HEALTH DEPARTMENTS AND AUTHENTIC COMMUNITY ENGAGEMENT

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Jiann-Ping Hsu College of Public Health

Commissioned Paper authored by

The Center for Public Health Practice and Research

with faculty, practitioners, and students from

Jiann-Ping Hsu College of Public Health at Georgia Southern University[1]

Cobb and Douglas Public Health[2]

Stacy Smallwood, PhD, MPH, Faculty[1]

Angie Peden, MPH, Faculty[1]

Andrew Hansen, DrPH, Faculty[1]

William Mase, DrPH, MPH, Faculty[1]

Gurleen Roberts, DrPH, MPH, Practitioner[2]

RoShonda Welch, MPH, Graduate Student[1]

Jill Johns, MS, Graduate Student[1]

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INTRODUCTION

The CDC defines community engagement as "the process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the wellbeing of those people" (Centers for Disease Control and Prevention). A vital component is the accessibility of these engagement opportunities. Cyril et al. (2015) states that, "disadvantaged populations are challenged by geographic access to healthcare, culturally inappropriate services, financial barriers, poor health literacy, and language barriers" (p. 298).

Methods and tools used to address accessibility include centralization of resources and interventions at a local level as well as providing transportation to the available resources. Ensuring that interventions are mobile and brought to the target population is paramount. Research indicates that community member participation increased when mobile interventions were located within ten minutes of their residence. If interventions lacked the ability to mobilize to the community, providing transportation to/from the Local Health Departments (LHDs) increased participation and favorable results.

Another method is to take a relationship-based care approach which "enjoys exceptionally high participation and satisfaction rates among community members because families are able to control the amount of information and intervention they receive" (Munson Healthcare, 1998). Establishing a "Together we can…" narrative within the community not only gives power to the community members as a collective, it empowers individuals to make the necessary changes for their health. Building cultural competence into the intervention to reach a specific community is vital to encourage engagement. Cyril et al. (2015) found that "...collaborative partnerships, which facilitated an improved understanding of traditional tribal and ethnic health beliefs among academic and other partners" have shown success in facilitating the development of "...locally relevant health policy initiatives for these groups" (p. 298). Incorporating group classes and peer educators into the mix succeeds in building trust between communities and providers because they are able to relate more with those who have an understanding of their background.

Key elements to encourage community engagement are consistency and transparency. To facilitate authentic community engagement in which community members are actively participating and interacting with health departments, these interventions need to have a long-standing presence and

relationship with the community (Cyril et al., 2015). Transparency is another essential element. Historically, there has been a distrust in healthcare systems, especially among marginalized populations who have a higher risk of negative health outcomes and lack access to services. The distrust comes from not being fully informed about the services they were receiving, the benefit it would have on their quality of life, and how the information would be used beyond their interactions.

Models and toolkits such as community engagement guides, Mobilizing for Action through Planning and Partnerships (MAPP), and Community-Based Participatory Research (CBPR) are commonly utilized in community engagement process. These models are used to determine areas of need, level of engagement, range of collaboration, willingness, and readiness of the community to engage and maintain health behaviors. The Community Engagement Guide is intended to "assist DOH programs and staff in ensuring a consistent approach to engaging communities" (Washington State Department of Health).

Using a roadmap with instructions on how to facilitate community engagement, the article, Community Engagement in Public Health, provides a "Ladder of Community Participation as a way to illustrate a range of approaches that can be used to engage communities around both traditional and emerging public health issues" (Morgan et al, 2006, p. 1). In addition to the ladder, The Community Participation Continuum, present in Community Engagements Guides, provide a list of community engagement activities while also placing them on a continuum from those led by the LHDs to those that are community led. MAPP was created to serve as a "community-driven strategic planning process for improving community health" (Institute of Medicine, 2002). MAPP is an essential tool in the facilitation of community engagement and the development of community interventions. The Agency for Health Research and Quality (AHRQ) defines CBPR as "... a collaborative research approach that is designed to ensure and establish structures for participation by communities affected by the issues being studies, representatives of organizations, and researchers in all aspects of the research process to improve health and well-being through taking action, including social change" (Moloughney et al., 2012, p. 7). The CBPR model seeks to "bridge the gap between research and practice through equitable engagement of the community to eliminate disparities in population health" (Cyril et al., 2015, p. 298).

Without funding, initiatives and interventions that encourage community engagement are not sustainable. With funding, intervention managers must have the flexibility to direct funding to

grassroots interventions and initiatives without the hindrance of hierarchy or complicated procedures to access the funding. Another barrier is LHD leadership buy-in. Michener et al highlights that "changing institutional culture starts with the leadership and commitment of top decision-makers in an institution" (Michener et al., 2012, p. 285). Without the combination of Flexible funding, manager autonomy, and leadership buy-in these interventions cannot thrive.

Utilization of authentic community engagement approaches by LHDs improves community health. Best practices are those that cater to the individual, social, and environmental needs of the community being served. If there is no consistency, transparency, or trust between providers and the community, community engagement becomes difficult to achieve. "Authentic community engagement should support partners' capacity to act" (Minnesota Department of Health). Hence the purpose of the paper was to explore how accredited health departments achieve authentic community engagement and how this can be effectively documented through PHAB's Standards and Measures.

METHODS

An exploratory qualitative research design was used to better understand the activities, markers, successes, and challenges related to health departments' efforts to exhibit innovative forms of community engagement. Based on the Public Health Accreditation Board's (PHAB) initial call for commissioned papers, the authors developed a 23-item interview guide which included questions about participants' assessment of current community engagement efforts, organizational considerations, evaluation of community engagement efforts, and recommendations for other health departments seeking to expand their community engagement activities. The interview guide also included a question about specific recommendations for how to strengthen the PHAB accreditation standards and measures related to community engagement. The interview guide was reviewed by PHAB leadership for clarity, pilot-tested with an accreditation coordinator at a PHAB-accredited health department, and revisions were made accordingly.

A list of 15 potential health department interviewees was generated by PHAB based on information about their community engagement work that was provided in their accreditation or annual reports. The authors contacted all of the health departments on the list and scheduled and completed full interviews with 12. Three of the interviews were one-on-one and the other nine interviews were conducted in a group format based on the availability of health department personnel with diverse

levels of experience with their respective health departments' community engagement efforts. Interviews ranged from approximately 45 to 100 minutes in length, and all interviews were digitally recorded, then transcribed verbatim. Informed consent was verbally obtained prior to conducting the interview and was included in the audio recording. All instrumentation and protocols were reviewed and approved by the Institutional Review Board at Georgia Southern University.

