PROJECT MUSE®

After 10 Years: A Vision Forward for *Progress in Community Health Partnerships*

Suzanne Dolwick Grieb, Latrice Pichon, Simona Kwon, Karen Kim Yeary,
Darius Tandon

Progress in Community Health Partnerships: Research, Education, and
Action, Volume 11, Issue 1, Spring 2017, pp. 13-22 (Article)

Published by Johns Hopkins University Press

DOI: <https://doi.org/10.1353/cpr.2017.0002>

➔ For additional information about this article

<https://muse.jhu.edu/article/661287>

After 10 Years: A Vision Forward for *Progress in Community Health Partnerships*

Suzanne Dolwick Grieb¹, Latrice Pichon², Simona Kwon³, Karen Kim Yeary⁴, and Darius Tandon⁵

(1) Johns Hopkins School of Medicine, Center for Child and Community Health Research; (2) The University of Memphis, Social and Behavioral Sciences; (3) NYU School of Medicine and Health, Center for the Study of Asian American Health; (4) University of Arkansas for Medical Sciences, Department of Health Behavior and Health Education; (5) Northwestern University, Medical Social Sciences

Submitted 02 March 2017, revised 17 March 2017, accepted 21 March 2017.

Abstract

Background: In 2007 the journal *Progress in Community Health Partnerships* was launched to advance the field of community-engaged research and the journal's editors engaged in a Delphi process to identify priorities for the journal and field. Ten years later, the increased adoption of community-engaged research continues to improve public health.

Objectives: The purpose of this manuscript is to identify community-engaged research priorities for the next 10 years.

Methods: The study engaged leaders in community-engaged research using a two-round Delphi process, whereby leaders in the field were asked to identify and then rank order topics in community-engaged research that needed to be prioritized for the next decade.

Results: In stage 1, 41 respondents generated 441 priorities across 8 categories (e.g., theory, epidemiology, intervention science) that were collapsed into 90 priority topics, ranging

from 8 to 15 per category. In stage 2, 73 respondents ranked five prioritized items for each category. The prioritized items are provided, with the following themes present across all categories: 1) improvements to equity among partners, 2) partnership sustainability, and 3) increased efforts to translate community-engaged research into policy change.

Conclusions: We compare the findings from this Delphi process with the priorities identified in 2007 to reflect on how the field has progressed. It is our hope that community and academic stakeholders will be able to use these priorities as a guide to their community-engaged research in the coming years.

Keywords

Community-engaged research, community-based participatory research, Delphi process, health partnerships, research priorities

The philosophical foundation of community-engaged research involves a collaborative partnership between community and institutional (academic and nonacademic) members. Community-engaged research operates on a continuum, with varying roles for community and institutional partners. The most equitable collaboration between all partners occurs within community-based participatory research (CBPR), whereby the research topic is identified by the community “with the aim of combining knowledge and action for social change to improve community health

and eliminate health disparities.”¹ Within the spectrum of community-engaged research, CBPR emphasizes the need for shared, equitable control among community and institutional partners. CBPR partners are involved in all stages of the research process, with all partners sharing their expertise, mutually making decisions, and claiming ownership of the research. Both community engagement, broadly, and CBPR, specifically, are important approaches to health promotion that can improve understanding of an issue, and then integrate the resulting knowledge into action, including social change

and policy solutions.²

In response to the rapid adoption of community engagement and CBPR in North America, the journal *Progress in Community Health Partnerships: Research, Education, and Action* (PCHP) was launched in 2007 to “improve our dialogue [about community-engaged research and CBPR], catalyze our efforts, expand our knowledge, and open new doors to truly being partners in our mutual desire to have a healthier community.”³ In the first publication, journal editors provided a vision for the fledgling publication. The editors outlined eight areas of scholarly activity to promote health partnership research, education, and action, and identified priority areas for the journal, within each scholarly area, as developed through a Delphi process with a panel of the journal’s editors.⁴

Over the last decade, the journal has published 10 volumes of four issues each, in addition to seven special issues. A total of 942 manuscripts have been submitted to the journal, with 427 (45.3%) published. Building on Eder et al.’s⁵ article in this journal issue that reflected on the past decade to assess the realization of the initial vision for PCHP, we look forward to the next decade, to the challenges that continue in community-engaged research and CBPR, and the opportunities to improve our collective efforts at improving health in partnership with others. This article describes our efforts to generate priorities for the next 10 years for the journal, which emphasizes CBPR specifically, and community-engaged research more broadly through the use of a modified Delphi process that elicited perspectives from leaders working in the field of community-engaged research. The objectives of the manuscript are to 1) report findings from the current Delphi process study, 2) compare the current findings with those from 2007 to reflect on how the field has changed, and hopefully progressed, and possible areas in need of additional insights and/or resources, and 3) suggest directions for the future of the field.

