

Strategies for Academic and Clinician Engagement in Community-Participatory Partnered Research

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THESE HAVE BEEN RECENT PRACTICE AND POLICY CONCERNS over the “quality chasm,” or gap between the promise of evidence-based medicine and the realities of community practice¹ with little variation by geographic and sociodemographic factors.² Studies document disparities in access of care for particular conditions, and there is widespread concern about disparities in health status and health risk factors disadvantaging underserved ethnic minority and lower-socioeconomic status groups.^{3,4} Addressing quality gaps and health disparities will require implementation of programs to address social determinants of health and improve services delivery across diverse communities. Doing so for underserved communities may be especially challenging owing to resource constraints, underdevelopment of research, and historical distrust in research and health care in some groups.^{3,5}

Experts recommend promoting public participation and engagement of diverse communities in research as a strategy to enhance its relevance and to address disparities more effectively.^{4,6,7} Community-based participatory research (CBPR) is the prevailing paradigm to facilitate these goals by promoting mutual transfer of expertise and power sharing in decision making and data ownership across community and academic partners.⁸⁻¹⁰ A recent review identified relatively few English-language CBPR studies in health but wide variation in extent and type of participation.¹⁰ Community-based participatory research has been used more as a paradigm for public health than for clinical or health services research.⁸⁻¹¹ Many features of CBPR—such as spending time in the community, power sharing, and action research methods—might challenge physicians, given their clinical training that often requires interactions under time pressure, the hierarchical structure of academic medicine, and the focus of medical research on controlled trials as the standard for evidence. However, opportunities (such as the recent National Institutes of Health announcement for CBPR research [<http://grants.nih.gov/grants/guide/pa-files/PAR-07-004.html>]) are emerging for conducting CBPR in substantive areas for which physician leadership could be helpful.

It is timely to familiarize clinical investigators with principles of participatory research and to offer strategies to build effective research partnerships that facilitate clinician leadership in efforts to improve health for all communities. Over several years, we collaborated in exploring ways of blending concepts and approaches from clinical services research and CBPR in research initiatives,¹² research training of physicians in the Robert Wood Johnson Clinical Scholars Program (<http://www.hscenter.ucla.edu/csp>), and a multicenter effort to develop infrastructure to support community-based research.¹³ This approach is based on community-partnered participatory research (CPPR), a form of CBPR developed by Healthy African American Families and Charles R. Drew Medical University with support from the Centers for Disease Control and Prevention (CDC), that emphasizes authentic community-academic partnerships as distinct from many collaborative research activities conducted at community sites without partnership in design, implementation, or product ownership. In collaboration with Keith Norris and Paul Koegel, we blended this model with methods from services research initiatives, such as Partners in Care, that addressed quality disparities.¹⁴ Community-partnered participatory research promotes equal community and academic partnership and power sharing in all phases of research, grounded in evidence-based practice as defined from academic and community perspectives, a framing of CBPR that is suited to physician coleadership.^{12,13,15}

This Commentary provides lessons learned from these applications. Recent examples are available at <http://www.communitytrial.org>. Many components of CPPR are partly based on CBPR models^{8,9,16,17} but are organized into a particular approach.

Definitions

The term *community* refers to individuals who work, share recreation, or live in an area. Other definitions range from

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any group with common interests¹⁸ to an approach that raises questions about who defines or represents community and makes decisions.⁹ This focus on geographic areas reflects the emphasis on local capacity building. Partnership approaches are also used in research with health care organizations; one prominent model is the Learning Collaborative (<http://www.ihl.org/ihl>). Health care system partnership is a more natural fit for physicians, so the focus is on community partnership issues.

Community engagement refers to values, strategies, and actions that support authentic partnerships, including mutual respect and active, inclusive participation; power sharing and equity; mutual benefit or finding the “win-win” possibility; and flexibility in pursuing goals, methods, and time frames to fit the priorities, needs, and capacities of communities.^{9,19} What is challenging for physicians is learning what respect means in a community context, sharing planning authority, and understanding the time frame and flexibility required to accommodate the course of events and to build trust.