Interview transcripts were analyzed by constructing a crosswalk between the interview questions and the objectives put forth by PHAB in the call for commissioned papers. Following a norming session, three of the authors engaged in line-by-line coding of four interviews each, based on interview question and qualitative content. After the initial round of coding, transcripts went through a second round of analysis to ensure consistency of coding between authors, and overall themes were identified.

FINDINGS

Background

Twelve health departments were included in the interview sample. The majority were county health departments: eight county health departments, three city health departments and one public health district that included multiple counties and a city. The sample of health departments were located across the county with three in the west, four in the east, and five in the midwestern region of the country. The average population served was 597,575 citizens with a maximum of 1.8 million served and a minimum of 44,151 served.

All interviewees were either health department or district directors/commissioners, accreditation coordinators, or community engagement coordinators. About 50% of interviewees were present during initial accreditation (13 present, 12 not present). Average tenure in position was five and a half years, ranging from three months to 29 years. Typical roles and responsibilities included planning for accreditation, leading community engagement/assessment/planning efforts for Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) coalitions, facilitating teams, and leading efforts for health equity and strategic planning.

Authentic Community Engagement

Health departments engage with community members in a variety of ways and this is often dependent on the specific initiative. CHA and CHIP processes, along with other initiative-specific

coalitions, are examples of traditional active engagement strategies. County health officials may provide funding for a specific health initiative or the health initiative drives the engagement.

Initiatives and partnerships. Many LHDs, through outreach workers, reach out to informal leaders and leaders of nonprofits who have influence in the community. These include houses of worship, masonic lodges, school liaisons, and Chambers of Commerce. LHDs build these partnerships to engage the community members around health initiatives. Other strategies included advisory councils for public health or budgeting, collaboration on strategic plans and in specific programs via social media, like Twitter, Facebook, Nextdoor, e-newsletters and other list-serves. In addition, canvassing, phone banking, customer satisfaction surveys, and Citizen Surveys were used to elicit community feedback. One LHD had a Leadership and Civic Engagement Academy that gives community members the opportunity to build their capacity.

Proxy measures. Once community partnerships were established, interviewees reported a number of indicators acting as proxies that demonstrated successful authentic community engagement. These proxy measures included observational and tangible outcomes. Observational outcomes included the progressively greater involvement of neighborhood associations and community members approaching the health department with requests; however, these are not always easy to quantify.

> *"And in terms of engagement, it's my read on it is more qualitative. And it boils down to the fact that we get a lot of requests, people come to us. We get a lot of responses when we query folks. But to show causal linkages, which is at the core of this question, that's been a little bit more difficult to measure."*

Another form of observing success included initial relationship development and the creation of new opportunities for residents or mini-grants providing the spark for wider community efforts. In the examples below, the initial partnership or community engagement initiative led to tangible outcomes, was sustained, and community led. In the third example, we see how funding from the LHD led to the tangible outcome of a garden and the process increased connections.

> *"It started off with one person who worked with us on a grant that got trained in diabetes prevention, became a community health worker, and then began to grow...started a business to hire others from the community."*
>
> *"We have a grocery store where we didn't use to. We have a piece of legislation on healthy food financing."*
>
> *"And we gave them a very small amount of funding. They built a community garden at the home of some of these adults with disabilities; and it involved over a hundred residents to support this community garden, to build it, to have vegetables. The adults that live in the home got community connections."*

When community capacity and power were increased through more involvement of the community members acting on steering committees, success took on the form of participation and then actual influence. The involvement was substantive in the form of power-sharing and decision-making with the health department and created feedback loops with essential services like grocery stores.

> *"We have as far as power sharing and decision-making, as far as our priorities are concerned, as far as the Ryan White project, as well. We have community members that are a part of our health improvement planning partnership steering committee. We have community members that are part of the leadership group."*

> *"I think those things are all opportunities for us to... What I like about the work is, with the grocery store work, is how basically the residents given the opportunity to go right to the store owner to say we want you to hire local. Then, they know that that also then creates a pipeline for jobs. That's a feedback loop with the owner. So, to me that creates power, it creates opportunity."*

Evaluation and assessment. In addition to observations, all health departments had some form of formal survey or assessment tool to measure community engagement. Measures reported included Action Team Sheets, CHA/CHIP, behavioral health surveys, youth surveys, performance management systems, program evaluations, and grant deliverables. One health department reported using a Performance Management System that was a specific initiative to track accreditation activities.

> *"Performance measurement is just a kind of spreadsheet that I've been keeping track pretty much since we became PHAB accredited and that's kind of evaluating the services that we provide based on 5… standards or activities under each measure that we selected as far as where we want to see our program is at. So we look at if the program is developed and/or maintained using public or stakeholder input."*

Several interviewees linked their community engagement efforts to the completion of CHAs for the purpose of developing their CHIP. Participants also talked about incorporating community members in their overall strategic planning processes. One participant indicated,

> *"CHIP committees are staffed with community leaders and community influencers within the—and we constantly refer to them to be the guides in our process."*

A simple solution employed by all LHDs to assess the involvement of community members was the utilization of community surveys: feedback surveys that accompanied an initiative or coalition, Citizen Surveys, and satisfaction surveys.

> *"May is Mental Health Month, and the entire month is the community that works on the Mental Health Task Force pulling together mental health promotion events. And at those, we usually have either a survey for participants—we obviously have participants sign in, so we can see, is the, you know, from year to year, is the participation increasing? We get testimonials from people in terms of what was really helpful to them."*

More elaborate surveys were used in the evaluation of programs to measure success through member feedback. Some of these evaluation assessments go as far as asking members how they feel they are being engaged.

> *"For some of our coalitions, specifically for the Violence Free Coalition, we are doing membership surveying. So, we're not just surveying the results of our group, but also just how membership feels that they are being engaged, what they're getting out of that partnership and kind of what their role is within the group or the collaborative."*

While assessment tools were used as much as possible, some LHDs who have measures admit that they are still in development and take caution to overburden community members.