METHODS

The Delphi process is a structured method that uses a series of questionnaires distributed in rounds, or stages, to gather information from experts or stakeholders.⁶ Each stage summarizes information presented in the previous stage, and is then presented again to the experts or stakeholders for prioritization to establish consensus.⁷ Through a Delphi process, a large number of individuals from diverse locations

can anonymously provide information that is then synthesized by the group without domination of the consensus process by one or a few experts or stakeholders.^{8,9}

The modified Delphi process to identify priorities in community-engaged research for the next 10 years was granted exempt status by the NYU School of Medicine Institutional Review Board. Thus, participants were not required to provide signed informed consent.

Identification of Categories for Priority Identification

Based on discussion of the important areas of focus within community-engaged research, the authors identified the following categories within which to identify priorities for the next 10 years: 1) community-engaged research theory, 2) community-engaged research partnerships, 3) community engaged-research methodology, 4) community-engaged research epidemiology, 5) community-engaged research intervention science, 6) community-engaged research implementation science, 7) community-engaged policy, and 8) community engaged training and education.

Identification and Description of Experts

The authors developed a list of experts in community-engaged research. From this list, email invitations were sent to request participation in the Delphi process. Invited participants included members of the American Public Health Association’s Community-Based Public Health Caucus, Directors of Centers for Disease Control and Prevention-funded Prevention Research Centers, Principal Investigators of National Institute on Minority Health and Health Disparities-funded Centers of Excellence (P20s and P60s), members of Clinical and Translational Award program Community Engagement cores, and current and former associate editors of PCHP, who include academic and community members. Email invitations were sent to 853 persons.

Data Collection

The Delphi process consisted of two stages, conducted between September 2016 and January 2017. For both stages, participants were sent email invitations that included information about the project goals and methods, in addition to a link to the online survey. For both stages, participants were provided two weeks to complete the anonymous survey using

the Qualtrics Insight Platform (Qualtrics, Provo, UT).

Stage 1: Idea Generation. Consistent with goals of using a Delphi process, the aim of the first round was to identify and gain expert consensus on community-engaged research priorities for the next 10 years. Participants were asked to identify up to five priorities for the next 10 years for each of the seven categories previously identified by the authors. Respondents provided open-ended responses for each of these categories, with no minimum or maximum character requirements. A list of responses for each of the categories was generated and subsequently reviewed by at least two authors. The authors independently grouped the responses, first removing duplicate responses, then grouping the remaining unique priorities identified by topics. Any disputes between the grouping of responses was resolved by the lead author.

Stage 2: Idea Prioritization. The second stage of the Delphi process asked participants to prioritize the topics that emerged from stage 1 within each category. Respondents were provided a list of the items within each category, and were asked to rank order five prioritized items for each category.

RESULTS

Stage 1

A total of 41 respondents completed the survey in stage 1 (Table 1), for a response rate of 4.8%. Respondents represented academic institutions (56.1%), community-based organizations (17.1%), government agencies (12.2%), non-academic affiliated research centers (4.9%), and other (including private industry and philanthropic foundations; 9.8%). More than one-half of the respondents (55.8%) reported that they had engaged in community-engaged research for more than 10 years, and 58.5% reported that more than one-half of their work was committed to community-engaged research efforts.

Stage 1 generated 441 recommendations across the eight categories: 71 recommendations under the category of community-engaged research theory, 87 in community-engaged research partnerships, 68 in community-engaged research methodology, 37 in community-engaged research epidemiology, 46 in community-engaged research intervention science, 37 in community-engaged research implementation science, 51 in community-engaged policy, and 44 in community-engaged training and education recommenda-

tions. The mean number of responses per respondent across categories was 10.8 ($SD = 6.0$), with a range of 2 to 28. The 441 recommendations were collapsed into 90 topics, ranging from 8 to 15 per category.

Stage 2

A total of 73 respondents completed the survey in stage 2 (Table 1), yielding a response rate of 8.6%. Respondents in stage 2 represented academic institutions (64.4%), community-based organizations (8.2%), government agencies (11.0%), non-health centers or clinics (5.5%), and others (8.2%). Almost one-half of the respondents (47.9%) reported that they have engaged in community-engaged research for more than 10 years, and 57.5% reported that more than one-half of their work was committed to community-engaged research efforts. There were no significant differences between the characteristics of the respondents in stages 1 and 2.

