The Role of Community Engagement in Implementation of Community Health Assessments: A Qualitative Study

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DISSERTATION

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DEDICATION

This dissertation is dedicated to my husband, Israel, and our beautiful children, Adyson and Marc, for their support and sacrifice throughout this incredible journey.
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Lastly, I would like to acknowledge the many participants in this study from the African American and Latino community for trusting me with their stories. You know who you are and I am deeply humbled by your participation in this study.

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<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AA</td>
<td>African American</td>
</tr>
<tr>
<td>ACA</td>
<td>Affordable Care Act</td>
</tr>
<tr>
<td>APEXPH</td>
<td>Assessment Protocol for Excellence in Public Health</td>
</tr>
<tr>
<td>CAT</td>
<td>Community Action Teams</td>
</tr>
<tr>
<td>CBO</td>
<td>Community Based Organization</td>
</tr>
<tr>
<td>CBPR</td>
<td>Community Based Participatory Research</td>
</tr>
<tr>
<td>CHA</td>
<td>Community Health Assessment</td>
</tr>
<tr>
<td>CHIP</td>
<td>Community Health Improvement Plan</td>
</tr>
<tr>
<td>CPPW</td>
<td>Communities Putting Prevention to Work</td>
</tr>
<tr>
<td>CV</td>
<td>Curriculum Vitae</td>
</tr>
<tr>
<td>EDCHIP</td>
<td>Evidence-Driven Community Health Improvement Process</td>
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<tr>
<td>FBO</td>
<td>Faith-Based Organization</td>
</tr>
<tr>
<td>FPL</td>
<td>Federal Poverty Level</td>
</tr>
<tr>
<td>IRB</td>
<td>Institutional Review Board</td>
</tr>
<tr>
<td>JIMH</td>
<td>Journal of Immigrant and Minority Health</td>
</tr>
<tr>
<td>JPHMP</td>
<td>Journal of Public Health Management and Practice</td>
</tr>
<tr>
<td>KI</td>
<td>Key Informant</td>
</tr>
<tr>
<td>LHIN</td>
<td>Local Health Integration Networks</td>
</tr>
<tr>
<td>MAPP</td>
<td>Mobilizing for Action through Planning &amp; Partnership</td>
</tr>
<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
</tr>
<tr>
<td>NAACP</td>
<td>National Association for the Advancement of Colored People</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>NIH</td>
<td>National Institutes of Health</td>
</tr>
<tr>
<td>PACE-EH</td>
<td>Protocol for Assessing Community Excellence in Environmental Health</td>
</tr>
<tr>
<td>PATCH</td>
<td>Planned Approach to Community Health</td>
</tr>
<tr>
<td>PH</td>
<td>Public Health</td>
</tr>
<tr>
<td>REACH</td>
<td>Racial and Ethnic Approaches to Community Health</td>
</tr>
<tr>
<td>SCC</td>
<td>Santa Clara County</td>
</tr>
<tr>
<td>SCCBOS</td>
<td>Santa Clara County Board of Supervisors</td>
</tr>
<tr>
<td>SCCPHD</td>
<td>Santa Clara County Public Health Department</td>
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</table>
SUMMARY

Community engagement is both a process and a strategy used by public health departments in the development of community health assessments (CHA). While not a new concept to public health practitioners, community engagement has taken on new importance particularly in the face of new public and private funding streams, public health accreditation, and a renewed emphasis on the importance of addressing the social determinants of health as one way to address health inequities and health disparities. Because community health assessments may include recommendations or strategies aimed at improving the health and well-being of minority communities, it is important to understand the facilitators and barriers to implementation especially when stakeholders from the community are involved in their development.

The objectives of this study are to describe the community engagement process in relation to public health department and community capacity to implement recommendations/strategies that result from community health assessments. In addition, this study provides African American and Latino community perspectives and experiences that may be used to help resolve barriers and challenges to implementation of CHAs.

Six constructs associated with effective community engagement (purpose, history, knowledge, power/authority, infrastructure, and ownership) and associated factors (beliefs, values, flexibility, equity, fairness, commitment, leadership) were selected as the conceptual framework for this study. Each of these constructs is examined in relation to the implementation phase of the CHA development process.

A single case study design with embedded units of analysis was chosen for this study because it allows for greater understanding of the meaning, experiences, and understanding of
community engagement across and within communities with varied backgrounds and social positions. The case study focused on the community engagement process between the Santa Clara County Public Health Department and two communities, African American and Latino. Archival records, documents, semi-structured key informant interviews and focus groups were the main data sources used in this study.

Data from 20 key informant interviews and 3 focus groups were analyzed to identify cross cutting themes and triangulated with data from 24 records/documents to support conclusions. Four main themes were identified across groups: (1) Nearly all study participants had a different understanding of the reasons for coming together to develop CHAs, (2) The collaborative process was challenged by the lack previous history together, distrust, and the PH research approach used to develop CHAs, (3) Minimal resources are in place at the community and PHD level to support implementation of community priorities and recommendations that result from CHAs, and (4) communities expect the PHD to continue to have a role in the implementation phase of a CHA.

Findings from this case study suggest that while local health departments may integrate model practices for community engagement into the development of community health assessments, and are open to being influenced by community priorities, these practices may not always be effective in African American and Latino communities.

Recommendations for more meaningful engagement of minority communities in the development of CHAs include: 1) allowing time and opportunities for public health employees to work with communities without time constraints or deliverables; 2) training and education to build skills for working with and learning about and from communities, 3) diversify the PH workforce because it is important that PH be representative of the communities it serves, 4) build
leadership capacity at all levels within the PHD and identify levels of leadership in the community; 5) build the visibility of PH to differentiate it from other government institutions and emphasize its connections and advocacy for social justice and equity; and 6) build accountability to communities through transparency and feedback loops that demonstrate the benefit of CHAs.
I. INTRODUCTION

Background

Assessment is a core function of public health. Assessment activities include a wide range of efforts undertaken to diagnose, monitor, and propose solutions to community health problems. These activities may include “surveillance, identifying needs, analyzing the causes of problems, collecting and interpreting data, case-finding, monitoring and forecasting trends, research, and evaluation of outcomes” (NIH, 1988). Public health departments are likely to combine assessment with planning efforts to better understand and address local health priorities. According to Friedman and Parrish (2009), assessment is both a process and a product that may include data collection, planning and the implementation of interventions. Moreover, they assert that when the goal of an assessment is to produce information on community health, it should be referred to as “community health assessment”. Because the term has evolved over the years, it has been used to refer to the collection of primary and secondary data; data collection for the purpose of evaluating public health interventions or to support practice-based research\(^1\) as well as the implementation of evidence-based approaches in public health settings. The term has also been broadly used to describe a diversity of other methods and processes such as the identification of important community stakeholders, the development of new relationships, coalition and partnership building, and community mobilization (Friedman & Parrish, 2006; Solet et al., 2009; Shah, Lovelace, & Mays, 2012; Jacobs, Jones, Gabella, Spring, & Brownson, 2012).