> *"Yeah, we're trying to get better at that. Again, it's, you know, surveys. Folks are surveyed to death. I can tell you that we did the community health assessment. We had over 1400 respondents to that survey. You know, is that a good thing, a bad thing? So it's hard. We can tell you what we're seeing."*

Health equity as a critical component. Health equity was an important aspect of the efforts and often considered crucial to successful community engagement. Many interviewees described their community engagement efforts in the context of health equity and often department missions and strategic objectives involved health equity.

> "*One thing I would add in this is we do have the Health Equity Action Team sheet. Our Health Equity Action Team is looking into – in addition to what you are saying, I agree with all of those. The Health Equity Action Team is looking at ways to continue to measure the success of our health equity work to make sure that we are addressing equity in all that we do. How do we measure that? How do we look at that? So we're considering some additional measures on top of some of those community population level measures that you already mentioned."*
>
> *"in 2017, we started our Health Equity Initiative, and that, we really wanted to increase our own staff's awareness and knowledge around health equity."*
>
> *"And then at the HHS level we also have the equity ward groups that are focusing on communication strategies, operationalizing equity, how we think about implementing some of the concepts that we're talking about, and thinking about training and development for our internal staff, as well as how that training impacts our work with our community."*
>
> *"So yes, I would say that as a Department we have an expectation to not only include community members, but to involve them early in the process, and really use the information that we have like the best practices, the tools, to achieve health equity."*
>
> *"I mean that is, as we try to advance our work around health equity and our equity impact plan, we do need to make sure we are working with our community and hearing their needs and trying to navigate and reduce the barriers for community members to access services."*
>
> *"Our mission is to achieve health equity across the city, so that requires – to achieve health equity requires us to make transformative changes, or begin to make that, which involved community members."*

Best and Promising Practices

When asked about the community engagement initiatives in which health departments are involved, many diverse strategies emerged across a wide spectrum, which are summarized in the following sections.

Health departments as conveners. Many interviewees mentioned the importance of serving as conveners for diverse community groups, coalitions, and collaborations. Participants discussed the value of using their role as health department professionals to bring community partners together around a wide variety of issues, including substance abuse, aging, mental health, HIV, healthy eating, active living, and violence prevention.

Building relationships and capacity. Many participants discussed the process of allowing community engagement efforts and partnerships to emerge organically from being present with community members in diverse settings. They described the importance of being present at community meetings without having specific agendas; rather, they supported and meaningfully participated in community initiatives that were not related to health department objectives or initiatives and found points of common ground with stakeholders that led to new partnerships. Interviewees stated:

> *"…I would say that's a lot of the way that we meet different community leaders is through other community meetings and working on other initiatives those social circles start to overlap."*

Interviewees emphasized the importance of cultivating mutually-beneficial relationships with community members. Trust and reciprocity were key components of building meaningful, sustainable community relationships.

> *"And we make a commitment to contribute to that work and add value because the next time we need to ask somebody else to contribute to our project or come to our table, we're going to expect them to bring value along with them, too…[W]e don't want to be the partner who never did the work in between the two meetings that you said you were gonna do and bring back to the table…[W]hen you're there, you're helping create something that we're all gonna benefit from."*

> *"So we've just really over time created, I think, a strong culture here that you don't get to just check in or check out when you go to those other meetings. And I think that creates a lot of trust and integrity then when people come to participate with us or partner with us. They say, 'You've always been a great partner for us. Here, let me help you, too.' And then they do. They add value. That makes a difference."*

Capacity-building was closely related to efforts to build relationships. Interviewees discussed the value of providing capacity-building support to community members, leaders, and coalitions to

support their efforts. Although the community projects may not be related to the health department's goals, interviewees looked for ways to leverage the health department's skill sets, expertise, networks, and resources to support those projects. Some participants said that it was important for them to amplify the voices of those who were actively involved in their communities, rather than the health department imposing or co-opting initiatives. Interviewees described the ways in which new community partnerships emerged from simply being present in community-initiated programs:

> *"I think just by, again, participating in projects that are ongoing, are out there, are happening, or bubbling up in the community, being a participating member in those and then uplifting them and building their network capacity is something that we do often. So we may hear of a small project, we may be able to lend either some funding or technical support to build that up and then we may also come back and promote that particular project whether it's through local press or social media to say, 'Look what they've done, look what they're doing to give that project a little more voice.'"*

> *"One example that comes to mind, a couple of years ago, we funded an individual…in one of our Hispanic neighborhoods to bring a farmers' market to her community. She was just a community member who was, you know, very disappointed by the lack of fresh, local produce that was available in her local area. And she just came to us and said, 'I need a farmers' market. How do I get a farmers' market?' So we worked with her and got a farmers' market up and running. She did all of the heavy lifting. We provided a little bit of funding support and some communication support.*

> *"And through community-wide promotion of events, for example, we will hear about there's a particular mother in one of our communities who started her own group, a very successful group on suicide prevention. And by hearing about some of the other events that were communicated or publicized, she was brought into those events, made herself known to our staff and introduced herself to our staff to attend some of her meetings; and then we built a really successful partnership with that individual and with her group and her coalition and her community work just by making ourselves visible."*

Community health workers. Some interviewees indicated that the recruitment of community health workers enhanced their community engagement work. Community health workers are community members who have been identified as trusted, respected opinion leaders who can then share credible health promotion and education information with other members of their communities (Hartzler, Tuzzio, Hsu, & Wagner, 2018). One health department partnered with a local community college to develop and provide a for-credit community health worker course.

Community health workers were considered especially important among Spanish-speaking and English as second-language (ESL) communities.

> *"…[W]ith the community health workers, it was a natural process from, they happen to be participants, they were of Latino descent and spoke Spanish. And so, you know, they had an interest in health promotion, and so it*

was a natural progression of…helping them first of all gain some of the knowledge that they…needed…just gradually helping them to assume more of a leadership position."

"I taught community health worker trainings through the health department in English and Spanish. And so I still stay in touch with a lot of the promotoras, the Spanish version of a community health worker."

One interviewee talked about the value of community health workers:

"I think oftentimes in research people draw a hard line between staff and community members. And especially in our localities, our staff are the community members. I mean, they're from there. They know people. They know the superintendent. They know the history and the politics. And we do rely on them for a lot of those leads."