Stage 2 respondents rank ordered the top five topics that they thought were most important for community-engaged research in the next 10 years within each category, selecting from the 90 topics identified in stage 1 (Table 2). The high-

Table 1. Participant Characteristics

	Stage 1 <i>n</i> (%)	Stage 2 <i>n</i> (%)
Affiliation		
Academic institution	23 (56.1)	47 (64.4)
Community-based organization	7 (17.1)	6 (8.2)
Government agency	5 (12.2)	8 (11.0)
Health center or clinic	0 (0)	4 (5.5)
Non-academic-affiliated research center	2 (4.9)	0 (0)
Other	4 (9.8)	6 (8.2)
Years working in community-engaged research		
0–5	10 (24.1)	14 (19.2)
6–10	8 (19.5)	22 (30.1)
11–15	10 (24.1)	15 (20.5)
>15	13 (31.7)	20 (27.4)
Work that can be designated as community-engaged research		
0–25	10 (24.4)	15 (20.5)
26–50	7 (17.1)	14 (19.2)
51–75	11 (26.8)	16 (21.9)
76–100	13 (31.7)	26 (35.6)

Table 2. Top Prioritized Topics for Community-Engaged Research/CBPR

Category and Topic	Endorsement, n (%)
Community-engaged research theory	
Development of theory and testable models for how community-engaged research/CBPR leads to improved community health outcomes	48 (65.8)
Development of theories and models for dissemination of research to promote implementation and policy application	44 (60.3)
Movement away from “empowerment theory” and “community capacity building” to theories that better incorporate the two-way empowerment and capacity building that occurs within community-engaged research/CBPR	34 (46.6)
Application of community-engaged research/CBPR to test current health behavior theories	33 (45.2)
Development of theories for intervention sustainability	30 (41.1)
Community-engaged research partnerships	
Increased focus on partnership sustainability (i.e., evidence of benefits for public health, best practices, funding options not grant specific)	43 (58.9)
Development of frameworks or models to improve transparency and increase equality between academic and nonacademic partners	42 (57.5)
Improvements in partnership equity and equality (i.e., funding, compensation)	36 (49.3)
Increased focus on understanding the “value added” to research and practice through participation of partnerships	32 (43.8)
Development of methods, frameworks, and/or best practices for building community research capacity	30 (41.1)
Community-engaged research methodology	
Identifying appropriate metrics/methods for documenting the population health impact of CBPR interventions	37 (50.7)
Development of new evaluation measures addressing areas unique to community-engaged research/CBPR (i.e., evaluating items reported as “stories from the field,” evaluating indirect outcomes on community partners as a result of equitable community participation in the research/program)	35 (47.9)
Increased focus on community-led/community centered evaluation procedures	32 (43.8)
Improving/increasing community-engaged data analysis and interpretation	31 (42.5)
Building models to improve the connections between evaluation strategies and implementation/dissemination research	29 (39.7)
Community-engaged research epidemiology	
Social epidemiology (i.e., social determinants of health, health disparities, healthcare access)	53 (72.6)
Increased focus on structural barriers to improving health outcomes	51 (69.9)
Development of measures to track the strengths of communities	50 (68.5)
Increased attention to data reporting, including standardization of reporting and translation of findings for community members and policymakers	40 (54.8)
Use of mobile technology to capture data in real time (i.e., intimate partner violence, street violence, discrimination, stress)	33 (45.2)
Community-engaged research intervention science	
Development of models for the shifting of power/resources for interventions from partnership to community over time	33 (45.2)
Further movement toward solution/community-driven intervention development (as opposed to research agenda-driven intervention development)	32 (43.8)
Improved understanding of the balance between replicability/scientific integrity of interventions and community-specific adaptations	30 (41.1)
Development of models and methods for improving the sustainability of effective interventions implemented in communities	27 (37.0)
Development and use of community-defined evidence of effective interventions	26 (35.6)

table continues

Table 2. *continued*

Category and Topic	Endorsement, n (%)
Community-engaged research implementation science	
Development of best practices of community leadership in dissemination of information around intervention implementation, the intervention results, and the integration of the results into policy and practice	45 (61.6)
Use of participatory approaches within implementation science	39 (53.4)
Best practices for accelerating the time for which an intervention can be designated as “evidence-based”	38 (52.1)
Increased emphasis and development of best practices for community evaluation of interventions to inform integration of the results into policy and practice	37 (50.7)
Development of postintervention methods to promote the integration of the results into policy and practice*	35 (47.9)
Development of alternative strategies for dissemination that promote the integration of the results into policy and practice*	35 (47.9)
Community-engaged policy	
Increased attention to policy at multiple levels (county, city, state, and federal as well as institutional and organizational)	37 (50.7)
Promotion of equitable team approaches to policy development (i.e., inclusion of community members, academics, private sector representatives)	35 (47.9)
Increased attention to the development of policy objectives	33 (45.2)
Promotion of community-engaged research requirements for all public health efforts that are supported by federal grants	32 (43.8)
Increased attention to policy implications and political advocacy in intervention and implementation science	30 (41.1)
Community-engaged research training and education	
Increased efforts to promote institutionalizing community-engaged research/CBPR course/practice requirements in public health graduate programs	51 (69.9)
Development of tools and programs addressing the histories (i.e., power, racism, poverty) that led to our current being (e.g., to assist partnerships of various backgrounds and lived experiences)	49 (67.1)
Expanded resources and trainings for established researchers interested in participating in community-engaged research/CBPR	45 (61.6)
Improved training options in cultural competency for all partners	41 (56.2)
Development of trainings in community epistemologies for academics, institutional leaders, and policymakers	40 (54.8)

Abbreviation: CBPR, community-based participatory research.