\( ^{1}\)Practice-based research is the “systematic inquiry into the systems, methods, policies, and programmatic applications of public health practice”.
Despite the lack of a single definition for assessment in public health and the diverse ways in which it may be carried out across local health departments, it is unlikely that “community health assessment” occurs without some degree of community participation. With the passage of the Affordable Care Act (ACA) and voluntary national public health accreditation, many health departments nationwide are focused on community health assessments (CHA) and community health improvement planning processes (CHIP) as one way to address population-level priorities and concerns. While these types of efforts are likely to highlight emergent or high priority focus areas such as chronic disease across subpopulations and communities, they may not represent priorities at the neighborhood level or reflect the priorities of vulnerable communities or communities of color particularly in urban areas with large and diverse populations.

Numerous studies have affirmed that racial/ethnic minority populations suffer a disproportionate burden of illness and disease compared to other groups. In addition, racial/ethnic populations experience significant disparities across important factors that contribute to health outcomes and quality of life such as education, housing, and wealth. In recognition of the important role of health departments to address health disparities and health inequities, public health practitioners have applied community based approaches and strategies to their assessment and planning functions in order to bring the voice and needs of marginalized or high risk communities to the forefront while building capacity to mobilize around important priority areas and issues. Likewise, community residents themselves have applied principles and practices of community organizing to bring focus, attention, and action to issues of mutual concern. Elements associated with community organizing such as assessment, action and evaluation have some similarities to the processes of data collection, planning, implementation,
and evaluation associated with community health assessments traditionally led by public health departments. Common to each of these processes is that they begin with assessment in order to increase knowledge about an issue or problem of concern to a community or a health department.

According to Minkler (2005), community health assessment is a first step in community organizing and community building because knowledge facilitates both empowerment and change. This becomes more relevant when you consider how public health staff engage members from communities of color in the community health assessment process. Minkler notes that while data generated by experts about a specific community health need may be sufficient, failure to engage the community “meaningfully” throughout the process is counter to the practices and principles associated with community building and community empowerment. In fact, she suggests that an important goal of a community health assessment should be empowerment.

While public health departments may not set out to simultaneously meet their traditional assessment functions and empower communities to take action, departments who purport to be working to eliminate health inequities or reduce health disparities must give serious consideration to the interplay between the assessment process, community engagement, and the action or inaction that results from these efforts. Clearly, assessment in itself is necessary, but not sufficient to address improvements in community health. Rohan, Booske, and Remington (2009), assert that community health assessments seldom lead to the action necessary to address issues identified in the process. In places like Santa Clara County, CA, where population health assessments are conducted on an annual basis, there is growing concern among community members and advocates that the health department’s emphasis is primarily on data generation rather than on achieving health improvement. “We have enough data, what are you doing about
what you already know”? (F. Ferrer, personal communication, November 2011) or “it seems that the health department only cares about gathering statistics. They should try to show more that they want to help. We at the bottom see things in full perspective. Those at the top feel pity for us but do not do anything to fix the problem” (Spanish focus group participant, personal communication, June 26, 2012). These sentiments reflect the general discontent being expressed by community stakeholders. For these reasons, community engagement and resident participation at any level of an assessment activity or process presents both a challenge and an opportunity for health departments because communities want and expect change to occur as the result of their involvement. Thus, a better understanding of factors that facilitate the implementation or action phase associated with an assessment activity undertaken by health departments is critical to prevent community and resident involvement from being reduced to merely an academic exercise.

Fortunately, public health practitioners and researchers in Santa Clara County and across the nation recognize the growing importance of community participation in public health assessment activities and have sought out models and approaches where community engagement is fundamental to both process and outcome. One such approach being applied successfully to public health practice-based research and assessment activities across many health departments is the application of community-based participatory research (CBPR) principles and practices. CBPR is defined as:

A collaborative process that equitability involves all partners in the research process and recognizes the unique strengths that each brings. CBPR begins with a research topic of importance to the community with the aim of combining knowledge and action for social change to improve community health and
eliminate health disparities. (Kellog Community Health Scholars Program, 2001, as cited in Minkler, Garcia, Rubin, and Wallerstein, 2012, p. 8)

In addition to CBPR, many well-known community planning models and frameworks have been used to guide partnership development between public health departments and community stakeholders including those from racially diverse communities to improve health. Mobilizing for Action through Planning and Partnership (MAPP), Protocol for Assessing Community Excellence in Environmental Health (PACE-EH), Assessment Protocol for Excellence in Public Health (APEXPH), Planned Approach to Community Health (PATCH), PRECEDE-PROCEED model and many others have been used in public health settings and written about extensively. The ladder of community participation is yet another promising framework which consists of seven strategies intended to support engagement between public health planners and communities around issues of public health importance (Morgan & Lifshay, 2006). A key tenet of each of these models and approaches is the focus on community engagement. Community engagement is defined 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 well-being of those people. It is a powerful vehicle for bringing about environmental and behavioral changes that will improve the health of the community and its members. It often involves partnerships and coalitions that help mobilize resources and influence systems, change relationships among partners, and serve as catalysts for changing policies, programs, and practices. (CDC, 1997, as cited in Agency for Toxic Substances and Disease Registry, Centers for Disease Control and Prevention, 2011, p. 7)
The concept of community engagement is not new to public health and has been referenced in the literature as fundamental to resolving a wide range of issues including the elimination of health disparities and health inequities. The importance of working with community has been reinforced at the highest levels of government through federal initiatives like REACH, Communities Putting Prevention to Work (CPPW), and funding of the Prevention and Public Health Fund. Yet despite decades of collaboration and community engagement across public health issues, program planning, assessment and research, translating and implementing evidence-based practices and applied research findings into practical solutions in communities often fail or are slow to take hold.

While it is sometimes difficult to categorize normal routine PH assessment activities like community health assessments as research, research is any activity whose purpose is to “develop or contribute to generalizable knowledge” (CDC, 2010). One could argue that the main goal of community health assessments are to generate localized knowledge rather than generalizable knowledge and are thus, not considered research. However, in Santa Clara County, it is not uncommon for public health staff to use community health assessments as the basis for publications in peer reviewed journals with the expressed purpose of disseminating and contributing to generalizable knowledge. Therefore, community health assessments and practice-based research activities that may contribute generalizable knowledge may be categorized as “research” and are subject to the same issues contributing to the gap between research and translation that is well documented in the literature. The inability to act on or implement recommendations that result from PH assessment activities particularly those that impact already vulnerable communities creates both a philosophical and operational challenge to
public health departments who work to resolve community and societal issues that contribute to poor health and well-being.