Diverse community partners, coalitions, and collaborations. Although direct engagement with community members is often upheld as a marker of authentic community engagement, interviewees emphasized the role of diverse community partners and coalitions in building bridges between health departments and community members. Categories of community partners included pharmacists, faith-based leaders, police, firefighters, housing authorities, elected officials, individuals representing grass roots organizations, community leaders, and librarians.

Identifying and supporting community leaders. Health departments reported engaging with diverse leaders in their respective communities. They valued the input of community leaders as contextual experts and gatekeepers, especially with hard-to-reach populations. Participants made a distinction between community partners (largely nonprofit organizations) and community-based leaders, who were identified primarily as residents or informal community leaders. However, they discussed the importance of working through their community partners to identify community leaders and other interested community members with whom they can collaborate. They also indicated that word of mouth was an effective way for them to connect with other community leaders.

"…[I]nformal community leaders, especially thinking about how we plan for the health equity report, we use a lot of the lived experience and expertise from the folks who have established relationships in the community."

"But within the community we know who the leaders are, and we have a few organizations that serve as the leaders. And so we always start there and then build out from that…"

"I think a lot of it's through word of mouth. We have a lot of community partners that we're working with, and they're well aware of who in the city is kind of wanting to step up and work on some of these initiatives."

One participant emphasized the importance of applying a critical lens in terms of what community leaders are represented in their collaborations:

"But one of the things that I like to do, and I think we're doing more of this, is in our process really identifying who we know and who's at the table, but who may not be at the table. And is there a lens or a perspective of a leader or someone that maybe is not at the table that we need to get to know and identify that person."

Participatory budgeting. A few of the health departments described a process where community members were involved in the development of either the health department or the city/county budgets where public health funds originate. This happened either directly or through a board or council.

"We do have our public health advisory council made up of community members, which provides input on like our budgeting process, program development, some of our legislative priorities, things like that."

"When you say community engagement, so the city has – and this is not a product of the health department, but we are a partner – so the participatory budgeting process, we've been doing this for five years. We are an active member of the planning committee."

"I think, too, getting community input into the budget process and helping to express their priorities for how discretionary dollars is something that was implanted kind of county-wide and is something that we're starting to look at."

And then as a county, our board of commissioners is working on some transparency around their own budgeting processes. So, this year they held several kind of community meetings so that gave community members opportunities to kind of provide input on where kind of budget priorities should be.

Most of the interviewees described community member involvement in departmental budget development as aspirational.

"The community members have not been involved in our overall department budget process. But they have been involved, yes, in projects-based budgets. Or if we're writing a grant, they're actively involved in the budget of that. But no, not the department-wide budget."

Health departments did share examples where community members were directly involved in the budget development for specific community initiatives. Most of these examples involved discretionary funds and some of the participatory budgeting happened at the health department level and some at the county or city level.

"We do have a budget process, where we have funds coming in for cannabis retail and cultivation permits. So that is going to the general fund, and the board of supervisors and a couple other county departments to do the community engagement process as part of getting community feedback for how to spend some of that money."

"Okay, so to the PB, so each year that pool – so I think it started out at half a mil, and each year the city manager and the city leadership have increased the appropriation by $100,000.00 each year. So now it's at a million dollars. I can tell you that it is incredibly popular to do this every year where there's a bucket, folks send in their proposals, there is a committee that votes on these things. So these are folks from the community, not outsiders, that propose these projects, but also the selection by residents and partners on the ground.

"This is something that I hold dear to my heart, because I was helping in the beginning of this project. So the project started back in summer 2018, and participatory budgeting is of course a direct democracy project that involves the community members to help us determine how to reallocate funds…And so with that project, we went into the community and we had canvassed, we phone banked, and we just asked the community, how would you spend $100,000.00?"

"We actually have some technical assistance because of our – ours was called "Our Money, Our Voice," and we got it from a group that's called "Our City, Our Choice," and so they helped us with the whole process of how to do this, and provided us with different materials that we needed, such as a program guide. We had a lot of conversations with them; they came here and visited us to help us. We were on a lot of calls with them. And so this actually has been modeled in multiple cities across the nation."

Cultivating a departmental culture and policies that value community engagement. While there was not unanimity across health departments, many participants stated that a commitment to community engagement was engrained in their overall departmental culture and expectations. A major point was made to emphasize the need to create an equitable "table" around which all participants were co-equal contributors to their respective initiatives. Establishing a welcoming environment was an important component of facilitating productive initiatives.

"And so we really emphasize that it's kind of part of a culture that when you're working with another group in the community, whether you're at the table as a co-equal partner, co-leadership kind of thing, but when you're there at the table on somebody else's project, you're a contributor, not just an attendee. You're not just there. You're not a visitor."

"I think that's one of our biggest priorities as a division is that we really try to collaborate with our community leaders and organizations in that work."

One health department talked about the use of participatory action research methods, such as photovoice, as a way to gather community input for policy-making:

We had the community submit photovoice submissions, like stories and pictures of what they felt hopeful about in the community, and that shaped some of that policy, so we decided we were going to do participatory budgeting, which was a big community engagement initiative that we did last year…And that was the key influencers, not only—try to do the grassroots."

However, concerns were expressed about how to operationalize community engagement. As one participant stated:

[Y]eah, it's an expectation, but…I think community engagement is the one we maybe struggle with the most. It's probably the newest thing we've done in the past five years, and so while I think we're making really great progress, we still have room for improvement and getting more input from the community."

Critical Activities

During the interviews, health department representatives were asked if community members were involved in the following activities:

- ✓ Setting priorities
- ✓ Participating in planning
- ✓ Playing a key role in decision-making
- ✓ Organizing for community action
- ✓ Advocating for policy and/or structural changes
- ✓ Community advisory groups
- ✓ Community action groups
- ✓ Town meetings
- ✓ Linking with community activities

Overall, many health departments responded that, yes, community members are involved in the listed activities. Many activities have community involvement at the programmatic level and many interviewees also stated that these activities occurred in conjunction with CHA/CHIP processes and heavily relied on community participation.

> "*We have community members that are very heavily involved in determining and setting the priorities for our health department's Community Health Improvement Plan. So, they were definitely involved in that. They participated in the planning of that, they were key decision makers in what we were gonna be doing for our goals, and I think that goes in vein with the other ways in which we're including our community members. They're not just kind of there to listen, they're there to be able to help inform us.*"

Additionally, interviewees discussed community-based planning councils and steering committees for initiatives addressing HIV, hard-to-reach populations, and LGBTQ groups.