Community-partnered participatory research is one approach to community program development and collaborative research that emphasizes equal partnership for community and academic partners while building capacity for partnered planning and implementation of research-informed programs. Some experts suggest that equal power sharing is rare in community-based research.⁸

A CPPR project involves a sequence of activities: (1) identifying a health issue that fits community priorities and academic capacity to respond; (2) developing a coalition of community, policy, and academic stakeholders that informs, supports, shares, and uses the products; (3) engaging the community through conferences and workshops that provide information, determine readiness to proceed, and obtain input; and (4) initiating work groups that develop, implement, and evaluate action plans under a leadership council.¹² Having predictable activities can facilitate community entry of physician researchers, particularly when multiple projects are implemented simultaneously, as in training programs.

In a community-partnered participatory research project, academic members become part of the community, community members become part of the research team, and all participants are research subjects, creating a unique working and learning environment. In training programs, stability is enhanced and community engagement is facilitated through consistent faculty and community leadership for each partner organization over time. Community-partnered participatory research is strength-based and celebrates community capacities and project accomplishments, often reinforced through social and creative activities incorporated into meetings and in framing of project goals. The perspectives of diverse community and academic members in a CPPR project can be integrated into agreed-upon priorities and agreements to differ.

Guiding Principles

1. Each activity in a CPPR initiative is coplanned by community and academic leaders who have equal power for making decisions. Implementing joint leadership requires diligent planning. Academic leaders may overpower community members, so it is helpful to have multiple community co-leaders. The CPPR focus on joint leadership differs from a purely community-driven perspective reflected in some CBPR approaches.²⁰

2. Community-partnered participatory research projects should have a written agreement that outlines goals, roles, privileges, and rules of engagement. Typical issues to be covered, recommended by several CBPR experts, include ownership and review of products and data, leadership structure and expectations, contributed resources and responsibilities, and dispute resolution.^{8,9,21} The agreement should be designed to protect academic and community interests and should be written early and reviewed regularly. An example is available at <http://www.witness4wellness.org>. A subcommittee is often needed to review whether the project leaders have adhered to the plan.

3. Community-partnered participatory research leaders should communicate regularly, follow mutually agreed upon reporting and authority lines and rules and use accepted means of maintaining order and productivity. Community-partnered participatory research projects should promote ongoing vertical and horizontal communication. Project leaders should acknowledge and learn from their mistakes and accept feedback from each other. Conflicts and disputes are common and should be viewed as necessary to growth. Communicating about their resolution creates a legacy of problem-solving strategies. Goals of groups should be coordinated through project-wide meetings reporting to overall project leaders. Meetings should have an agenda, observe standard rules of discussion, and be documented with minutes or recordings. Work groups should initiate resource requests in a timely manner. Productivity is supported through following approved action plans and timelines. A jointly developed organizational and communication plan promotes respect of all partners for the project.

4. Project activities, methods, and concepts should be transparent to all participants. All project ideas and procedures should become understood by all academic and community leaders. Concepts and methods can be explained to community participants through joint presentations that benefit from stories, music, or other forms of expression that promote engagement and understanding.^{22,23} Some academic leaders may be uncomfortable with such formats and need help from partners; others may enjoy the outlet. Leaders should support members in asking questions, developing hypotheses and designs, analyzing and presenting data, seeking funding, and implementing human-subject and data-collection procedures.⁸

5. Community partners require financial or in-kind resources to participate. Academic leaders should assist

community partners in obtaining funding. It is important to initiate projects mindful of the resources required and to fit scope to resources. Individual community members may need financial support for their roles. Funders and academic institutions may be unaccustomed to shared resources.²⁴ Joint presentations can help raise awareness of this need.

6. Community-partnered participatory research leaders should respect and follow community values and time frames; CPPR projects should be viewed as activities of the community in which the academic leaders are invited to participate; and CPPR projects involve long-term commitments that often supersede time frames for funded initiatives. Participants are permitted to move “on and off the bus,” or engage and disengage as commitments change.¹⁶ Leaders are difficult to replace, so it is helpful to recruit members as potential leaders. Clinician participants face issues of balancing clinical, research, and community commitments and responding to unmet needs of community members through research, clinical, and advocacy roles.