Durlak and DuPre (2008) found that the implementation process is affected by 23 contextual factors. These factors impact the community and provider level, the innovation type, organizational capacity, and the prevention support system. While factors associated with each of these is complex, and multi-dimensional, many of these factors are applicable across settings. For instance, previous research experience, politics, funding, skills and training necessary for implementation, shared vision and decision-making are all factors that may impede or facilitate implementation activities intended to benefit a community or group.

One perspective is that communities must be at a certain level of readiness in order to implement interventions that are culturally specific and culturally relevant (Thurman, Edwards, Plested, & Oetting, 2003). Because public health practitioners understand this, they will purposefully seek collaboration with entities where trust already exists or where a certain level of infrastructure, resources, or commitment has been established. In other instances, well established groups will forge a relationship with public health departments around a common goal or priority area. However, what happens when vulnerable community groups that may lack infrastructure, resources, or strong networks partner with a health department and forge deep relationships in order to advance a community driven initiative through an applied research project or community health assessment process? Does this mean automatic failure in implementation?

**Statement of the Problem**

Public health departments apply a range of community engagement models to generate public health data and encourage action within racial and ethnic minority communities that
historically have been under-studied. While collaborative models such as the use of community-based participatory research (CBPR) principles have advanced the capacity of health departments to partner in meaningful ways with underrepresented and hard-to-reach communities, less is known about how or why community health assessment processes that have support and commitment from both the community and health departments fail or are slow to reach the implementation phase. Despite several studies that have examined a wide range of factors that contribute to or influence momentum for action and full implementation across issues, groups and communities, there is a need for more information about the perspectives and experiences of individual community leaders in African American and Latino communities about the role that engagement may play in mobilizing for action and advancing the translation of community health assessment recommendations and strategies into practice in their communities. Understanding the experiences of important community leaders and gatekeepers that have been involved with community health assessment efforts is especially important given the projected demographic shifts and the significant health disparities and inequities experienced by these populations.

**Significance of the Study**

The main purpose of this case study is to provide different perspectives about the community engagement process that takes place during public health assessment activities and its relationship to implementation capacity within a public health department and the community. Exploration and analysis will take place at two levels. First, an analysis of the engagement process and outcome of a community health assessment project between a local health department and two communities, African American and Latino. Second, an analysis of
similarities and differences related to facilitators, barriers, challenges, and successes experienced by these two communities will be provided.

This study has two main objectives. The first aim is to build knowledge that may inform changes in public health practice and approaches to community health assessment. The second aim is to explore the unique experiences of two vulnerable communities, one small and one large, which are often the target of community health interventions by health departments and their many community partners. A deeper understanding about how representatives from these communities are involved in the process of developing health assessments may contribute further knowledge about factors that contribute to or prevent the implementation of recommended strategies or interventions that often accompany such assessments.

Research Questions

Main research question:

1. How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

Sub-research question:

2. What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete?
3. What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?

**Leadership Implications:**

Addressing health disparities and health inequities are daunting challenges for public health leaders. Addressing the root causes of health inequities will require thoughtful, committed, culturally specific interventions, and risk taking on the part of affected communities and public health professionals. Critical to this work are effective partnerships that work together to translate data and evidence-based research findings and practices into affected communities in a timely manner. Effective partnerships require clear and explicit expectations that are understood and agreed to in order to increase the probability of translating assessment or research findings into practical and effective solutions.

Local health departments are in a unique position to create meaningful partnerships with communities. By integrating community perspectives, experiences, strengths, and ideas into routine health assessment, applied research activities, planning, and evaluation processes, the implementation of public health interventions into practical solutions that take into account both health department and community capacity are more likely to take place. However, research suggests that community engagement of vulnerable communities by health departments is inconsistent across the assessment, planning, and implementation continuum. Community engagement that is consistent; based in shared understanding and leadership, culturally specific, and founded on trust and mutual respect is likely to facilitate the progression from assessment to implementation of joint efforts.
When health departments collaborate with community groups from underrepresented communities on assessment activities and disengage once studies are complete, they run the risk of further marginalizing already vulnerable communities which is counter to the fundamental underpinning of public health practice which is based in a strong belief in social justice principles and actions. Likewise, when community groups are primed and fully engaged in community health assessment activities with health departments, but are challenged to advance the work, they are likely to lose trust and commitment to further partnership development.

Public health department leaders may benefit from a better understanding of how the various aspects within the broad concept of “community engagement” play a role in assessment activities and in the creation of meaningful long-term commitment from disproportionately affected communities such as the African American and Latino communities. Effective community engagement may increase the probability of advancing assessment findings and accompanying recommendations to action with the overall aim of improving the health and well-being of these communities through the elimination of health disparities and health inequities.
II. LITERATURE REVIEW AND CONCEPTUAL FRAMEWORK

Literature review

The literature review was conducted using Web of Science, Google Scholar, and PubMed databases to provide context and relevant insights necessary to explore the research question in this dissertation study. The following search terms and/or phrases were used: ‘community engagement and public health’, ‘assessment and public health’, ‘African American/Latino community and local health department’, and ‘implementation science and assessment’. The results were categorized into four broad areas: the definition of community engagement, community engagement frameworks and practices used in public health, assessment and its relation to research, and moving from research to practice in public health settings.

Community Engagement Definition and Frameworks

Community engagement as public health strategy to improve the health and well-being of vulnerable populations is well documented in the literature. Community engagement is defined 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 well-being of those people” (CDC, 1997). While many disciplines have contributed to the concept and application of community engagement, community engagement has become a fundamental core strategy for public health departments working to eliminate health disparities and health inequities that disproportionately affect minority communities. Recognizing the influence of social determinants on health, programs, policies, interventions, and funding streams have shifted their orientation to include the perspectives and lived experiences of the people and communities whom are often the subject of activities intended to benefit them.
Community engagement is often conceptualized as a continuum of participation as illustrated by Figure 1 which is an adaptation of the spectrum of participation developed by the international association for public participation. This model illustrates how community participation can begin as a passive process where communities receive information and communication is unidirectional i.e. outreach, and increasingly becomes more active leading to optimal shared leadership, decision-making, and where reciprocal meaningful communication occurs. The spectrum of participation is also emphasized in a similar model named the ladder of community participation, based on the early seminal work of Sherry Arnstein’s ladder of citizen involvement.

