognizes the importance of considering intersectionality in defining community, as individuals often belong to multiple and intersecting identities. As such, examples of community could include faith-based organizational networks partnering to improve health across a state, neighbors in a local area seeking environmental changes to improve health and well-being, or a multi-stakeholder network with community-based organizations, primary care providers, and hospitals addressing opioid addiction. The conceptual model should be flexible for use in assessing the impact and influence of engagement in any community.
- **Define health holistically.** The conceptual model should focus on physical and mental

health and well-being (Roy, 2018). Often, references to health are only aligned with physical health. The conceptual model should consider that health is not just about being free of disease or infirmity, but that individuals and communities have the right to thrive—to reach “the enjoyment of the highest attainable standard of health” (WHO, n.d.).

- **Allow the community to see itself in or identify with the language, definitions, and context.** The conceptual model should make sense to the community, be usable by the community, and be written in language familiar to the community. The model and the language used in it should allow communities to see themselves in it and emphasize the positive aspects of the community. At the same time, the Organizing Committee recognized that all communities are not monoliths. The conceptual model should be adaptable to the needs of the communities using it—each community and its partners should be able to review the terms and measurement areas presented in the model and collaboratively decide on how to define, apply, modify, or implement them to support their needs.
- **Embed equity throughout the model.** Equity must be the central focus for every decision related to conducting meaningful community engagement and thinking about person-centered health and health care (Simon et al., 2020). Equitable and continued engagement with those traditionally left out of conversations and decision making about the health and health care systems, programs, interventions, and policies that affect them opens a pathway to true health system-wide transformation. The conceptual model should reflect that transformation is not possible without systematically embedding equity into its core components, not just its outcomes.
- **Emphasize outcomes of meaningful community engagement.** The Organizing Committee underscored the importance of the processes, strategies, and approaches used in engagement. Each community is different and wants to be engaged in various and multiple ways. The Organizing Committee recognized that there are myriad toolkits, reports, articles, and examples on how to engage communities. Certainly, more work is needed to understand the influence of

and measure these processes to achieve desired outcomes. However, the conceptual model is being developed to support outcome-based accountability. If stakeholders cannot achieve meaningful community engagement based on the selected agreed-upon outcomes, modifying or changing their engagement process should be considered. The main purpose of this conceptual model is to reflect the dynamic relationship between engagement and outcomes, not present or address processes for engagement.

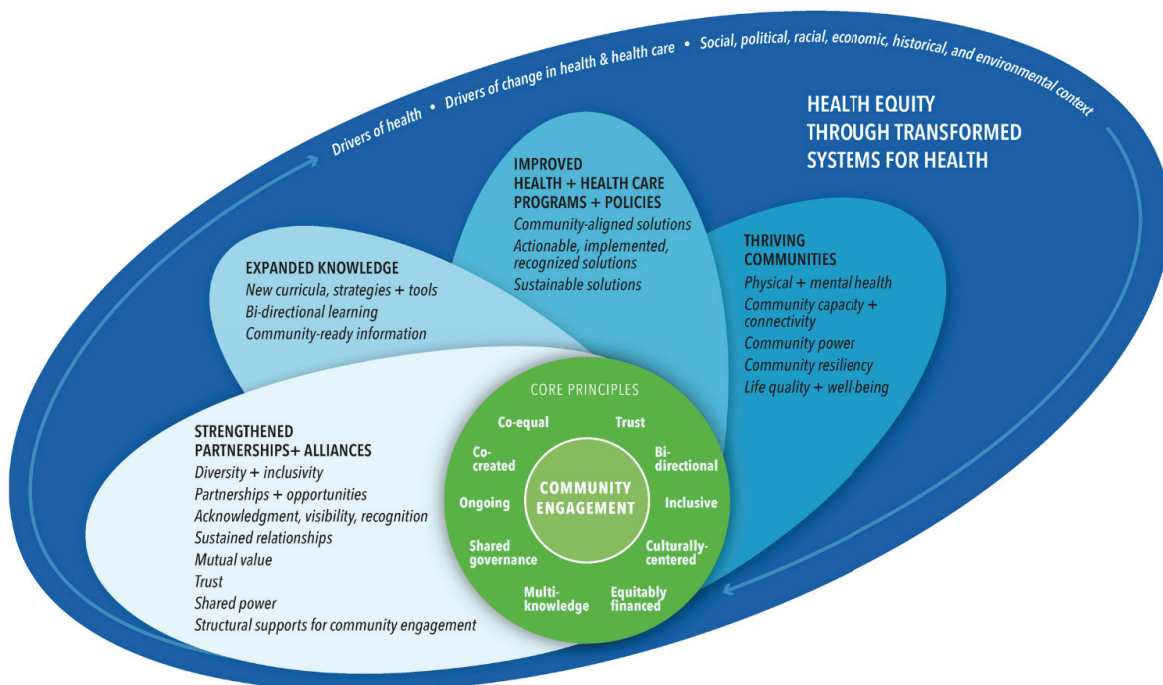
- **Present a range of outcome options for various stakeholders.** As many are committed to assessing the impact of community engagement on health and health care policies and programs, the conceptual model should be relevant to and usable by the range of aforementioned stakeholders. This conceptual model should explain the connection between community engagement and outcomes, and the Committee insisted that a range of options be provided for assessing community engagement to reflect local priorities and interests rather than assume that all communities want or need the same outcomes. In other words, different communities will want to focus on different outcomes. Additionally, the model should support various stakeholders (e.g., federal, state, and local agencies; tribal communities; advocacy and community-based groups; funders, philanthropy, and financiers; academic researchers and institutions; and payers, plans, and industry) looking to evaluate the impact and influence of engagement with the community in health and health care policies and programs.
- **Communicate the dynamic and transformative nature of engagement.** The Organizing Committee believed that the conceptual model should place community and community engagement at the center and that all impact and influence should accelerate toward meaningful outcomes that ultimately ensure health equity through transformed systems for health. The image and shape used to depict the relationship between community engagement and outcomes should be dynamic, reflecting the movement toward equity and system transformation when communities are actively and meaningfully engaged.