7. All leaders should seek to achieve the highest standards of productivity, impact, and accountability. Academic leaders should be comfortable in bringing their strengths forward. Abandoning academic goals to fit into the community disappoints partners by failing to bring academic credibility and impact while exclusive attention to academic goals undermines the “win-win” principle. It is important for leaders to find their best fit of scientific and social strengths with project goals and structure.

8. Academic leaders should seek help from community leaders when they run into conflicts, or “put their foot in their mouth.” When academic leaders “get in trouble,” for example, by offending a member when asserting a view too strongly, the community partner may be more aware of the meaning of the concern and how best to address it. Academics often intervene too quickly and independently. Problems are best solved collectively to maintain a high level of trust, respect, and productivity.

9. Academic leaders should build their capacity to understand community priorities and histories in context of their background and partnership. Academic leaders should seek the mentoring of community leaders to learn the history and culture of the community and develop an awareness of their own background and history of their institution’s involvement in the community. Community mentors can help academic members understand issues raised by their background and affiliation. Conflicts about personal and institutional racism or bias might be raised. Open discussion of such issues and how to address them in the project are important to building trust. The principles of community engagement (such as respect and equal power sharing) and outside facilitators can be useful in initiating discussions and solutions. Learning how to understand and work within a historical and social context is key to services research and CPPR.

10. Project leaders should strive to develop the social capital of the community by supporting sustainable leadership and promoting individual growth. The social justice perspective of CPPR means that projects serve community capacity-building priorities. This perspective can be challenging to sustain because academic medicine is competitive while CPPR is inclusive and collaborative. Joint authorship and presentations should be routine and supported by the memorandum. Academic leaders should proactively establish mechanisms, such as meeting with partners before writing begins, using tape recorders or telephone dictation to facilitate community input, or offering a writing or evaluation course. Developing ways to recognize members, such as participation certificates, can build confidence. It is important to help members develop opportunities and resources for using project products in community venues. Many medical sciences are interdisciplinary and multiauthored publications are common, yet the need to facilitate community leadership in science may be a new role for academic clinicians.

11. Academic leaders should seek the support of senior members of their institutions to support their own professional development and recognition for the field. Promotion committees may expect researchers to assert the lead when it might not be in the interest of the partnership or might fail to appreciate time requirements.⁹ Developing agreements with chairs or deans on the importance and features of this field can facilitate advancement and recruitment. Obtaining grants and publishing in good venues are key to professional credibility, while achieving impact (as defined by the community) is key to community credibility.

12. Community-partnered participatory research projects should have a transparent process for evaluating progress and impact. Academic and community leaders should work together to agree on goals and develop evaluation tools. This may require a logic model specifying how activities affect goals and specifying measurable outcomes and inputs. Accountability is a key feature of CPPR that includes developing and following action plans, honoring community priorities matched to academic strengths, and implementing rigorous research. There are excellent resources demonstrating diverse evaluation methods for participatory research.^{8,9,21}

Implementation Stages

Community-partnered participatory research activities and principles are integrated through 3 implementation stages that we refer to as the vision, valley, and victory. The *vision* is developing the shared view of the goal. The *valley* is doing the collaborative work, which may be full of challenges. The *victory* is completing the product and celebrating the process. Project components can exist in different stages. Leaders play a critical role in helping participants identify and progress through stages to avoid losing sight of goals or getting caught in conflicts. As projects evolve,

what was once a victory may become a valley and reorientation is necessary to achieve the next victory. For example, working groups might pursue distinct action plans that later must be integrated to achieve impact, requiring a shift from independence to interdependence.

Community-partnered participatory research represents engaged scholarship blended with participatory capacity building. It is a form of CBPR that promotes equal partnership with a strong emphasis on negotiated evidence-based approaches, suitable to physician leadership. The structure of activities, guiding principles, and implementation stages helps participants to move forward while clarifying and tolerating conflicts and differences. Describing the model simply does not mean to suggest that the work is easy or suited to all investigators. Participatory research can be transformative and deeply rewarding at personal and professional levels. The broader public health question is whether such a partnered approach improves outcomes and develops planning capacity relative to alternatives, such as no intervention or no partnership. Developing such evidence will require methods, innovations, rigorous demonstrations, and funders that understand the implications of partnered research for resources, leadership and time frames, and perspectives on evidence.