**Figure 1**: Spectrum of participation

<table>
<thead>
<tr>
<th>Increasing Level of Community Involvement, Impact, Trust, and Communication Flow</th>
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<tbody>
<tr>
<td><strong>Outreach</strong></td>
</tr>
<tr>
<td>Some community involvement</td>
</tr>
<tr>
<td>Communication flows from one to the other, to inform</td>
</tr>
<tr>
<td>Provides community with information</td>
</tr>
<tr>
<td>Entities coexist</td>
</tr>
<tr>
<td>Outcomes: Optimally establishes communication channels and channels for outreach.</td>
</tr>
</tbody>
</table>

Source: Adapted from the International Association for Public Participation
participation which includes eight rungs or stages organized into three categories that include nonparticipation, tokenism, and citizen power. Similarly, the ladder of community participation reflects a continuum of approaches that can be used by public health departments and communities based on the activity and desired level of involvement. The ladder is comprised of seven strategies that include: 1) health department initiates and directs action, 2) health department informs and educates community, 3) limited community input/consultation, 4) comprehensive community consultation, 5) bridging, 6) power-sharing, and 7) community initiates and directs action (Morgan & Lifshay, 2006). These concepts are reflected in the varied perspectives and opinions about the value, effectiveness, best models and approaches to community engagement across settings (Israel, Schulz, Parker, & Becker, 1998). Despite the notion that community engagement may mean different things to different people across different contexts (Kumar, 2005), community engagement with marginalized communities is an especially important area for health departments to both understand and apply effectively.

There are many community engagement frameworks and studies that provide recommendations and guidelines for how to engage minority and ethnic communities. One such framework was developed by the National Institute for Health and Clinical Excellence (NICE) in the United Kingdom (2008). It provides 12 recommendations for effective community engagement organized under four domains: 1) pre-requisites for effective community engagement, 2) infrastructure, 3) approaches, and 4) evaluation. Recommendations range from commitment to long-term investment, power-sharing, trust, formalization of partnerships, deep engagement and utilization of community residents, to the evaluation of the impact and outcome of community engagement on health and social outcomes. Using this framework Lane and Tribe (2010) developed a four-step model to further guide health professionals in community
engagement with underrepresented communities. The four steps include: 1) making sure everyone is ready, 2) consultation, 3) talking to action, and 4) feedback and follow-up. In each of these steps, there are both subtle and explicit considerations that must be taken into account. For instance, the extent, benefits and the limitations of the community engagement process must be made clear to all participants from the start. While time is always a factor in any engagement process, building time in and commitment to the process in a way that respects and honors the cultural-specific beliefs and practices about health, is important when working with minority communities.

Similarly, a framework for effective community engagement in Ontario, Canada offers yet another perspective and approach for public health professionals to consider when working with communities. Jabbar and Abelson (2011) used a “concept mapping” approach to identify statements of ‘effectiveness’ with staff working in Local Health Integration Networks (LHIN). Statements were ranked, clustered and evaluated against public engagement and effectiveness literature. The emerging framework identified six categories for effective community engagement. They include collaboration to improve health, giving people access to the process and allowing their voice to be heard, accountability to the community, education in the form of transparency and information, working to ensure meaningful engagement, and organizational capacity.

While these are just a few of the vast number of community engagement frameworks or models found in the literature, they serve to emphasize the importance of cross cutting concepts, ideas, and principles that may be applicable to public health settings.
Community Engagement Practices in Public Health

Despite a plethora of information related to the umbrella concept of community engagement, there is less information in the academic literature about the process and operationalization of these concepts in local health departments specifically when working with minority and ethnic communities. Much of the published literature comes from community participation in academic and clinical public health research initiatives and studies, with more information and references to community engagement in governmental settings appearing in the grey literature. Nevertheless, important concepts and applications are noted and help frame the context for how public health departments apply constructs of community engagement to advance and improve community health in minority communities. An understanding of the communitarian philosophical belief in trust, mutuality, cooperation, social justice, social capital, and inclusion as elements of community and community relationships can act as a broad organizing frame for understanding how these concepts have been used across a range of public health strategies for working with diverse communities (Arai & Pedlar, 2003).

Community engagement with vulnerable communities begins with building relationships based on trust, respect, and cultural understanding. A community’s knowledge and practices can affect a wide range of issues including the process of building trust. Knowledge is often contextualized within cultural practices that often translate to how communities relate to leadership, make decisions, and communication. Culture informs how community needs and interventions are viewed and identified (Allen, Mohatt, Beehler, & Rowe, 2014). Culture also helps to inform an understanding of power and its relation to the important concept of empowerment.
The practice and application of the concept of empowerment is critical for local health department staff to understand when working with diverse communities. Empowerment is a process that leads to a redistribution of power, resources, and decision-making so that people can gain greater control over their lives and achieve important goals (Maton, 2008). Like community engagement, empowerment or control exerted by a community group can also be placed along a continuum. Depending on the level of community participation, which can be active or passive, empowerment can be viewed as a dynamic process that could be exploited due in part because of the complex nature of bringing varying perspectives together (Maiter, Joseph, Shan, & Saeid, 2013; Kofinas, 2005; Chung, & Lounsbury, 2006).

Public health practitioners and researchers appear to understand the importance of power sharing and its relationship to community engagement. Ahmed and Palermo (2010) developed a community engagement framework for researchers based on the premise that researchers need to become part of the community and that the community needs to become part of the research team. This framework is based on an understanding that community engagement requires “power sharing, maintenance of equity, and flexibility in pursuing goals, methods, and time frames that fit the priorities, needs and capacities within the cultural context of communities”. Likewise, Collie-Akers, Fawcett, and Schultz (2013) applied the concept of empowerment in a study working with a Latino community in Kansas which they believed could bring about change in the community. However, they found few ways to measure whether the process itself actually led to change.

Nevertheless, evidence suggests that public health researchers not only understand the link between empowerment and health equity, but that more and more of them are applying the
principles and practices associated with these concepts when working with communities (Scutchfield, Hall, & Ireson, 2006; Rifkin, 2003). In fact, public health practitioners working in governmental settings also understand that the root causes of poor health outcomes are rooted in a larger context. For this reason, researchers including practice-based researchers such as epidemiologists and community planners engage communities with the belief that community issues must be owned and solved in part by communities themselves. More importantly, there is now enough understanding that the process of issue identification requires thinking together and making explicit the values and the costs of dealing with a particular issue. Framing the issues in a manner that ordinary citizens understand is an important precursor to moving towards public action. There is also recognition that unstated power differentials could deter meaningful engagement when working with communities and that how public health officials see and view a problem may be different from how communities view and see a problem. Regardless of the many challenges facing communities, public health researchers are now more aware of the root causes of these problems and have created models and frameworks that explicitly incorporate important concepts aimed at meaningful engagement of communities in both identifying and resolving issues most important to them.