A three-stage methodological process that leverages these foundational and guiding standards was used to design the conceptual model. In stage one, a subset of 14 Organizing Committee members, including community leaders, researchers, and policy advisors, identified the key overarching components and outcomes to include in the model over the course of several discussions. In stage two, extensive in-depth interviews were conducted with a select group of Organizing Committee members, representing 11 community leaders not involved in stage one, which generated a dozen iterations of the model. The community leaders detailed specific terms, phrases, language, and additional components needed to ensure that the conceptual model was authentic to community perspectives, easy to understand, aligned with other efforts on community engagement, complementary to existing models, and recognizable by those who would benefit the most by using the model. The community leaders also discussed and modified the relationships between the key components and appropriate alignment among outcomes. During this stage, community leaders reviewed outcomes identified in a preliminary literature search to see if elements were missing from the model. Only one additional outcome was added at this time. In

stage three, the entire Organizing Committee was re-engaged to review, refine, and agree on the resulting conceptual model presented in this commentary.

### Review of the Conceptual Model

The conceptual model titled *Achieving Health Equity and Systems Transformation through Meaningful Community Engagement*, and also known as the Assessing Community Engagement (ACE) Conceptual Model, centers community engagement and core engagement principles (see *Figure 1*). Four “petals” or “propellers” emanate from the center and radiate from left to right, reflecting major meaningful domains and indicators of impact that are possible with community engagement. Impact in these domains leads to the fundamental goal of health equity and systems transformation and is contextualized by the drivers of health; drivers of change; and social, political, racial, economic, historical, and environmental context. While the ACE Conceptual Model can be viewed as linear and sequential, end users also have the flexibility to focus on specific indicators depending on needs and interests. Below is a description of the details and definitions of all the key components of the conceptual model.



**FIGURE 1 | A Dynamic Relationship: Achieving Health Equity and Systems Transformation through Meaningful Community Engagement**

### Community Engagement

Community engagement is the linchpin or central focus of the conceptual model. Engagement of the community, as defined above, represents both the start and the hub of movement toward outcomes. It is only with community engagement that it is possible to achieve and accelerate progress toward the goal of health equity through transformed systems for health.

### Core Principles

The core principles identify attributes that should be present in the process of community engagement. Those involved must ensure that community engagement is grounded in trust, designed for bidirectional influence and information flow between the community and partners, inclusive, and premised on culturally centered approaches. The core principles also include equitable financing, multi-knowledge, shared governance, and ongoing relationships that continue beyond the project time frame and are authentic and enduring. Engagement should be co-created, and participants should be considered coequal. Principle-informed community engagement creates a readiness that can propel teams into productive motion and accelerate engagement outcomes and the ultimate goal of health equity and systems transformation.