When considering actions for next steps, many health departments mentioned looking towards a more "agency-wide" approach to community engagement. While some health departments reported an overall culture of community engagement throughout the agency, many stated that their efforts are more programmatic and also grant-driven. One interviewee reported when asked about next steps that she would like to see,

> *"more programs that are learning from the existing work that's already underway about how to, so that we cannot go from 0 to 100, but we want to continue to advance along that ladder of participation. Toward more resident involvement."*

Another interviewee discussed the need to refresh and revisit some older partnerships,

> *"as you know, with working with community members, people are definitely engaged, but they don't stay engaged forever. So, you can't just continue to rely on the people you've worked with in the past, and you need to keep looking to say who is the next person in the community or the other people that are, you know, could be really*

great assets and wanna do some work to support their city and looking at how we can continue to engage those people."

Other next steps included additional training opportunities, trust building, academic health departments, and shifting the power back to the community.

"I think just more of what we're doing. We definitely want to move towards kind of shifting the power, and making sure that community members do have a voice in helping to shape practices, policies at various levels of government, and how we can do that more, not only in the bureau that we're already implementing it, but in some of our other bureaus as well."

Skills

Communication, authenticity, cultural humility & trust. Communication and cultural humility emerged as top skills for successful community engagement followed closely by trust, training, authenticity, and community understanding (see Figure 1).

Figure 1 – Most frequently mentioned skills

Communication is significantly tied to other skills and behaviors mentioned such as honesty, trust, empathy, shared leadership, and language sensitivity. Proper and clear communication allows both the health department representative and the community member to clearly understand expectations to ensure that everyone's needs are met. One interviewee shared,

"I think, for working with community members, it's very important to have a clear ask or clear expectations for them, what we would like them to be a part of and why, to be considerate of their time, respectful of their viewpoint, and then acknowledge their contribution. But I think that a clear ask is important."

Speaking the language of the members and using a clear message was stressed. In one case this was valued to the extent that plain language training was utilized.

"And I think when we talk about public engagement, having a clear message, having a simple way of communicating with folks is really a great way to begin the engagement process and then continue and make sure that folks feel heard and represented and that they hear your message as well.

"We did the plain language training from the perspective of health equity, considering different languages spoken in our community. We know that if you're using plain language in your written communication, it's easier to translate into other languages. But also, there's different reading levels, et cetera, different ways of accessing information. So, we just wanted to make sure that we had that at the forefront of all of our communications."

Along with communication, the idea of "role knowledge" was used to explain the importance of health department staff fully understanding their role in a community:

"Understanding the role that the health department and government has, and that how we approach audiences may not – there's no cookie cutter way to do that. It's to understand that. I don't know, I'm saying this wrong, but just to understand that we may not be able to go to X community group and say, 'We wanna do all this,' but that the engagement comes through."

Cultural humility and sensitivity were also seen throughout this section of the interview as well as throughout many of the sessions. Numerous health departments are pairing their community engagement efforts with health equity training and related initiatives. This pairing helps us to understand why cultural humility and sensitivity are discussed so frequently in this section. One interviewee explains the challenge of hidden bias,

"my answer to that is one of the things is kind of this whole work that we're beginning to do around hidden bias and cultural transitions of like transition work because, you know, my impression of what I see in the health department and in the county is everybody truly wants to do this work in community engagement and they have in their heart of hearts to do it and yet there's so many habits and ways of thinking and ideas of cultural superiority, they get in our way. We just don't even know it."

Many of the health departments understood that in order to successfully participate in community engagement they needed to examine both their health department and their community through an equity lens. Many mentioned needed skills and behaviors directly or indirectly linked to cultural sensitivity such as language sensitivity, humility, authenticity, and respect.

Understanding and communicating with the community. Finally, the idea of exploring and understanding the needs of the community was discussed multiple times. This was not in the context of the structured CHA, but rather the skill of understanding and communicating with the

community to understand what is actually needed—the idea of not duplicating efforts or "stepping on the toes" of other grass-roots community action groups.

> "*we talk about that a lot of times, not duplicating work, and that's how we try to make sure that with all the individuals that work in the department, we ask questions to see like what are you all doing, or what are other people that you work with in the community that's outside of the health department, what are they doing? And then that's how we collaborate, instead of trying to recreate something that's already being done.*"
>
> *"I mean, and that's one of the reasons that we, again, as a health department, we don't see our role in duplicating or trying to compete with existing efforts, for the most part."*

Guidelines, Models, & Tools

MAPP (http://www.naccho.org/MAPP) was the most extensively utilized model; however, LHDs reported utilizing a variety of other models or toolkits, demonstrating the need for a variety to meet the needs of the community and community engagement initiatives. Among the models mentioned were:

a. Community Health Improvement Plan (CHIP): A community health improvement process uses CHA data to identify priority issues, develop and implement strategies for action, and establish accountability to ensure measurable health improvement, which are often outlined in the form of a community health improvement plan. (https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment)

b. Academic Health Departments Model: The formal affiliation of a health department and an academic institution that trains future health professionals. (http://www.phf.org/programs/AHDLC/Pages/Academic_Health_Departments.aspx)

c. Community Chief Health Strategist Model: Part of a community multi-collaborative health approach, a Community Chief Health Strategist is an engaged change leader (or group of leaders) who builds community coalitions that investigate and take action to make meaningful progress on a community health issue. (http://www.phf.org/consulting/Pages/Becoming_the_Community_Chief_Health_Strategist.aspx)

d. Best Practices from other health departments: NACCHO's Model Practices program is a great way to find current public health best practices. It is not limited to community engagement but there are examples involving the community. (https://www.naccho.org/membership/awards/model-practices)

e. University of Kansas Community Toolbox: The Community Toolbox is a free, online resource for those working to build healthier communities and bring about social change. Our mission is to promote community health and development by connecting people, ideas, and resources. (https://ctb.ku.edu/en)

f. Paving the Road to Health Equity: (https://www.cdc.gov/minorityhealth/publications/health_equity/index.html)

g. Health Equity Guide: (https://healthequityguide.org/)

h. Human Impact Partners: (https://humanimpact.org/)

CBPR was the most favored approach used by health departments interviewed for developing partnerships. In one case, CBPR was less about research "R: and referred to as functional partnerships in the sense that the partnership is a mutually beneficial one.