* Tie.

est endorsed topics within each category were development of theory and testable models for how community-engaged research leads to improved community health outcomes (65.8%; theory); increased focus on partnership sustainability (e.g., evidence of benefits for public health, best practices, funding options not grant-specific; 58.9%; partnerships); identifying appropriate metrics/methods for documenting the population health impact of CBPR interventions (50.7%; methodology); social epidemiology (e.g., social determinants of health, health disparities, healthcare access; 72.6%; epidemiology); development of models for the shifting of power/resources for interventions from partnership to community over time (45.2%; intervention science); development of best

practices of community leadership in dissemination of information around intervention implementation, the intervention results, and the integration of the results into policy and practice (61.6%; implementation science); increased attention to policy at multiple levels (county, city, state, and federal as well as institutional and organizational; 50.7%; policy); and increased efforts to promote institutionalizing community-engaged research/CBPR course/practice requirements in public health graduate programs (69.9%; training and education).

Cross-Cutting Themes Across Categories

Three cross-cutting themes emerged across all eight categories. Improved equity among partners was a theme prioritized by

respondents across the topical categories of inquiry. For example, within the category of theory, almost one-half of respondents (46.6%) prioritized the need to move away from “empowerment theory” and “community capacity building” to theories that better incorporate the two-way empowerment and capacity building that occurs within community-engaged research.

Advancing sustainability in practice was another cross-cutting theme that was identified. Respondents identified the need to better understand how to sustain partnerships, in addition to understanding how partnerships developed for specific projects (often grant-specific) benefit long-term efforts to improve health outcomes.

Community-engaged research to impact policy was also dominant theme across the Delphi categories. More than one-half of the respondents prioritized the development of theories and models for the dissemination of research to promote implementation and policy application (60.3%); the development of best practices of community leadership in dissemination of information around intervention implementation, the intervention results, and the integration of the results into policy and practice (61.6%); an increased attention to data reporting, including standardization of reporting and translation of findings for community members and policymakers (54.8%); and an increased emphasis and development of best practices for community evaluation of interventions to inform integration of the results into policy and practice (50.7%).

REFLECTING ON PRIORITIES FOR THE NEXT 10 YEARS: 2007 AND 2017

Reflecting on the identified priorities for the next 10 years as identified in 2007 and 2017 can allow us to consider how the field has changed, and hopefully progressed, and possible areas in need of additional insights and/or resources.

In 2007, the journal’s editors identified an important priority—the documentation of best practices and lessons learned in building community partnerships. During the past 10 years, the development of partnerships has been published upon extensively, focusing on building trust,^{10–12} developing capacity of community and institutional partners,^{13–15} and examining considerations for partnering with specific populations.^{16–18} Community-engaged research, and in particular CBPR, relies on strong, equitable partnerships to influence community health. Thus, in 2017 we included a category specific to partnerships in the Delphi process. Respondents con-

tinued to prioritize partnerships, albeit the focus is currently on equitable and sustainable partnerships, which indicates progress in the field and suggests a more specific focus on partnership enhancement for the next 10 years.

Progress may also be evidenced through the shift observed with respect to methodology. In 2007, the initial Delphi process prioritized CBPR methods that were valuable tools for partners conducting health assessments and defining health issues (e.g., photovoice, nominal group techniques, windshield tours). Since then, new frameworks, guidelines, and considerations for these methods have been developed, reviews on the contribution of these methods to improving health have been conducted, and a wide range of examples of these methods in use have been published. For example, Strack et al.¹⁹ provide a logic model informed by the social-ecological model of health to guide photovoice participants and planner. Ponc and Jategaonkar²⁰ provide ethical protocols for employing photovoice research with women who have experienced violence, and Teti et al.²¹ discuss ethical considerations of conducting photovoice with people living with HIV/AIDS. Hergenrather et al.²² and Catalani and Minkler²³ provide reviews of photovoice as a method to address health. Demonstrations of methods in practice have been published, including the use of photovoice to address a range of topics such as housing and homelessness,^{24,25} environmental issues affecting health,²⁶ specific health topics including HIV/AIDS,^{27–29} mental illness,^{30,31} and obesity,^{32–34} and social concerns such as violence³⁵ and racism.³⁶ In the current Delphi process, respondents prioritized the identification of appropriate metrics and measures to document the population health impact of CBPR interventions as well as the development of metrics to evaluate areas unique to community-engaged research. Thus, a shift has occurred between further documenting, refining, and improving the scientific rigor of methods often used in community-engaged research, to better understanding how, through the use of these methods, community-engaged research affects and provides unique contributions to population health.