One popular well-known approach for working with communities within a research paradigm is community-based participatory research (CBPR). CBPR is both a framework and process that has been used by public health researchers that incorporate and reinforce key constructs associated with community engagement. Minkler, Garcia, Rubin, and Wallerstein (2012) outline 11 principles for CBPR in their report to PolicyLink as follows:

(1) recognizing community, (2) communities have strengths and assets, (3) equitable partnership across all phases of research and a strong belief and application of the
practice of empowerment and power-sharing, (4) foster co-learning and capacity building among all partners, (5) balance knowledge generation and intervention for mutual benefit of all partners, (6) focus on ecological perspectives and attends to the multiple determinates of health, (7) involve a cyclical and iterative process, (8) disseminate results to all partners and involve them in wider distribution of results, (9) involve a long-term process and commitment to sustainability, (10) openly addresses issues of race, racism, and social class, and embodies “cultural humility”, (11) work to ensure research rigor and validity but also seeks to “broaden the bandwidth of validity” with respect to research relevance. (p.11)

CBPR is one model that has been used with varying levels of success when working with diverse communities including, African Americans, Latinos, Native Americans, and immigrants. It is also a model that local health departments are beginning to build capacity to utilize (Paschal, Oler-Manske, Kroupa, & Snethen, 2008; Jernigan, 2010; Hill, You, & Zoellner, 2014).
**Community Health Assessment as Research**

The CDC (2010) defines research as “systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge”. Despite an overarching belief that community health assessments fall outside of the definition of “research” because they are not aimed at contributing data that is generalizable, a small percentage of them are likely to be designed or developed with the expressed purpose of contributing generalizable knowledge. In these cases, health assessment activities would fall within the definition of research and be considered research in the traditional sense. Regardless of one’s perspective, community residents, advocates, and stakeholders who participate in data collection activities conducted by a public health department may view public health staff involved in such activities as ‘researchers’ even if the intent behind the activity is non-research in nature.

In health departments like Santa Clara County, epidemiologists and community planners are often charged with facilitating community stakeholder engagement related to the development of community health assessments, applied research projects, survey research, or program based evaluation studies. Staff have applied several models and approaches to this work including the application of a community engaged research framework. Barkin, Schlundt, and Smith (2013) define community engaged research as a process or “framework for conducting research that uses relationships between researchers and communities”. The practice and process of engaging communities and particularly minority communities in research is complex and is made more challenging by the lack of trust that exists due to historical abuses. Corbie-Smith, Thomas, and St. George (2002) found that trust was a key factor among African
Americans in research participation and suggested that engagement with the community be ongoing and involve repeated interactions as part of a long-term relationship.

While much of the information about the barriers and consequences related to community participation in research comes from the academic literature, there are practical recommendations and cautions that are relevant to public health departments and settings. First, if community health assessment is regarded as research, then public health staff directly involved with these activities are researchers. Second, if public health researchers are using a participatory approach, then they must be cognizant that “participatory research is about conducting research with a group, rather than conducting research on a group, and with a community rather simply in a community or for a community” (Westfall et al., 2009).

**Moving from Research to Practice in Public Health**

Evidence suggests that despite the many models and frameworks and widespread commitment to community engagement and participation to eliminate health disparities and health inequities and improve community health, public health practitioners, including those working in local health department settings, face challenges in operationalizing important principles and research findings into practice. First, there are two main approaches being utilized today, each with strengths and weaknesses. The first approach is a research-driven approach where challenges to implementation from trials to practice are well documented (Chaudoir, Dugan, & Barr, 2013; Durlak, & DuPre, 2008; Glasgow, Vinson, Chambers, Khoury, Kaplan, & Hunter, 2012). The second approach is the application of health improvement models where community input is sought in identifying health priorities and in the implementation of health interventions. While these two approaches appear distinctly different, new models and
approaches have been developed to leverage processes and practices from both. One such model is the evidence-driven community health improvement process (EDCHIP) developed by Layde et al. (2012). While this framework offers an alternative to community health planning, implementation, and evaluation that emphasizes community priorities, ownership and knowledge, it is not without limitations. This framework requires communities to be skilled and resourced in order to implement the process and implement interventions that are feasible and fit well within the parameters and constraints of the community.

There are several additional challenges identified in the literature. A few noteworthy obstacles include limited research in how to best deliver effective public health strategies in diverse communities and organizational settings (Mays, Hogg, Castellanos-Cruz, Hoover, & Fowler, 2013). In addition, vulnerable and disadvantaged communities may face their own unique challenges to participating in research or community improvement activities because either research has failed to address their needs or they have not benefited in a meaningful way from participation. There is also a need to foster a reciprocal learning environment and a commitment to long-term sustainability efforts from all partners that has proven difficult across settings (Braun et al., 2012). There is also a sense from some communities that researchers actually control the process and engaging communities is actually a means to an end, or “business as usual” (Wallerstein & Duran, 2010).

In summary, public health practitioners working in academia or local health departments understand the value of engaging with communities to help identify solutions to complex problems. However, there is little information in the published literature linking the process of community engagement to positive health outcomes. There is also a void of information linking
factors associated with community engagement strategies used by local health departments in community health assessment or applied research efforts leading to effective implementation of minority community priorities. In an era of renewed commitment to eliminating health inequities and health disparities, local health departments working with vulnerable or marginalized communities must do so in recognition of the ethical principles guiding public health practice. Specifically, those principles that reinforce the role of public health to support and empower disenfranchised communities and collaborate in a manner that builds trust and lasting community change (Public health leadership society, 2002). Therefore, engagement with vulnerable communities must be approached in full awareness that anything less than full commitment may result in further marginalization and reinforcement of the notion of ‘doing to communities’ rather than with communities.

**Conceptual Framework:**

The literature review helps frame an understanding of how public health departments apply a variety of approaches with the aim of improving community health. Community engagement and associated factors are referenced in nearly all planning models and research approaches used by public health practitioners. Health departments are well known for applying community health planning models that incorporate important steps such as a pre-planning phase, engagement of the community, developing a vision, conducting an assessment, prioritization of community issues, developing a community health improvement plan, implementation, monitoring and evaluation (CDC, 2014). More recently, the Affordable Care Act and voluntary national public health accreditation have renewed an interest and provided unique opportunities for partnership development with both traditional and nontraditional community partners such as hospitals, to conduct both community health assessment and
community health improvement processes and plans that specifically call for community involvement. Figure 2 depicts a traditional process used in the development of community health assessments.

**Figure 2:** Traditional community health assessment process

![Diagram of traditional community health assessment process](source: Adapted from the workgroup for community health and development, University of Kansas)

Given the persistent and significant health disparities and health inequities experienced by many communities in the United States, health departments and their partners have begun to incorporate an equity focus in their assessments by including a broader, but more comprehensive approach that includes the social determinants of health (Figure 3). In these instances, it is critical that representatives from the affected communities are involved. “Community residents and their organizations must be active partners in any efforts to eliminate health inequities and
the LHD must be accountable to the community” (Hofrichter, 2006). Therefore, community engagement is necessary at all phases of a community improvement effort: assessment, planning, implementation, and evaluation.