> *"functional partnerships and the development of functional partnerships which to me, as I am now engaged in masters of public health program, look and sound a lot like to me participatory research,"*

Policies. Achieving goals and using a specific approach takes practice and commitment among staff. One LHD even had county policy on their side to ensure an equity approach is always used while another had a Multicultural Advisory Council.

> *"Our county has a racial and social equity policy, and a lot of our work is we advance health in all policies, and our original CHIP and of course agency work has always been to focus on health equity. So it's a natural, for us it's a natural extension. It's not specific to health equity. It's broader which encompasses health equity"*

Consultants. In addition to models and approaches utilized within the department, outside consultants and agencies were sought out to bolster engagement. Some LHDs included their academic partner as an outside agency while most worked with consultants for specific expertise when working on a project, with a specific population, or for evaluation of a program.

> *"… when we did the African American Ancestry health assessment, we brought in a consultant who was of African American ancestry to sense who could really help facilitate a conversation with the community about the meaning of the data and how they wanted to portray the data and really facilitating the survey questions that the community wanted to answer was based out of the peace partnership."*

> *"So the main consultant we've been working with is the Health Resources in Action, HRA. They have been an uber catalyst for us. They've been with us from day one years ago, six years ago, when we started the first iteration of the health assessment and the health improvement plan. They are working with us right now for the 2.0 version of both those documents as well as our departmental strategic plan. So, yes. We have worked with a few consultants over the years, but the largest grouping has been with Health Resources in Action."*

> *"So we contract with an independent evaluator to evaluate a lot of our SHIPs, Statewide Health Improvement Partnership programs. And she does a lot of work directly with our partners. In addition, we work with consultants on worksite health partnership and that worksite structure to help employers be leaders in terms of the health and wellbeing of the population that they employee. So she is a consultant with us that does assessments and a variety of strategies to amplify and develop the capacity within an employer's system."*

Barriers

Although there are many benefits and advantages to advancing community engagement, health departments also encounter several barriers and challenges.

Reaching out to underrepresented communities. Health departments discussed the importance of reaching out to communities and groups that were the most underrepresented, especially racial/ethnic minority groups and LGBTQ+ populations. However, their staff did not always reflect the diversity of the communities with whom they sought to partner. Health departments often framed this difference through the lens of health equity and cultural competence/humility.

> *"…it's difficult to determine how best to convene that group or that population to somehow talk to – let's say we wanted to do Hispanic families and what is it like to be a Hispanic person in this community and are there barriers that you face that are different on this heath equity kind of lens, that kind of thing. The cultural centers for many of these groups are still over in [S]which is the community to the west of us or maybe even still in [M], a community even further west. And so for us, kind of finding that cultural center where we could have that conversation or we might be able to convene the group,that is difficult for us and has been for some time."*

> *"So we have more trouble engaging populations where English is not their first language."*

> *"And so different communities might need different strategies, including the basics, like language to communicate effectively, and our populations are so much smaller that it's really hard if you wanted someone who is Spanish-speaking, but also could work with refugees, and to have someone who is both sort of culturally familiar and has the language, and then all the other skills you need to be able to do good engagement and outreach, I think that that can be very challenging, because the scale is so much smaller."*

Logistical capabilities. Many participants linked their difficulties in engaging hard-to-reach populations with logistical challenges that can prohibit their ability to be present at community health events, most notably transportation and childcare.

> *"But those we struggle a little bit more to engage with are those who are typically disenfranchised. And I think that's common in a lot of communities, but it's particularly difficult in our community with access to transportation for those that have lower income and just the way that we are geographically spread and structured and because of some of those cultural centers that exist outside the boundaries of our county."*

> *"We also have some difficulty engaging populations that have transportation barriers or have work schedules that don't allow them to participate in in-person types of meetings."*

In addition to logistical challenges on the part of community members, health department personnel also faced barriers in their ability to be present for the communities they seek to serve. Some of these challenges included the amount of time involved with participating in, as well as traveling to and from meeting sites:

"And so to truly be engaged, we would need a couple more of us to really be out there, to have time to go to meetings with the people you meet at the meetings, to get involved in some more grassroots community things."

"If we go to one of those inter-agency council meetings, it takes an hour of driving, more or less, each way, an hour and a half for the meeting. You're talking a half day just to go to a meeting…"

Depending on the size of the jurisdiction, multiple staff members may be necessary to maintain meaningful relationships with the communities they serve; however, lean staffing may not lend itself to multiple staff members being able to participate in the process. Also, health department staff need to be adequately trained on how to engage diverse communities in an authentic way, and such training may not be readily available for all jurisdictions.

Funding. Often, health departments' efforts were due to their commitment to community engagement as a first principle. However, authentic community engagement practices conflicted with the outcomes or deliverables associated with many of the funding mechanisms that supported their work. Community engagement requires a significant commitment of time and resources, but funding directives often did not include budget lines that would support such efforts.

"But I do think it's really important that the way our funding is set up in [C] and the way we're typically allocated positions, it's not only a question of identifying, but also having the resources to actually be able to engage and engage authentically."

Recommendations from Health Departments

The health departments shared numerous recommendations for successful community engagement.

Be present in the community. When community members see the health department interacting and supporting the community they serve, members are more likely to participate in health department initiatives. One interviewee shared that,

"*where we show up when there's no agenda, where we truly, authentically partner to shift decision-making authority and power, then we are co-designed, co-partners in advancing this work."*

Another interviewee shared that when engaging communities, be sure that it is mutually beneficial:

"Make sure that the engagement is mutually beneficial, that it's not just beneficial for our organization, but that it's also beneficial for the community."

Interviewees also expressed the need for shared leadership when working with community members:

"The only other thing I would add is to look for more opportunities for power sharing, more power-sharing opportunities to share power with the community. Look for more opportunities to do that."

Start where they are. This idea was pervasive throughout the majority of the interviews. Many of the health departments supported the idea of going to the community and asking them about their needs rather than barging in with a prescription for success.