Although a comparison of the findings from the 2007 and 2017 Delphi processes to identify priorities for community-engaged research demonstrate some progress in the field, it also highlights areas of stagnation. The translation of research into policy and practice, and increased inclusion of community partners in this process, was prioritized among respondents in the current Delphi

process as well as in 2007. It is clear from the continued prioritization of this issue that additional work is needed to realize the potential of community-engaged research in policy.

Reflection on the 2007 and 2017 findings also suggest that additional resources are needed to support community-engaged research at the institutional level. In 2007, respondents to the Delphi process identified a need for “CBPR curriculum and graduate medical education reform” and “training new investigators.” In 2017, respondents continue to identify this as a priority, noting a need for “increased efforts to promote institutionalizing community-engaged research/CBPR course/practice requirements in public health graduate programs” as well as “expanding resources and trainings for established researchers interested in participating in community-engaged research.” Thus, program development to train new and established researchers, diffusion of existing programs, and structural changes within academic institutions are still needed to support community-engaged research.

FUTURE DIRECTIONS

The modified Delphi process identified a range of priority areas for partners working to improve health through community-engaged research and CBPR. Given the range of affiliations and time practicing community-engaged research among the selected panel of experts that participated in the Delphi process, the identified priorities represent perspectives from both long-standing researchers in the field and from those who more recently joined the effort for community-engaged health promotion. The following section provides a more in-depth discussion of the priorities identified across categories. Community and institutional partners who review these priorities in light of their own work may identify ways in which their efforts can address these priorities to the field’s advancement.

The prioritized items across the categories identify a need to better understand the unique contributions and benefits of conducting research in partnership with community stakeholders. Many interventions designed through traditional research to reduce health disparities have not been as successful during implementation and dissemination as hoped.^{37,38} As a result, including the perspectives and expertise from a range of stakeholders, including community members, provides potential for the more effective strategies that address the complex behavioral, situational, environmental, and political

factors influencing health.³⁹ A better understanding of facilitative processes for community-engaged research in more nuanced and targeted ways to improve health outcomes is necessary to advance science. For example, community-engaged research offers a framework to include diverse stakeholders in the research process through structural changes in funding sources and training institution policies and programs.

CBPR incorporates the understanding that all parties bring diverse expertise, skills, perspectives, and experiences that are shared through reciprocal exchange among partners.^{40–42} Improved equity among partners, however, was a theme prioritized by respondents across the topical categories of inquiry. Within the category of theory, almost one-half of respondents, prioritized the need of move away from “empowerment theory” and “community capacity building” to theories that better incorporate the two-way empowerment and capacity building that occurs within community-engaged research. Empowerment theory and community capacity building, as currently used, often imply a deficit in the community that is “filled” through engagement with institutional partners. In contrast, community-engaged research generally, and CBPR specifically, advocate co-learning and capacity building for all partners. Additionally, the prioritization of equity emerging from the Delphi process included improvements in equity at the partnership level (e.g., in institutional/project funding and compensation), further movement toward community-driven intervention development (as opposed to research agenda driven), increasing the role of community stakeholders in research methodology that may often be dominated by the institutional partners, and increased attention to the promotion of equitable team approaches to policy development. The Delphi findings suggest, therefore, that a greater emphasis on equity among partners is needed both in theory and practice.

Numerous factors impact the formation and maintenance of CBPR partnerships, and a considerable literature exists on these topics.^{10,43–46} Respondents, however, identified continued needs for advancing sustainability in practice as a priority. Partnerships often struggle to maintain their existence as a result of funding pressures that dictate the partner’s progress, and this may jeopardize the partnership as a result of unequal determination of direction.^{46,47} In addition to increased focus of sustainability related to funding, respondents also identified the need to better understand how sustainable partnerships, and

not just partnerships developed for specific projects (often grant specific) impact long-term efforts to improve health outcomes.

Finally, although “community-engaged policy” was a unique category within our Delphi process, the use of community-engaged research to inform policy was a dominant theme across the Delphi categories. More than one-half of the respondents prioritized the development of theories and models for dissemination of research to promote implementation and policy application, the development of best practices of community leadership in dissemination of information around intervention implementation, the intervention results, and the integration of the results into policy and practice, an increased attention to data reporting, including standardization of reporting and translation of findings for community members and policymakers, and an increased emphasis and development of best practices for community evaluation of interventions to inform integration of the results into policy and practice. Community-engaged research generally, and CBPR specifically, aim to use research for action or social change, including informing policy to reduce health disparities.