### Domains and Indicators of Meaningful Engagement

With community engagement and the core principles, it is possible to understand if meaningful engagement is taking place by assessing some or all of the outcomes based on the needs and interests of the community. Therefore, the Organizing Committee developed a taxonomy to classify, describe, and standardize outcomes to assess community engagement (Aguilar-Gaxiola, 2014). The taxonomy used in the ACE Conceptual Model considers domains, indicators, and metrics.

The conceptual model posits four broad categories or domains of measurable outcomes:

- Strengthened partnerships and alliances
- Expanded knowledge
- Improved health and health care programs and policies
- Thriving communities

Under each domain are potential and relevant indicators. The conceptual model presents 19 mutually exclusive indicators divided across the four domains. As indicators are not yet quantifiable, each indicator is, in turn, associated with specific metrics. These metrics are the questions that are both supported by results

and that can be used to assess if the engagement taking place is meaningful. The Organizing Committee identified metrics associated with meaningful community engagement through a literature review and aligned them with the indicators presented on the conceptual model. Given the space limitations in the conceptual model, only domains and indicators are listed; the metrics identified in the literature and associated with the indicators will be made available later.

Ultimately, with community engagement and its core principles embedded into all collaborations and partnerships, movement and progress should occur in multiple domains and indicators present in the model. Below are explanations on how the Organizing Committee characterized the domains and indicators in the conceptual model.

### Strengthened Partnerships and Alliances

The first assessment domain identified by the Organizing Committee relates to strengthened partnerships and alliances, which the Committee defines as how participants emerge from engagement with new or improved relational benefits that are carried forward. This domain also reflects the qualities of leadership that allow alliances and partnerships to be strengthened, and it has the following eight indicators:

- Diversity and inclusivity
- Partnerships and opportunities
- Acknowledgment, visibility, and recognition
- Sustained relationships
- Mutual value
- Trust
- Shared power
- Structural supports for community engagement

*Diversity and inclusivity* ask for constant consideration of the representation, inclusion, and lived experiences of those engaged in the efforts. Representation should be intentionally diverse, comprising multicultural, multiethnic, and multigenerational perspectives, particularly those not traditionally invited or involved in improving health and health care policies and programs. Perspectives should reflect the composition of the community, be based on the culture of the community, and reflect multidisciplinary expertise from the community. Diversity and inclusivity should also be reflected in the intentional integration of the interests and, importantly, in knowledge, resources, and other valuable entities from all community members during conversations and deliberations.

*Partnerships and opportunities* ensure that those engaged are fully benefiting from participation through deepened and mutually supported relationships. This indicator assesses whether participants have benefited from bidirectional mentorship or other forms of professional investment; gained access to new financial or nonfinancial opportunities; received certificates, earned degrees, or otherwise benefited from skills development; or shared and connected to an expanded network of partners, influencers, and leaders.

*Acknowledgment, visibility, and recognition* reflect how community participants are seen and recognized as contributors, experts, and leaders and can benefit from their participation. This indicator encompasses public acknowledgment of participant contributions and recognizes the legitimacy of the partnership.

*Sustained relationships* require that the community, institutions, and relevant disciplines maintain continuous and ongoing conversations that are not time-limited or transactional. The community should be engaged at the beginning of an effort and normalized as an essential stakeholder. Involvement and engagement of the community should have depth and longevity.

*Mutual value* ensures that communities engaged are equitably benefiting from the partnership. This indicator requires balanced engagement between the community and others involved in the partnership, as marked by reciprocity that considers how the community will benefit from, not just contribute to, the effort. The value exchange can be financial or nonfinancial but must be defined by, not prescribed for, the community. Mutual value is grounded in the need for understanding and respect for the community and all partners. It requires valuing the knowledge and expertise of all individuals, agreeing to a shared set of definitions and language, and committing to bidirectional learning.

*Trust* is a core component of engagement. It requires showing up authentically, being honest, following through on commitments, and committing to transparency in order to build a long-lasting and robust relationship. Genuine partnerships grounded in trust require change on the part of all partners. Trust also requires that entities engaging communities commit themselves to being *trustworthy*. Mistrust among communities of representatives of health care and other systems is often an adaptive response to historical and contemporary injustice perpetrated by these systems. A foundational component of building trust with communities is demonstrating that community trust is warranted and will not be abused or exploited.