> *"Start where they are, in terms of what their priorities are. I think that's one of the limitations, when so much of our funding is categorical. If we don't start where the community is, in terms of their priorities, then it's more challenging to meet the grant deliverable through community engagement."*

Go to them. This may be a challenging recommendation considering funding, space, work schedules, and all-around health department capacity, but going directly to the community members was discussed as essential for success.

> *"They definitely have to go to the community. We're a large county and semi-rural. It's very important to go to the community."*

Meet where the community is most comfortable; provide childcare, food, and stipends for time. When health departments have capacity issues, utilize partnerships to enhance engagement:

> "*I'm going to go with partnering. Because I think even in our rural localities there are activities happening, and I really don't think each organization needs to reinvent the wheel and do their own thing."*

Additionally, be mindful to engage the appropriate community members for an initiative:

> *"Make sure that who you're gonna invite to the table really is hopefully gonna have an interest in that topic."*

Trust takes time. Authentic community engagement cannot be rushed and trust is essential. One interviewee shared,

> *"in the beginning of this work, it wasn't about doing a presentation. Just fellowship in a church. That was it. And engaging with some of the members who had invited me, just feeling like, wow, she came all the way and sat here for an hour and a half. I've been to events, Korean events that I didn't understand a word and they've been like – I went again a second time this past Christmas. They just couldn't believe it. And I told them I didn't have to hear the words. The music, all this, I could just feel the vibe and it was – I enjoyed it. Which is true."*

Many interviewees shared that although authentic community engagement is time-consuming, that time is what makes the engagement real and successful:

> *"So it's making the time. You can't hurry this. You have to be sincere. You have to – the whole point of engagement is for us to work with them to kind of improve our work. But up front it should be about learning about them because the community is so diverse."*

Interviewees shared that when they took the time to listen and engage, this also made it easier to include traditionally hard-to-reach-populations.

Write community engagement work into job descriptions. This is also a challenging recommendation. When discussing barriers, the idea of categorical funding was brought up numerous times. By including community engagement in written job descriptions and also as grant deliverables, it is possible to directly fund those efforts. This also allows upper administration to better understand how time-consuming authentic engagement is:

> *"I just think it should be supported from the top down. So, knowing that it is a time-consuming concept to pull in community engagement and that you need to, you know, sometimes be out in the community more in order to be able to make those relationships and build that up."*

Additionally, having detailed job descriptions can allow human resource departments to look for personnel who have the skills needed to succeed in community engagement:

> *"I really would advise looking for a different skill set and building those community facilitation conversation facilitators/conveners. That's a skill that you don't necessarily learn in public health training or undergraduate training. Being trained as a skilled facilitator is something that we're going to have to have for the future."*

Learn from your mistakes. It is not enough to just read about best practices and then brush mistakes under the rug. Many interviewees discussed the desire and need to learn from not only their mistakes but from others. One interviewee shared,

> *"I do think in addition to talking about our successes, it's also really helpful to learn from what didn't work or what could've been done better. And I do think that oftentimes we tend to shy away from some of those conversations."*

Health Department Suggestions for Domain 4

Health departments gave some suggestions and feedback for how Domain 4 can be improved in the Standards and Measures 2.0 iteration. It was suggested to add a requirement for community education on policies and policy development as well as education on how the public health system represents the community in the development of local, state, and federal policies. One health department noted that there is not a required model/strategy/approach/policy like in some of the other standards to make community engagement a cohesive process or plan. The idea that Domain 4 promotes Public Health 3.0 work was discussed and some interviewees requested that this idea be expanded. Additionally, the idea of ethics was discussed in direct relation to community engagement. One health departments shared that there are,

> *"Side effects of community engagement - unauthentic engagement - shuffling residents and focus groups to show how agencies are engaged in the community and tokenizing community members and trotting them out. Risks of forcing health departments to engage with the community leads to using the community rather than contributing to it."*

Authentic community engagement has the needs of the community members at the forefront; placing grant deliverables or accreditation requirements first can be detrimental if not destructive. This idea will be discussed further in the recommendations section.

CONCLUSIONS

In order to better appreciate community engagement from the local health department workforce perspective, this analysis employed a qualitative study design based upon in-depth interviews with a convenience sample of LHD staff who self-identified as early adopters of community engagement as part of their regular activities. Consistently the LHDs participating in this study reported that central to effective engagement is developing effective communications with community groups and organizations with mindfulness that the community needs to be the leader, and the LHD the follower. LHDs reporting successful community engagement support their community constituents by getting the right people at the table, attending to community-identified concerns, assisting the community at the right time for action, participating within the community-based setting, and by seeking solutions that are sustainable. Ultimately, effective community engagement is characterized by the elements of person, place and time. These three elements are further informed by what public health services are needed. Finally, it is beneficial for LHDs, in partnership with the community, to seek to understand why these needs exist within the community in order to better forecast future needs.

One of the key aspects toward productive and effective community engagement, as reported by LHDs, was attention to community-held values. Staff need to serve multiple roles within the dynamic process of service delivery. These partnerships are active within the ever-changing settings of public health practice. Health equity as a construct is straight forward, yet measurement of successful indicators of health equity accomplishment presents challenges. LHDs reported use of traditional community surveys and community health assessments. One challenge with respect to successfully implementing effective metrics of equity is awareness of sectors within the larger community who might be left out. These individuals' voices are often not heard due to bias within the formalized systems approach. When only what is accomplished is measured, activities left undone are not only unmeasured but often overlooked as needed.

Diversity is key to authentic and effective engagement. Respect for individual and community differences was consistently reported as essential in the promotion of effective and meaningful

public health service delivery. The importance of cultural competencies of the LHD workforce was consistently highlighted, whereby LHD leadership sought to infuse cultural awareness, cultural competence, and cultural attentiveness to the diversity and complexity of the multiplicity of communities for which they partner and serve. The most successful LHDs intentionally sought to engage those within the community that are often overlooked, underrepresented, and marginalized by traditional health and human services organizations.