Although examples of this may be found in the literature,^{48–51} attention within published community-engaged research efforts have primarily focused on the collection of data rather than the translation of this research into policy change. It is possible that policy implications occur more frequently, but are not reported in peer-reviewed articles. Policy changes, however, are often long-term outcomes that may take more time to achieve than is available through typical grant funding cycles, reinforcing the need for more information and support for sustainable partnerships. Additionally, our findings suggest that a barrier to translating research to policy change may be the lack of planning for policy change efforts from the onset of community-engaged research efforts, and a greater awareness of how best to do this. Themba and Minkler’s⁵² overview of different conceptual frameworks for influencing policy and practice through community-engaged research may be an important guide for community and institutional partners. In addition, Cacari-Stone et al.⁵³ provide two additional conceptual frameworks and demonstrate their use in two CBPR partnerships in California that made substantial contributions to policymaking. Further, Izumi et al.⁵⁴ provide a practical tool to guide partners in the development of a “one-pager,” commonly used as a communication tool in

policy advocacy. It is also evident that planning for political impact should be included at the start of partnership efforts.

CONCLUSIONS

The 2017 Delphi process to identify priorities within community-engaged research over the next 10 years provides perspectives from experts in the field, and sheds light on progress as well as continued challenges. Community and institutional partners would benefit from using this information in their efforts to improve health equity. However, reflecting on the Delphi process conducted in 2007 and our findings, it is evident that academic institutions must increase efforts to promote, and support, community-engaged research and CBPR. Examples of efforts to promote this can be seen in the development of training programs for faculty (i.e., the Detroit Community-Academic Urban Research Center’s CBPR Partnership Academy) and growing number of public health graduate programs offering CBPR courses and certificates (i.e., University of Kansas, University of North Carolina Chapel Hill, and the University of Pittsburgh). In 2006, the National Institutes of Health launched their Clinical and Translational Science Award initiative, supporting academic institutions to conduct translational research, with community engagement as a core component in this effort. Through these efforts, opportunities exist for new and established researchers to gain training in community-engaged research, but diffusion of these opportunities is warranted. Additionally, structural changes within academic institutions is still needed to support researchers interested in community-engaged research with respect to funding and tenure and promotion requirements, for example, that may hinder participation in equitable partnerships.

However, limitations in interpreting these findings should be noted. First, more than one-half of all respondents represented academic institutions. Had more community partners participated in the process, the findings may have been different. For both stages, the response rate was low. Had more participants contributed to the ideation and prioritizing, the findings may have also differed. Finally, because of the small sample size, the recommendations and prioritizations of respondents were combined and were not analyzed by community or institutional affiliation. Exploring differences between community-engaged researchers by affiliation may have also illuminated differences in priorities.

Interest in community-engaged research, and CBPR in particular, continues to grow, and the field has established itself as a critical component to advance health equity and promote community health. The field continues to progress, and the priorities identified in the Delphi process discussed here may

shed light on ways to advance the science and public health impact further. It is our hope that community and institutional stakeholders will be able to use these priorities as a guide to their community-engaged research in the coming years.