*Shared power* is fundamental to strong and resilient partnerships with the community. Shared power reflects that community participants are involved in leadership activities such as codesigning and developing the partnership's shared vision, goals, and responsibilities. It emphasizes that community members have influence and can see themselves and their ideas reflected in the work. Shared power includes true equitable partnership and governance structures that ensure community partners occupy leadership positions and wield demonstrable power equivalent to other partners. Shared power relies on collaborative and shared problem solving and decision making, joint facilitation of activities, and shared access to resources, such as information and stakeholders.

*Structural supports for community engagement* provide the infrastructure needed to facilitate continuous community engagement. This indicator asks about operational elements for engagement such as established and mutually agreed-upon financial compensation for community partners, requirements for equitable governing board composition, protocols to ensure integration of community partners into grant writing and management, and equitable arrangements for data sharing and ownership agreements, among others. These structural supports ensure the longevity of community engagement and the partnership's sustainability over time.

### **Expanded Knowledge**

The second domain, expanded knowledge, refers to the creation of new insights, stories, resources, and evidence, as well as the formalization of respect for existing legacies and culturally embedded ways of knowing that are unrecognized outside of their communities of origin. When co-created with community, expanded knowledge creates new common ground and new thinking, and can catalyze novel and more equitable approaches to the transformation of health and health care. The three indicators under expanded knowledge include new curricula, strategies, and tools; bidirectional learning; and community-ready information.

*New curricula, strategies, and tools* are formal products of community engagement that encapsulate new knowledge and evidence in ways that allow it to be disseminated, accessed, replicated, and scaled. This indicator looks for the development of new curricula, strategies, and tools that enable other partnerships to learn from, build on, and advance new practices in their community engagement.

*Bidirectional learning* is when the community and partners can collaboratively generate new knowledge, stories, and evidence that reframe how community is described and appreciated. This indicator looks for representations of community that are asset- and resiliency-based, improved cultural knowledge and practices among partners, and broader cultural proficiency and respect for community differences across the partnership. Bidirectional learning equally values all forms of knowledge and wisdom, including stories and lived experience.

*Community-ready information* is an indicator referring to the creation of actionable findings and recommendations that are returned to the community in ways they understand, value, and can use.

### **Improved Health and Health Care Programs and Policies**

The third domain of the conceptual model is improved health and health care programs and policies. This is the stated goal of many partnerships; however, creating programs and policies that communities want and will use—a prerequisite to effectiveness in real-world settings—requires alignment between those who design programs, services, and policies and those who are expected to use them. Community engagement is essential to creating a productive context for developing solutions that are “fit to purpose,” as well as embraced and championed by those they are designed to serve. The three indicators within this category include community-aligned solutions; actionable, implemented, recognized solutions; and sustainable solutions.

*Community-aligned solutions* come from and speak to the priorities of the community. This indicator looks for community-defined problems, shared decision making, and cooperatively defined metrics. It also ensures that care models, communication, and solutions are tailored to the community setting and needs.

*Actionable, implemented, and recognized solutions* are important indicators of success. Results should be visible within and across communities. This indicator looks for solutions that are recognized and endorsed by community members and leverage the assets in the community and the partnerships that produced them; are referenced publicly or within academic literature; and show measurable adoption, growth, and reach.

*Sustainable solutions* reference new interventions, programs, and policies that can extend past their initial period of support. This indicator looks for residual infrastructure and other resources that remain in the community to support sustainability and further adjust or refine solutions in the future, if needed.

### **Thriving Communities**

As motion accelerates through strengthened partnerships and alliances, expanded knowledge, and improved health and health care policies and programs, assessing the impact of community engagement moves to the fourth domain: thriving communities. The Organizing Committee identified five indicators that suggest engagement has led to thriving communities:

- Physical and mental health
- Community capacity and connectivity
- Community power
- Community resiliency
- Life quality and well-being

*Physical and mental health* refer to a “whole-person” definition of health reflected in a community’s physical and mental health status. Physical and mental health include a shared awareness and view of health and health-related activities, self-efficacy in managing health and chronic conditions, shared decision making in health care treatments and priorities, increased confidence and capacity to make decisions that improve an individual’s own health, and increased resiliency.