**Figure 3:** Social determinants of health

Source: Michigan Health Equity Roadmap, 2010
Clearly, many of the existing models and frameworks being applied to address community health problems emphasize the importance of community engagement, but many lack details about the operational pathway to effective community engagement. Effective community engagement may be even more important when working with already vulnerable communities such as the African American or Latino communities in places like Santa Clara County, CA. African Americans and Latinos in Santa Clara County experience significant health disparities, and are also the focus of cross system countywide efforts because these communities are over represented in the foster care, health care, and criminal justice systems compared to other groups.

Without a doubt, community engagement is important, but what constitutes effective community engagement? To some extent, effective community engagement depends on the context. In this case study, effective community engagement implies that the processes associated with the development of community health assessments lead to practical, tangible, and lasting benefits for communities. Community engagement is therefore, the main construct that underpins the conceptual model (Figure 4) in this study and is intended to answer the question “how do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?”

The conceptual model emphasizes key sub-constructs found in the community engagement literature for effective community engagement prior, during, and after a community health assessment process. This includes factors associated with sustaining a desired change and for evaluating precursors associated with implementation. These factors will be explored to
determine the impact or influence of these factors across all phases of the community health assessment process including assessment, planning, and implementation. A key question and main driver of the problem statement is, if the Santa Clara County Public Health Department and participating communities have been fully committed and engaged in all aspects of community based health assessments, are community identified recommendations being implemented? If so, how and why? Is there meaningful community engagement from the start? What level and type of community engagement is necessary to support community driven priorities across the continuum from data collection to implementation? There is no paucity of information about the significant contribution that community engagement and associated principles contribute to advancing public health priorities. However, the level and type of community engagement necessary to advance community driven priorities that emerge from partnerships with local health departments, as part of conducting health assessments is not well known, particularly those that involve different minority communities. There is also a gap in knowledge about whether community engagement practices are sufficient to support implementation capacity or improve community health outcomes (Lasker & Weiss, 2003). More recent studies and frameworks such as those from the National Institute for Health and Clinical Excellence (2008) suggest that when communities are engaged as equal partners, health outcomes are likely to be positively impacted.
Figure 4: Research study conceptual model
III. METHODS

Research Design and Analytic Approach

This study applied a qualitative, single case study design with embedded units to examine how different aspects of community engagement affect the health assessment processes, undertaken by the Santa Clara County Public Health Department, a mid-sized health department in Northern California. This study also examined the perspectives and experiences of public health professionals, African American and Latino community members who collaborated on an assessment project or activity. The African American and Latino communities were selected as the focus of this study because of their consistently lower socioeconomic status compared to other populations in Santa Clara County.

As a researcher and public health practitioner with a constructivist view of the world, who believes that people’s experiences shape their beliefs and world views, a qualitative research design provides the best methodology necessary for deep exploration and discovery while allowing for flexibility to build upon an a priori framework. The a priori framework is reflected in the conceptual map or model for this study (Figure 4) and is comprised of key constructs associated with community engagement supported by the literature. The conceptual framework helps provide both context and support for the main research question of this study. The a priori concepts also formed the basis for deductive coding of interviews, focus groups, and relevant documents. Findings from the interviews and focus groups were triangulated with documents collected in this study. Triangulation was used to help support the validity of the findings from the interviews and focus groups. Specifically, triangulation was used to complement findings as well as identify areas of divergence.
The research design is dictated, in part, by the research question. According to Yin (2009), a case study research design is a proper design when the research question is the form of “how” or “why”. In this study, a single case study with embedded units of analysis allowed for greater understanding of contextual factors that influence the implementation capacity of two distinct communities’ priorities when partnerships are forged with a governmental health entity to advance community identified health priorities and strategies. This was an explanatory case study which is used “when the researcher has little control over the events and when the focus is on a contemporary phenomenon within some real-life context” (Yin, 2009).

**Figure 5**: Single case study with embedded units

Source: Case study research design and methods, 4th Ed., 2009
Yin (2009) defines a case study as “an empirical inquiry that investigates a contemporary phenomenon in depth and within its real-life context, especially when the boundaries between phenomena and context are not clearly evident”. Because this study aimed to discover the meaning, experiences, and understanding of community engagement across and within communities with varied backgrounds and social positions, in relation to typical health assessment activities undertaken by health departments to improve health and/or reduce health inequities, a case study approach was an appropriate research design for this study. The study design is an embedded single-case study as depicted in Figure 5.

According to Yin (2009), a single case study design is appropriate when a case study is “representative or a typical case” and where the “lessons learned from these cases are assumed to be informative about the experiences of the average person or institution”. In this study, the case or main unit of analysis was the community engagement process used by the SCCPHD in the development of community health assessments. A common and typical approach used by many health departments across the United States. The embedded units are the African and Latino communities. Because the context or setting in which these partnerships are formed is the same, this case study is designed as a single case study rather than a multiple case study design.

**Research Setting and Context**

This study took place in Santa Clara County (SCC), California, which is located at the southern end of the San Francisco Bay Area. It has approximately 1.9 million residents and is the 6th largest county in California. There are 15 cities in SCC. This includes the City of San Jose, the country’s 10th most populous city.
The County’s population is very diverse. 38% of residents are White, 33% Asian, 27% Latino/Hispanic, slightly more than 2% are African American, and 3% are other. There are over 100 languages spoken and 3 out of 4 residents were born outside of the U.S. SCC is also a place of enormous wealth and highly educated professionals. In 2010, more than 4 in 10 households had an income of over $100,000. Yet despite this prosperity, SCC is also a place where 10% of children and 12% of adults live in poverty (FPL). In February 2016, the median home price in Santa Clara County was $956,100 (Zillow.com)

The Santa Clara County Public Health Department (SCCPHD) is responsible for preventing disease and providing for the health and well-being of residents across all 15 cities. SCCPHD is part of a large integrated health and hospital system comprised of a 574 bed county hospital, ambulatory care clinics, a county health plan, behavioral health, and custody health departments. SCCPHD has a total 427 employees and is organized into five branches that provide a wide range of programs, services, and activities. The health department is led by a health officer/director who is an appointee of the county executive. The county executive has lead responsibility for all government operations and reports to the Santa Clara County Board of Supervisors (SCCBOS). The SCCBOS is comprised of five elected officials. The Board members tend to be strongly democratic with 4 out of 5 currently belonging to the party. Board members are viewed as fairly progressive with the passage of such policies such as the elimination of toys from kid’s meals, universal children’s health care coverage or the push to change the age for smokeless tobacco to age 21. While health and health care coverage has long been a County priority, its governance structure and its relationship with 15 independent cities and its many constituents, has created a naturally politicized environment in which departments like Public Health must become adept to in order to successfully meet public health strategic
priorities. Over half of the county’s near five billion dollar budget is allocated to the health and hospital system with the majority going to clinical health services.