REFERENCES

1. Community Health Scholars Program [Internet]. Stories of impact. Ann Arbor (MI): Kellogg Health Scholars;2002. [cited 2017 Jan 25]. Available from: http://www.kellogghealthscholars.org/about/ctrack_impact_scholars_book.pdf.
2. Israel BA, Eng E, Schulz AJ, et al. Introduction to methods in community-based participatory research for health. In: Israel BA, Eng E, Schulz AJ, et al, editors. *Methods in community-based participatory research for health*, 2nd ed. San Francisco: Jossey-Bass, 2013. p. 1–38.
3. Fox E. Editorial: Every effect has its cause. *Prog Community Health Partnersh*. 2007;1(1):1–2.
4. Tandon SD, Phillips K, Bordeaux BC, et al. A vision for progress in community health partnerships. *Prog Community Health Partnersh*. 2007;1(1):11–30.
5. Eder M, Holzer J, Calhoun K, et al. A Retrospective on the Vision for Progress in Community Health Partnerships: Research, Education, and Action. *Prog Community Health Partnersh*. 2017;11(1):1–12.
6. Fink A, Kosecoff J, Chassin M, et al. Consensus methods: Characteristics and guidelines for use. *Am J Public Health*. 1984;74:979–83.
7. McIlrath C, Keeney S, McKenna, et al. Benchmarks do effective primary care-based nursing services for adults with depression: A Delphi study. *J Adv Nurs*. 2010;66(2):269–81.
8. Adler M, Ziglio E. *Gazing into the oracle: The Delphi method and its application to social policy and public health*. Philadelphia: Jessica Kingsley Publisher; 1996.
9. Jairath N, Weinstein J. The Delphi methodology (part one): A useful administrative approach. *Can J Nurs Adm*. 1994;7:29–42.
10. Jagosh J, Bush PL, Salsberg J, et al. A realist evaluation of community-based participatory research: partnership synergy, trust building and related ripple effects. *BMC Public Health*. 2015;15(1):725.
11. Johnson CE, Ali SA, Shipp MP. Building community-based participatory research partnerships with a Somali refugee community. *Am J Prev Med*. 2009;37(6):S230–6.
12. Christopher S, Watts V, McCormick AK, et al. Building and maintaining trust in a community-based participatory research partnership. *Am J Public Health*. 2008;98(8):1398–406.
13. Amico KL, Wieland ML, Weis JA, et al. Capacity building through focus group training in community-based participatory research. *Educ Health (Abingdon)*. 2011;24(3):638.
14. Masuda JR, Creighton G, Nixon S, et al. Building capacity for community-based participatory research for health disparities in Canada: The case of “partnerships in community health research.” *Health Promot Pract*. 2011;12(2):280–92.
15. Moreno G, Rodríguez MA, Lopez GA, et al. Eight years of building community partnerships and trust: The UCLA family medicine community-based participatory research experience. *Acad Med*. 2009;84(10):1426–33.
16. Rachel Parrill RN, Kennedy BR. Partnerships for health in the African American community: Moving toward community-based participatory research. *J Cult Divers*. 2011;18(4):150.
17. Baldwin JA, Johnson JL, Benally CC. Building partnerships between indigenous communities and universities: Lessons learned in HIV/AIDS and substance abuse prevention research. *Am J Public Health*. 2009;99(S1):S77–82.
18. Sánchez J, Silva-Suarez G, Serna CA, et al. The Latino Migrant Worker HIV Prevention Program: Building a community partnership through a community health worker training program. *Fam Community Health*. 2012;35(2):139–46.
19. Strack RW, Lovelace KA, Jordan TD, et al. Framing photovoice using a social-ecological logic model as a guide. *Health Promot Pract*. 2010;11(5):629–36.
20. Ponc P, Jategaonkar N. Balancing safety and action: Ethical protocols for photovoice research with women who have experienced violence. *Arts Health*. 2012;4(3):189–202.
21. Teti M, Murray C, Johnson L, et al. Photovoice as a community-based participatory research method among women living with HIV/AIDS: Ethical opportunities and challenges. *J Empir Res Hum Res Ethics*. 2012;7(4):34–43.
22. Hergenrather KC, Rhodes SD, Cowan CA, et al. Photovoice as community-based participatory research: A qualitative review. *Am J Health Behav*. 2009;33(6):686–98.
23. Catalani C, Minkler M. Photovoice: A review of the literature in health and public health. *Health Educ Behav*. 2010;37(3):424–51.
24. Halifax NV, Yurichuk F, Meeks J, et al. Photovoice in a Toronto community partnership: Exploring the social determinants of health with homeless people. *Prog Community Health Partnersh*. 2008;2(2):129–36.
25. Grieb SM, Joseph RM, Pridget A, et al. Understanding housing and health through the lens of transitional housing members in a high-incarceration Baltimore City neighborhood: The GROUP Ministries Photovoice Project to promote community redevelopment. *Health Place*. 2013;21:20–8.
26. Kondo MC, Mizes C, Lee J, et al. Toward participatory air pollution exposure assessment in a goods movement community. *Prog Community Health Partnersh*. 2014;8(3):263–4.