*Community capacity and connectivity* speak to growth in skills and capacity of the community, both as individual members and as a whole, to act on its own behalf. This indicator highlights the connectivity between community members and available resources, how engaged and activated community members are, and the investments available to develop new community leaders (e.g., financial, educational, career).

*Community power* manifests in a sustained paradigm shift that ensures processes and procedures are favored, initiated, and guided by the community. Community power arises with an increased rate of new efforts in the community and new efforts that are defined, initiated, and owned by the community. Community power is also indicated by cultural change—including changes in community dynamics, such as expectations that they will be meaningfully invited to and want to participate in problem solving and priority setting and will experience true equity (e.g., social equity, racial equity, health equity, equity across the drivers of health).

*Community resiliency* refers to the overall strength of a community and its internal capacity to self-manage. This indicator reflects the ability of the community to recognize and mount a locally relevant response to new adversities and to engage and advance culturally effective strategies to strengthen the community over time. The inherent culture and strengths of the com-



munity should be both visible and valued. Importantly, resiliency must not be invoked as a backstop for initiatives that perpetuate trends of a lack of external investments, protections, and support for the community. In other words, resilience is valuable for the internal benefits and strengths that it generates among community members; it is not, however, a replacement for adequate and tangible external investments in the resources that communities need to thrive.

*Life quality and well-being* refer to improvements in the drivers of health (e.g., education, economic and racial justice, built environment). Life quality and well-being highlight the ability to heal, hold hope for the future, and experience greater joy, harmony, and social equity.

### **Health Equity through Transformed Systems for Health**

When community engagement takes place with core principles guiding its processes and activities, it propels strengthened partnerships and alliances, expanded knowledge, improved health and health care programs and policies, and healthier communities. Improvements in these domains and their associated indicators create motion and catalytic action that moves us toward health equity and well-being through transformed systems.

### **Drivers of Health; Drivers of Change; and Social, Political, Racial, Economic, Historical, and Environmental Context**

The domains and indicators that align with meaningful community engagement and lead to health equity through transformed systems for health are influenced by several contextual factors. *Drivers of health*, many of which align with the social determinants of health, expand far beyond “traditional” factors like health status and health care into food, transportation, housing, community attributes, affordable child care, and economic and racial justice, among many others. *Drivers of health* extend to the factors that ultimately influence and impact well-being (Lumpkin et al., 2021; NASEM, 2017; NCIOM, 2020). *Drivers of change* are the key levers that influence stakeholder action, including data-driven, evidence-based practice and policy solutions; grassroots organizing; regulations; and financial incentives, to name a few. The relevant *social, political, racial, economic, historical, and environmental context* also underpins all community engagement efforts. It is critical to understand that the dynamic relationship between meaningful community engagement and health and health care policies and programs exists within these

structural systems. The Organizing Committee believes that with meaningful community engagement, it is possible to motivate health equity through transformed systems for health and significantly transform and positively alter these contextual factors. A feedback loop is created and reflected through the arrows that move from community engagement, the core principles, and the domains of meaningful engagement through to these contextual factors.

### **Conclusion**

The United States health and health care system reflects origins and a history that did not center communities as true partners in designing, implementing, evaluating, and redesigning the system. The Organizing Committee believes that community engagement is not a supplement to enacting better health and health care policies but rather its foundation. The increased focus on community engagement in the health and health care system over the years represents an opportunity for change to ensure meaningful and sustainable impact. The Organizing Committee believes now is the time to catalyze and accelerate the paradigm shift toward engagement to ensure system transformation and equity. Sustained and widespread changes toward improved health and well-being cannot occur until systems change, and that cannot happen without the engagement of those closest to the challenges and the solutions. The processes to engage the community are essential, and assessing and evaluating the engagement is just as essential to understanding whether and how true impact occurs. Without this critical step, it is impossible to truly understand where to focus efforts to transform the health system. Health and health care stakeholders must measure what matters—community engagement—and ensure that it is meaningful.

The ACE Conceptual Model is only one major element of the work needed to ensure that stakeholders can assess the engagement with community. As part of this effort, the Organizing Committee will also be:

- **Developing impact stories** told through videos and other creative modes to demonstrate how different partnerships have assessed their engagement, the influence that engagement has had on their communities, and the alignment of their outcomes with the domains and indicators in the conceptual model. These impact stories will highlight what is possible and how transformation can take place at a community, hospital, health system, and state level.