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REFERENCES

- Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press; 2001.
- Asch SM, Kerr EA, Keeseey J, et al. Who is at greatest risk for receiving poor-quality health care? *N Engl J Med*. 2006;354:1147-1156.
- Institute of Medicine. *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*. Washington, DC: The National Academies Press; 2003.
- Institute of Medicine. *Promoting Health: Intervention Strategies From Social and Behavioral Research*. Washington, DC: National Academy Press; 2000.
- Freimuth VS, Quinn SC, Thomas SB, Cole G, Zook E, Duncan T. African Americans' views on research and the Tuskegee Syphilis Study. *Soc Sci Med*. 2001;52:797-808.
- Tunis SR, Stryer DB, Clancy CM. Practical clinical trials: increasing the value of clinical research for decision making in clinical and health policy. *JAMA*. 2003;290:1624-1632.
- Zerhouni EA. Translational and clinical science—time for a new vision. *N Engl J Med*. 2005;353:1621-1623.
- Israel BA, Eng E, Schulz AJ, Parker EA, eds. *Methods in Community-Based Participatory Research for Health*. San Francisco, Calif: Jossey-Bass; 2005:31-51.
- Minkler M, Wallerstein N. *Community-Based Participatory Research for Health*. San Francisco, Calif: Jossey-Bass; 2003:53-76.
- Viswanathan M, Ammerman A, Eng E, et al. *Community-Based Participatory Research: Assessing the Evidence*. Rockville, Md: Agency for Healthcare Research and Quality; July 2004. Publication 04-E022-2.
- Wells K, Miranda J, Bruce ML, Alegria M, Wallerstein N. Bridging community intervention and mental health services research. *Am J Psychiatry*. 2004;161:955-963.
- Bluthenthal RN, Jones L, Fackler-Lowrie N, et al. Witness for Wellness: preliminary findings from a community-academic participatory research mental health initiative. *Ethn Dis*. 2006;16(suppl 1):S18-S34.
- Wells KB, Staunton A, Norris K, Council C. Building an academic-community partnered network for clinical services research: the Community Health Improvement Collaborative (CHIC). *Ethn Dis*. 2006;16(suppl 1):S3-S17.
- Wells KB, Sherbourne CD, Schoenbaum M, et al. Impact of disseminating quality improvement programs for depression in managed primary care: a randomized controlled trial. *JAMA*. 2000;283:212-220.
- Wallerstein N. Challenges for the field in overcoming disparities through a CBPR approach. *Ethn Dis*. 2006;16(suppl 1):S146-S148.
- Israel BA, Schulz AJ, Parker EA, Becker AB. Community-based participatory research: policy recommendations for promoting a partnership approach in health research. *Educ Health (Abingdon)*. 2001;14:182-197.
- Metzler MM, Higgins DL, Beeker CG, et al. Addressing urban health in Detroit, New York City, and Seattle through community-based participatory research partnerships. *Am J Public Health*. 2003;93:803-811.
- Macaulay AC, Commanda LE, Freeman WL, et al; North American Primary Care Research Group. Participatory research maximises community and lay involvement. *BMJ*. 1999;319:774-778.
- Moini M, Fackler-Lowrie N, Jones L. *Community Engagement: Moving from Community Involvement to Community Engagement—A Paradigm Shift*. Santa Monica, Calif: PHP Consulting; 2005.
- Fetterman DM, Wandersman A. Empowerment evaluation principles. In: *Practice*. New York, NY: Guilford Publications; 2004.
- Green L, Daniel M, Novick L. Partnerships and coalitions for community-based research. *Public Health Rep*. 2001;116:20-31.
- Patel KK, Koegel P, Booker T, Jones L, Wells KB. Innovative approaches to participatory evaluation in the Witness for Wellness experience. *Ethn Dis*. 2006;16(suppl 1):S35-S42.
- Chung B, Corbett CE, Boulet B, et al. Talking wellness: a description of a community-academic partnered project to engage an African American community around depression through the use of poetry, film, and photography. *Ethn Dis*. 2006;16(suppl 1):S67-S78.
- Pechura CM. Commentary for special issue of Ethnicity and Disease on Community-Academic Partnership for Research to Improve Health in Communities: a foundation officer's perspective. *Ethn Dis*. 2006;16:S154-S155.