**Research Participant Profile**

*Profile of the African American Community:*

The proportion of African Americans in Santa Clara County has been declining since 1990. Today, the population is the smallest racial/ethnic group in Santa Clara County (2.4%). This community experiences a wide range of health disparities and inequities compared to other racial/ethnic groups. Despite improvements in some health indicators over the last several years, disparities persist. While the population is small, the community is well educated with over 35% having a bachelor or higher degree, and 45% have some college or an associate’s degree. Despite high educational attainment, the median household income for African American’s is lower than Asian and White households. Nearly 1 in 6 (16%) adults live in poverty. African American men have the lowest life expectancy of all groups in the county, women have highest rate of infant mortality, and as a community, the highest rates of newly reported HIV infection among adults and adolescents. In 2011, African Americans had the highest rate of emergency department visits in the county compared with other groups. African American youth report higher rates of bullying at school, expulsions, and discrimination. African American children are also over represented in the juvenile and foster care systems in Santa Clara County.

Nevertheless, the African American community enjoys a strong support network, and deeply rooted community institutions such as churches, mosques, and other places of worship. The African American community has well established and well known organizations.
throughout the county including: The Black Leadership Kitchen Cabinet (BLCK-a consortium of 50+ professionals across sectors), African American Community Services Agency, Black Infant Health Advisory Board, 100 Black Men of Silicon Valley, Ujima Adult and Family Services, and an office of the NAACP.

Profile of the Latino Community:

In 2010, the Latino community was the third largest racial/ethnic group in Santa Clara County. This population is projected to comprise 36% of the population by 2050. The median age for Latinos is 27 compared to the county’s overall median age of 35. Nearly a third of this population (33%) was under the age of 18. This population is disproportionately affected by socioeconomic conditions that impact their health and overall quality of life. Latinos have less education, lower incomes, and higher unemployment compared to other racial/ethnic groups in the county. Latinos also have higher rates of obesity and overweight, diabetes, teen births, and account for 4 in 10 homicides in the county. Latino youth report the highest use of tobacco, marijuana, and alcohol. Latinos are overrepresented in the foster care and juvenile justice systems. Latinos are also the highest beneficiaries of health care services from the Health and Hospital System. While there are many Latino serving and Latino led organizations, the Latino community is loosely networked and has no unifying or central backbone organization in the county.

Data Collection

For this study, complementary qualitative data was collected from semi-structured key informant interviews, focus groups, documents, field notes and memos written during coding in order to answer the main research question as well as the two sub-research questions. A
comprehensive data collection table and protocol based on the conceptual framework for this study was used to guide the data collection process (Appendix A). Data collection for this study began in December 2015 in full compliance with the Institutional Review Board (IRB) requirements at the University of Illinois at Chicago and the Santa Clara Valley Health and Hospital System Health Services IRB. Data collection was conducted in the following sequence:

Archival Review

A web search of public records using the following search terms was conducted:
- Santa Clara County Public Health Department, health assessment, African American and/or Latino
- Santa Clara County, supervisors, health assessment, African American and/or Latino
- Santa Clara County, health, African American and/or Latino

Key objectives guiding the archival review were as follows:

a) Identify and list health assessment reports, surveys, and activities conducted by the Santa Clara County Public Health Department about African American and Latino residents of Santa Clara County.

b) Document and list specific organizations and/or key individuals acknowledged in reports, surveys, and county specific public announcements. The names and organizations were entered into an excel spreadsheet and comprised an initial list of potential study participants.
Documents

Relevant documents for this study were collected in three phases. In phase one, all available public documents such as implementation plans/workplans, agendas, contractual agreements, and planning documents relevant to the assessments that involved African American and/or Latino communities were collected and logged. In phase two, complementary documents were added based on references made by key informants during interviews. In phase three, additional documents were sought based on references made during focus group sessions.

Key objectives guiding documentation review were as follows:

a) Collect multiple data sources to enable triangulation of data.

b) Use the data collection protocol (Appendix A) to assist in the identification of relevant information to assist in answering the research questions.

c) Document background, context, and impetus for health assessment activities of the African American/Latino communities (as available) using the key constructs of community engagement being studied and research questions as guides.

Semi-Structured Key Informant Interviews

Selection Criteria:

Interviews were held with individuals who reported high levels of participation with the Santa Clara County Public Health Department in community health assessment activities focused on the health of African American and Latino communities in Santa Clara County. High level participation was defined as involvement in the planning, design, identification of topic/focus areas, and overall structure of a community health assessment. Individuals participating at high
levels are those that may have served on a steering committee, or workgroup, or other formal structure responsible for an assessment. These participants are normally those who have dedicated a substantial amount of time to the development of a community health assessment.

The inclusion criteria for each specific group were as follows:

**Health Department Personnel:**

1. Staff who spent at least half their time working on health assessment activities with Latino or African American community stakeholders in the past 10 years.
2. Community planner(s) and epidemiologist(s) assigned to either the African American or Latino health assessments, or other assessment activities focused on these populations.
3. A department leader: Director, division director, deputy director, or senior manager.
4. Intra-county representative, if assessment was sponsored by an entity outside of the health department. For example - ambulatory clinics; health plan, elected board staff etc.

**African American and Latino Community**

1. Representatives from agencies, coalitions, consortiums, universities, or programs external to the health department who worked in collaboration/partnership with the health department on health assessment activities over the past 10 years.
2. Representatives from traditional and nontraditional entities who participated as community gatekeepers, advisors, or participated directly in data collection either as a participant or as a facilitator, coordinator, or data collection team member. For example: a traditional entity could be an academic institution; a non-traditional entity could be a grassroots 501.3c organization such as Somos Mayfair or Community Action Teams (CAT).
Interview Guide:

Two separate key informant interview guides each containing 16 questions was used to guide semi-structured interviews with health department personnel, African American, and Latino community members. The local health department version includes questions to explore the genesis of the partnerships developed with each community to conduct a specific health assessment or related activities; questions about contextual factors contributing to both successes and challenges of working with African American and Latino communities in health assessment or related work; questions about how constructs associated with community engagement are integrated into assessment processes; and other PH functions and activities, and, finally questions about lessons learned or advice for other health departments. The interview questions are aligned with the research questions and are informed by the conceptual framework. The community version includes similar questions except that the questions are framed from the perspective of the specific community. However, in order to highlight the complexity of the phenomena under study while honoring specific and salient issues pertinent to each subunit, additional issues and topical areas were allowed to emerge and were explored where applicable.

Early drafts of the interview guides were reviewed and discussed with two colleagues who have experience with assessment and community planning functions in public health. Their input led to the addition of several additional prompts, but no substantial changes to the questions or question order. The interview guides used for the interviews are found in appendices B and C.
Interview Procedures:

The recruitment process for participating in an interview followed a three step process: review, recruit/screen, and assign (Figure 6). First, a list of potential study participants and agencies were developed from archival records and documents. Individuals from this list were contacted using a recruitment/screening script to ensure that eligibility criteria for a key informant interview were met with the exception of public health employees. A gatekeeper was used to recruit public health employees. Gatekeepers are those “who can help facilitate or interfere” in gaining entry into a community or in negotiating specific relationships (Maxwell, 2013). This was a method used to minimize the possibility of coercion or undue influence on public health employees by the researcher. Public health employees with an interest in the study were asked to contact the researcher by email or via phone.