- **Conducting a literature review search** using PubMed and other databases, as well as inclusion and exclusion criteria, to identify specific metrics or individual survey questions, tools, or questionnaires (referred to as instruments) that were developed, implemented, or evaluated with community engagement.
- **Synthesizing assessment instrument summaries** that identify instruments that align with the domains and indicators in the conceptual model. These summaries, based on findings from a literature review, will include information on how engagement was used to develop or implement the instrument, populations, and communities involved in using the instrument, psychometric properties (i.e., validity, reliability, and feasibility), the instrument's questions, and alignment with the domains and indicators in the conceptual model.
- **Developing a framework to support end users** who want to measure community engagement using the conceptual model and instruments identified.

The ACE Conceptual Model presented in this commentary is drawn from the active engagement and embedding of perspectives from community leaders, academics, researchers, and policy makers. While testing the conceptual model is needed to understand the most effective context and circumstances for its use, this model presents an additional resource for end users to support the assessment of meaningful community engagement. Further, the model reflects what the Organizing Committee believes are necessary elements of meaningful engagement that should be measured and evaluated early and often. This model is evolving and not stagnant, much like the movement depicted in the shape of the model. It represents a guiding framework to catalyze meaningful community engagement and radically propel the U.S. toward health equity through systems transformation.

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## FULL-LENGTH ARTICLES

# Commentary on Community-Based Participatory Research and Community Engaged Research in Health for Journal of Participatory Research Methods

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Launching a new journal on participatory research methods provides a wonderful opportunity to both acknowledge and deepen contributions to the vibrant fields of community-based participatory research (CBPR) and community-engaged research (CEnR) in the health fields. Many other disciplines, such as education, sociology, community and regional planning, communication, etc., share overlapping terms with similar commitments to shared power in research, including participatory action research, action research, participatory research, youth participatory action research, public involvement, practitioner research, collaborative research, citizen science, street science, and, a newer term in health, participatory health research, from the International Collaborative of Participatory Health Research. Within health, CBPR has been the most well-recognized form of community-engaged research for over thirty years (Wallerstein et al., 2018). Since 1998, it has operated with principles well-defined by Israel et al. (2013), and a widely-distributed definition launched in 2001 by the W.K. Kellogg Foundation. The principles and definition ground research practitioners in long-term commitments to co-develop research with community partners, and to build from community strengths and priorities for the purposes of translating research results into policy, practice, or system-change actions towards improving health and health equity. Minkler et al. (2012) added the principles of cultural humility and importance of addressing racism, sexism, homophobia, and other inequities of power hierarchies within academic-community partnerships and in society. While CBPR has often been seen as calling for involvement of grassroots people from communities, neighborhood associations, or social movements, community partners in CBPR can extend to other stakeholders, such as staff from community-based organizations, public agencies or private-sector settings, and policy makers.

Each of the terms and fields named above have different histories, yet they are often divided into two separate traditions (Wallerstein et al., 2018). In the 1950s, Kurt Lewin defined “action research,” often referred to as the Northern tradition, as a process of action/reflection/ action to engage teams of multiple stakeholders in research, predominantly for improving organizational settings (Lewin and Gold 1999). “Participatory research,” often called the Southern

tradition, emerged from activist scholars in the 1970s, drawing from the emancipatory philosophy of Paulo Freire (1970) to join forces with social movements in Latin America, Africa, and Asia to challenge societal inequities. An integrated term, participatory-action research (PAR), has often reflected this more political, Southern agenda within education.

While many of the terms from different fields increasingly overlap in their intent, it remains important to examine each partnership's or project's practices to determine their values and goals. As Trickett (2011) so eloquently described, goals can vary from a utilitarian perspective, such as the need of academics to recruit minorities into their institution's clinical trials, versus a larger worldview of promoting social justice. Along with other traditions such as tribal-participatory research based on tribal sovereignty (Fisher & Ball, 2003), decolonizing methodologies from indigenous (Smith, 2013) and critical theory approaches (Lykes et al., 2018), and calls for knowledge democracy and cognitive justice from the Global South (de Sousa Santos, 2013; Hall et al., 2015), CBPR practice leans toward social justice principles and demands that academics honor community wisdom, autonomy, and leadership.