It starts with being present within the community. That is, be present and listen to the needs of your community members. Communication is critical, clarity of expectations essential, and coming to agreement as early in the process of initiating new efforts is paramount. Along with the importance of effective communication is the need to share power within the decision-making processes that promote, deliver and sustain community health and wellness initiatives. Community-based organizational leaders are vital, serving to forge the path by which the LHD personnel can follow toward the accomplishment of shared goals and objectives. Key indicators of successful engagement are recognized by the implementation of programs and services that are truly community centered. These successes are demonstrated in metrics such as CHA and CHIP. Community health assessment and the importance of avoiding duplication of services and activities is essential. In some circumstances LHDs can dominate or hinder successful community-based initiatives that are in place. In these circumstances the LHD, by lack of awareness or by directive from above, move into the community spaces where area non-profits and grass roots organizations are already mobilized. This is a traditional problem experienced within the dynamic of community – public health organizational interplay.

Strategic planning and effective operations management were reported to be a critical facilitator of the initial work that results from LHD engagement efforts in service to the community. Once the strategic plan is set, key performance measures are established as well as future-focused quality improvement metrics. The utility of evidence-based data assessments tools such as CHIP, CHA, and MAPP are vital to the LHDs formal and operational strategy by which community engagement is assured. Often, LHDs include community engagement articulation within position descriptions as well as performance evaluations of the workforce. Survey assessment of community members who have received support and assistance through LHD initiatives is also a key performance indicator.

Much of the landscape of LHD efforts, in partnership with their communities, is characterized by the dynamics surrounding the scarcity of resources. Funding of public health outreach plans,

initiatives, and efforts are often top down, issued by state and federal authorities, as opposed to community-centered or community-placed. Often programmatic specific funding and/or grant-driven initiatives can be confusing to the public and frustrate the communities they are intended to serve. An effective LHD will bridge the community needs gap within their respective publics by linking to, connecting to, and providing for community members' essential health education and health promotion needs.

RECOMMENDATIONS

Community engagement, when approached with care and authenticity, can be a critical tool for improving the health and well-being of diverse constituencies. Local health departments, in particular, are uniquely positioned to engage in processes and initiatives designed to involve many different stakeholders in the development of equitable health programs. Based on evidence from the literature review and interviews with community-engaged health departments, we offer recommendations for all health departments to consider as they seek to expand their community engagement efforts.

Commit to institutionalizing community engagement. Community engagement should be considered an integral first principle of a health department's efforts, not simply an add-on. Effective community engagement is enhanced when it is understood and supported by all levels of administration and management.

Community engagement should be incorporated in health departments' strategic plans, setting SMART objectives and identifying strategies to achieve those objectives. Keep in mind that the objectives and measures used should be designed to reflect progression, as community engagement is not a "checkbox" that can be accomplished quickly or easily. Consider developing rubrics that reflect such progression for performance markers (e.g., "beginning," "developing," "proficient," "exemplary").

In addition to the strategic plan, policies and procedures should be instituted to provide health department staff with both funding and flexibility to attend community meetings, build relationships with community members, and participate in non-health-department initiatives. It is also important for each health department to critically evaluate its community's needs and assets, as well as its internal capacity to support meaningful community engagement. One size does not fit all jurisdictions, so approaches should be tailored to the local community context.

Shift the culture. Policies are only one component of moving toward meaningful, authentic community engagement; the health department's culture must also be conducive to support these efforts. In particular, health department personnel at all levels must demonstrate a commitment to principles and practices that advance community engagement, such as deep, active listening and viewing community members as co-equal partners. Health department administrators and managers should not only express support for such approaches, but should model them as well to demonstrate their importance. Health departments may also consider identifying community engagement champions within the organization who can serve as opinion leaders and internal consultants.

Additionally, a culture of humility should also be fostered to enhance community engagement. Cultural humility requires a commitment to centering the needs and experiences of communities, as well as continual self-reflection and critique of one's own beliefs and biases (Yeager & Bauer-Wu, 2013). In order to foster co-equal partnerships with community partners and members, health department staff must take time to learn about the diverse communities that they serve, while also becoming aware of their own social identities, power, and privilege.

Support training for staff and community members. Staff involved in community engagement efforts should develop skill sets that will enhance their ability to work with diverse communities. For example, training in CBPR and participatory action research (PAR) can provide staff with knowledge, skills, and mindsets that will enhance health departments' ability to accomplish community engagement goals. Health equity training can also aid in the development of critical knowledge and skills.

In addition to staff, community members should also take part in training related to community engagement. Since community partners, coalition members, and other stakeholders are expected to be co-equal partners in engagement, training opportunities should be extended to them as well. This will help to ensure that all parties understand the expectations and procedures necessary to facilitate meaningful engagement within their respective communities.

Know your community. Similar to the popular adage that "all politics is local," health departments must recognize that community engagement strategies must be designed to work within a local context. Every jurisdiction is different in terms of demographic distribution, culture, values, assets, and needs. Before initiating any community engagement programs, health departments should spend time in conversation with diverse community members to better understand local strengths and

concerns. These conversations can take place in many different forms, from formally-organized town halls/focus groups/interviews to informal interactions with community members following community organizational meetings or events.

Use existing models. Models can assist LHDs with creating a cycle of community engagement by emphasizing the importance of continuously assessing, planning, and implementing. In addition to making use of models such as MAPP, Academic Health Departments, and Community Toolboxes, health departments can learn a lot from their peers who are engaged in advanced community engagement efforts. Accrediting bodies should consider offering webinars or virtual grand rounds to facilitate peer-to-peer learning.

Advocate for allocated funding. For many health departments, community engagement may often be considered an unfunded mandate, which may limit efforts. Many of the health departments interviewed for this commissioned paper were able to engage in high levels of community engagement because of some kind of funding or dedicated resources to support such efforts. Flexible funding was also identified as a facilitator of community engagement in the extant literature. Therefore, health departments should explore funding opportunities through external grant funding and advocacy through their local boards of health.

Caveats. While great care was taken to curate these recommendations, there are some specific caveats that should be noted. The health departments interviewed for this commissioned paper were identified by PHAB as highly-functioning community-engaged organizations, with considerable time and effort invested to attain such levels. As such, the achievements of these health departments may not be feasible, at least short-term, for those who are beginning their movement toward becoming more community-engaged. Organizations should be ambitious, yet realistic, about their initial steps to enhance community engagement.

Another caveat that could affect health departments' ability to move forward is the onset of the COVID-19 pandemic. Interviews were conducted in February and March 2020, immediately before most health departments shifted most of their resources toward COVID-19 testing, contact tracing, and shelter-in-place efforts. The immediate threats posed by the pandemic may limit the ability to focus on advancing community engagement initiatives.

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