27. Rhodes SD, Hergenrather KC, Wilkin AM, et al. Visions and voices: Indigent persons living with HIV in the Southern United States use photovoice to create knowledge, develop partnerships, and take action. *Health Promot Pract*. 2008;9(2):159–69.
28. Kennedy T, Teti M, Hayes D, et al. “Unmasked to a positive triumph”: Women with HIV share the benefits of showing their faces through photovoice. *Prog Community Health Partnersh*. 2016;10(4):505–13.
29. Kubicek K, Beyer W, Weiss G, et al. Photovoice as a tool to adapt an HIV prevention intervention for African American young men who have sex with men. *Health Promot Pract*. 2012;13(4):535–43.
30. Thompson NC, Hunter EE, Murray L, et al. The experience of living with chronic mental illness: A photovoice study. *Perspect Psychiatr Care*. 2008;44(1):14–24.
31. Cabassa LJ, Parcesepe A, Nicasio A, et al. Health and wellness photovoice project: engaging consumers with serious mental illness in health care interventions. *Qual Health Res*. 2013;23(5):618–30.
32. Findholt NE, Michael YL, Davis MM. Photovoice engages rural youth in childhood obesity prevention. *Public Health Nurs*. 2011;28(2):186–92.
33. Torres ME, Meetze EG, Smithwick-Leone J. Latina voices in childhood obesity: a pilot study using Photovoice in South Carolina. *Am J Prev Med*. 2013;44(3):S225–31.
34. Woolford SJ, Khan S, Barr KL, et al. A picture may be worth a thousand texts: Obese adolescents’ perspectives on a modified photovoice activity to aid weight loss. *Child Obes*. 2012;8(3):230–6.
35. Graham LF, Reyes AM, Lopez W, et al. Addressing economic devastation and built environment degradation to prevent violence: A Photovoice project of Detroit youth passages. *Community Lit J*. 2013;8(1):41–52.
36. Ornelas IJ, Amell J, Tran AN, et al. Understanding African American men’s perceptions of racism, male gender socialization, and social capital through photovoice. *Qual Health Res*. 2009;19(4):552–65.
37. Minkler M, Wallerstein N. Introduction to community based participatory research. In: Minkler M, Wallerstein N, editors. *Community-based participatory research for health*. San Francisco: Jossey-Bass; 2003. p. 3–26.
38. Wallerstein N, Duran B. Community-based participatory research contributions to intervention research: The intersection of science and practice to improve health equity. *Am J Public Health*. 2010;100(S1):S40–6.
39. Rhodes SD, Duck S, Alonzo J, et al. Using community-based participatory research to prevent HIV disparities: Assumptions and opportunities identified by the Latino partnership. *J Acquir Immune Defic Syndr*. 2013;63:S32–S35.
40. deKoning K, Martin M, editors. *Participatory research in health: Issues and experiences*. London: Zed Books; 1996.
41. Israel BA, Schulz AJ, Parker EA, et al. Review of community-based research: Assessing partnership approaches to improve public health. *Annu Rev Public Health*. 1998;19:173–202.
42. Israel BA, Schulz AJ, Parker EA, et al. Critical issues in developing and following CBPR principles. In: Minkler M, Wallerstein N, editors. *Community-based participatory research for health: From process to outcomes*. 2nd ed. San Francisco: Jossey-Bass; 2008. p. 47–66.
43. Rhodes SD, Mann L, Alonzo J, et al. CBPR to prevent HIV within racial/ethnic, sexual, and gender minority communities: successes with long-term sustainability. In: Rhodes SD, editor. *Innovations in HIV prevention research and practice through community engagement*. New York: Springer; 2014. p. 135–60.
44. Hoefl TJ, Burke W, Hopkins SE, et al. Building partnerships in community-based participatory research budgetary and other cost considerations. *Health Promot Pract*. 2014;15(2):263–70.
45. Simmons VN, Klasko LB, Fleming K, et al. Participatory evaluation of a community-academic partnership to inform capacity-building and sustainability. *Eval Program Plann*. 2015;52:19–26.
46. Young S, Patterson L, Wolff M, et al. Empowerment, leadership, and sustainability in a faith-based partnership to improve health. *J Religion Health*. 2015;54(6):2086–98.
47. Cobb PD, Rubin BA. Contradictory interests, tangled power, and disorganized organization. *Adm Soc*. 2006;38(1):79–112.
48. Minkler M. Linking science and policy through community-based participatory research to study and address health disparities. *Am J Public Health*. 2010;100(S1):S81–7.
49. Minkler M, Salvatore AL, Chang C, et al. Wage theft as a neglected public health problem: An overview and case study from San Francisco’s Chinatown district. *Am J Public Health*. 2014;104(6).
50. Tajik M, Minkler M. Environmental justice research and action: A case study in political economy and community-academic collaboration. *Int Q Community Health Educ*. 2006;26(3):213–31.
51. Gonzalez PA, Minkler M, Garcia AP, et al. Community-based participatory research and policy advocacy to reduce diesel exposure in West Oakland, California. *Am J Public Health*. 2011;101(S1):S166–75.
52. Themba M, Minkler M. Influencing policy through community based participatory research. In: Wallerstein N, Minkler M, editors. *Community-based participatory research for health*. San Francisco: Jossey-Bass; 2005. p. 349–70.
53. Cacari-Stone L, Wallerstein N, Garcia AP, et al. The promise of community-based participatory research for health equity: A conceptual model for bridging evidence with policy. *Am J Public Health*. 2014;104(9):1615–23.
54. Izumi BT, Schulz AJ, Israel BA, et al. The one-pager: A practical policy advocacy tool for translating community-based participatory research into action *Prog Community Health Partnersh*. 2010;4(2):141.