With this background, in the start-up of this new journal I would like to respectfully raise several questions for authors, editors, and all of us who are participatory practitioners to consider: first, what do we mean by the terms that each of us uses, and how might these terms reflect similarities and differences in diverse international and national contexts; second, what is the difference between a participatory research approach versus participatory research methods; and third, what collaborative or partnership practices are promising for their impact on outcomes?

For the first question, an example in health from the United States will be illustrative. Since 2006, the use of the term community-engaged research (CEnR) has grown with National Institutes of Health (NIH) funding for Clinical Translational Science Awards to academic health centers; early CTSA funding cycles required community engagement cores and this practice, while sometimes not required, has largely remained. The challenge, however, has been that community engagement – and therefore CEnR – has been presented as a continuum, with one end of the spectrum being “outreach” (or academics providing unidirectional educational outreach to communities), and the other end being “shared leadership” (McCloskey et al., 2011).

With the back-drop of historic research abuse and mistrust of research by communities, CBPR has embraced shared leadership and power, and adds a further dimension of “community-driven” research, both of which fit within the Southern tradition of challenging power inequities. CBPR, as well as participatory-action research (PAR) within the field of education, has increasingly called for self-reflection by practitioners on their own positionalities of power and privilege in order to challenge traditional hierarchies of academics and community/ practitioner stakeholders (Fine, 2018; Wallerstein, Muhammad, et al., 2019; Wallerstein et al., 2020). The creation of the ICPHR in 2009 enabled steering committee members to

identify the term “participatory health research” that could be used across nations, with one of the first products, a position paper of shared definition, principles and values (International Collaboration for Participatory Health Research (ICPHR, 2013). With the diversity of terms in health and across fields, however, it becomes critically important for community-engaged and participatory-research practitioners to articulate their principles, values, and processes of participation, such as style of decision-making or formal agreements for such issues as use and publication of data. As Arnstein (1969) articulated, participation can range from citizen control to manipulation, and the degree of participation remains important today as we strive to ensure goals of shared power and community leadership in the research process (Gaventa & Cornwall, 2015).

For the second question, many have asserted that CBPR, CEnR, PAR, or participatory health research is not a set of research methods, but an overall approach that changes the relationship between researcher and researched (Abma et al., 2019; Israel et al., 2013; Wallerstein et al., 2018). The challenge is that any research method, whether qualitative or quantitative, can be implemented in a participatory or non-participatory way. Focus groups, for example, which often are seen as highly participatory, can effectively engage community stakeholders in identifying research questions or reviewing curriculum materials. Still, a focus group itself does not transform academic-community relationships if academics are making all the research decisions. A fully participatory approach requires a structured mechanism, such as community advisory boards, community research teams, or community scientific research committees, so that academic researchers can work in ongoing partnerships with other stakeholders. One of the best indicators of partnership is the commitment to involve diverse stakeholders, whether they are non-profit staff, community leaders, government actors, educators, or clinical or social service practitioners, as equal participants in all stages of the research process. This would include each stage, from identifying research questions and co-developing the design, to collecting data, co-interpreting, and translating results into action. While community members might not have skills to use statistical analytic packages, they can co-create survey questions and be part of decision-making on analysis questions, interpretation, and, ultimately, dissemination and use of data for change.

Despite this difference between an overall participatory approach and specific methods, the *commitment to practice participatory methods* is critically important to ensure genuine engagement. In fact, participatory methods can support collaborations to evolve over time towards greater power-sharing and partnership, as participatory methods often create opportunities for collective reflection on these very issues and lay the groundwork for transformation of partners as they work together towards common goals.

For the third question on promising practices, the field has reached sufficient maturity where we can claim that partnering practices are associated with outcomes. Since the 2004 seminal Agency for Health Care Research and

Quality CBPR publication, which identified 12 articles with outcomes, there has been a tremendous growth in studies that document outcomes associated with collaborative processes (see Anderson et al., 2015; O'Mara-Eves et al., 2015). More astonishingly, a just-completed scoping review has identified 100 reviews of community-engaged research from 2005-2018 (using multiple search terms across fields and across systematic, narrative, and meta-reviews, among others). This review found 55 reviews reporting evidence of different outcomes (Ortiz et al., 2020). The importance of conceptual models has also grown in terms of identifying theories of change and pathways of practices contributing to outcomes (Eder et al., 2013; Greenhalgh et al., 2016; Jagosh et al., 2012; Oetzel et al., 2018; Ward et al., 2018).

Since 2006, a National Institutes of Health-funded collaboration across the U.S. has been seeking to strengthen the science of CEnR/CBPR, with current partners: Center for Participatory Research, University of New Mexico; Indigenous Wellness Research Institute, University of Washington; Community-Campus Partnerships for Health; National Indian Child Welfare Association; RAND corporation; the University of Waikato, New Zealand; and a national Think Tank of community and academic practitioners. Our first funded phase (2006-2009) was to derive a CBPR conceptual model based on the literature with four domains: contexts, partnering processes, impact on research and interventions, and intermediate and long-term outcomes. We then identified measures and metrics for each of these domains. The second phase (2009-2014) was to conduct the first-ever mixed-methods study of diverse partnerships across the nation, with internet surveys of practices and outcomes of 200 federally-funded academic-community research projects and 7 in-depth case studies (Lucero et al., 2018). Out of this phase, we have psychometrically validated the instruments (Oetzel et al., 2015) and produced analyses of promising practices associated with outcomes, including involvement of community members in different stages of research and culture-centeredness (Duran et al., 2019; Wallerstein, Oetzel, et al., 2019). A structural equation model identified two pathways of partnering processes: relational practices such as trust, dialogue, or participatory decision-making; and structural practices, such as formal agreements and sharing of resources (Oetzel et al., 2018). In the current phase, Engage for Equity (2015-2021), we have refined measures and surveyed another 179 federally-funded CEnR/CBPR partnerships, and 36 new partnerships; codified our own theoretical emancipatory approach; and provided workshops and web access (<http://engageforequity.org>)<sup>1</sup> to qualitative and quantitative collective reflection tools to strengthen partnerships in reaching their goals (Parker et al., 2020; Wallerstein et al., 2020). We have seen the use and adaptation of

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1 See Engage for Equity (E<sup>2</sup>) website for resources: 1) for full CBPR Model with text boxes under each domain, see <https://engageforequity.org/cbpr-model/full-model/>; 2) for workshop agendas and examples, see [https://engageforequity.org/tool\\_kit/using\\_tools\\_resources/](https://engageforequity.org/tool_kit/using_tools_resources/); and 3) for Visioning Guide, see [https://engageforequity.org/tool\\_kit/visioning\\_cbpr\\_model/](https://engageforequity.org/tool_kit/visioning_cbpr_model/). See also UNM Center for Participatory Research for further history of E<sup>2</sup>: <https://cpr.unm.edu/research-projects/cbpr-project/index.html>



the CBPR conceptual model being disseminated internationally, with a recent chapter showing examples from Australia, Sweden, Nicaragua, and the United States (Wallerstein et al., 2021). Analyses are showing validation and extension of metrics and measures, as well as continuing identification of practices that contribute to outcomes (Lucero et al., 2020). Other studies by other research groups, nationally and internationally, are in process to add to our collective knowledge of participatory models, measures, metrics, and promising practices which contribute to impacts and outcomes.

It is exciting to see a new journal emerge with an opportunity to contribute to the cutting edge of not only the participatory health research field, but also the larger context of participatory research more broadly. A few recommendations might be helpful as the *Journal of Participatory Research Methods* moves forward and as our collective goals to strengthen all of our practices continue to evolve.

1. Support authors to include a description of their values and principles as part of their discussion of the terms and participatory methods used in each study.
2. Support partnering structural practices that demonstrate value of community knowledge and contributions. These could include co-authorship with community and stakeholders other than academics; and/or supplementary materials that, for example, illustrate data sharing and ownership agreements.
3. Support discussion of lessons learned in each project or collaborative process, including our challenges and difficulties, as well as our successes, such as how transformation can occur from more minimal community engagement to greater community partnership.
4. Support reporting on evaluation of partnering practices within the descriptions of participatory research methods and the potential contribution of these practices to impacts, with potential for supplementary materials that showcase evaluation tools.

In conclusion, the opportunities to learn from others' work and to continue to add new methods and practices to the field which are most likely to contribute to health and social justice outcomes are vast. We also know that impacts do not just occur at the end of a project, but are important to identify throughout the research process. Impacts which transform power relations during the process become especially critical in today's world as we together seek greater social and health justice in our local conditions and larger societal context of structural racial and other intersectional inequities.



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