Representatives from the African American and Latino community were contacted initially via email if an email was available. If not, a phone call was placed. Individuals who inquired about the study were sent a follow up introductory email. The study’s information sheet was attached to the introductory email. The introductory email provided each potential study participant with an overview of the purpose of the study, stressed the voluntary nature of participation, as well as confidentiality, and the right to withdraw at any time. Individuals who were interested in participating in the study were offered an in-person or phone interview. In two instances, individuals referred additional potential study participants by forwarding the introductory email. In all cases, potential study participants were contacted by phone to review the screening criteria one additional time prior to scheduling a time and date for the interview. Once a time and date was set, a confirmation email was sent to the study participant. If the study
participant opted for a telephone interview, the confirmation email asked that the consent be returned prior to the date of the interview. For study participants who preferred an in-person interview, the consent was reviewed and signed prior to commencing the interview. The consent review process included emphasizing the voluntary nature of participating in the study and stressed that participation in the study would have no deleterious effects on current or future employment and/or partnership or collaboration with the health department. In addition, study participants were asked to complete a short demographic section of each information sheet that was kept on file with the signed consent by placing an x or check mark next to each of the following categories: gender, ethnicity, age category: 13-35, 36-55, and 56+, and nativity. The majority of respondents entered their current age, and checked the appropriate age category.

The interviews lasted between 45 minutes to an hour, and were be audio-recorded with the consent of the study participant. In-person interviews were audio recorded with a hand held mobile device. Phone interviews were recorded using Uber conference software. Each interview began with the researcher reading a confidentiality statement to the participant. The statement emphasized that no names would be used in association with this study’s final report.

All interview recordings were kept on a laptop and home computer. The recordings were transcribed verbatim. Each study participant was asked if they would be willing to review the transcripts for accuracy. While every participant agreed, only two participants actually reviewed their transcripts for completion and accuracy. Participant demographics were captured as follows: gender, age category, race/ethnicity, and nativity.
Figure 6: Study participant recruitment flowchart
Focus Groups:

Selection criteria:

To complement the semi-structured key informant interviews, focus groups were held with members of the African American and Latino communities. Focus groups were conducted in an effort to generate further discussion and generate new ideas or areas of exploration on the topic of this study. Individuals who reported participating in an advisory or supportive role with the Santa Clara County Public Health Department in community health assessment activities focused on the health of African American and Latino communities in Santa Clara County were invited to participate as part of a focus group.

Participants in an advisory role are generally individuals with specific knowledge or expertise who make recommendations or provide important information to guide the development and operationalization of community health assessments. Individuals in this category may have participated on an ‘as needed’ basis. For example, a CEO of a community clinic who is both Latino and serves a largely Latino population may have been asked to consult on how to best reach the Latino population in neighborhoods where clinics are located.

Participants in a support role are those individuals who may have facilitated, coordinated or participated in a data collection event associated with a community health assessment of the African American or Latino community. Specifically, the inclusion criteria for focus group participants were as follows:

African American and Latino Community
1. Representatives from agencies, coalitions, consortia, universities, or programs external to the health department who worked in collaboration/partnership with the health department on health assessment activities over the past 10 years.

2. Representatives from traditional and nontraditional entities who participated as community gatekeepers, advisors, or participated directly in data collection either as a participant or as a facilitator, outreach or site coordinator, or data collection team member. These individuals may include clinic staff, CBO staff, or promotoras.

3. Representatives involved in the implementation of strategies or activities that result from an assessment activity.

The focus groups were conducted in accordance with the data collection protocol (Appendix A), and scheduled at one or more of the following locations with permission of the agency and/or locale (TABLE I). Generic names are used to protect the identity of the participating sites.

Where possible, focus groups were scheduled to align with an already existing meeting time to allow for maximum participation and ease recruitment challenges.

**TABLE I: Focus Group Locations**

<table>
<thead>
<tr>
<th>Agency/Entity</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Based Organization</td>
<td>Downtown San Jose</td>
</tr>
<tr>
<td></td>
<td>East San Jose</td>
</tr>
<tr>
<td>Ambulatory Clinic Site</td>
<td>San Jose</td>
</tr>
<tr>
<td>Gilroy Library</td>
<td>Gilroy</td>
</tr>
</tbody>
</table>
Focus Group Guide:

A focus group guide containing 12 questions was used to guide and facilitate the focus group discussions with African American, and Latino community members. Similar to the semi-structured interview guides, the focus group questions explore the genesis of the partnerships developed with the public health department to conduct a specific health assessment or related activities; questions about contextual factors contributing to both successes and challenges of working with the health department; questions about how constructs associated with community engagement are integrated into assessment processes such as decision making; and questions about the role of the community and the health department in implementing recommendations.

The focus group questions are aligned with the research questions and are informed by the conceptual framework (Appendix A).

The focus group guides were reviewed by two colleagues with experience in facilitating focus groups. Their input led to the addition of ground rules which helped to ensure everyone who wanted to speak had the opportunity to do so without judgement (Appendix D).

Focus Group Procedures:

The recruitment process for participating in a focus group followed the same three step process: review, recruit/screen, and assign, used for key informant interviews (Figure 6). First, an initial list of potential study participants and agencies were developed from archival records and documents. Individuals were then contacted using a recruitment/screening script to determine their interest in the study and to ensure that eligibility criteria for a focus group were met. The initial contact was done by email if an email address was available. If not, a phone call was placed. The study’s information sheet was attached to the introductory email (Appendix E).
The introductory email provided each potential study participant with an overview of the purpose of the study, stressed the voluntary nature of participation, as well as confidentiality, and the right to withdraw at any time. Individuals who were interested in participating in the study were offered a few pre-scheduled dates, times and location of focus group sessions specific to the particular community.

The second method of recruiting focus group participants was done by placing outreach flyers at focus group locations. This method generated a great amount of interest from community members, but very few individuals met the selection criteria for this study. With the exception of a few emails, most interested individuals called the number on the flyer for additional information.

The third method of recruitment for focus group participants was through the use of community gatekeepers. The gatekeepers were not present during key informant interviews or focus groups, but may have participated in an interview or focus group if they met the study’s inclusion criteria. Their main role was to circulate the research flyer and/or provide the researcher with names of potential study subjects. While the majority of eligible study participant names may be found in public documents, the use of gate keepers to facilitate connecting potential study participants to the study was an important strategy particularly for recruiting participants from the African American community.

The focus groups lasted between 60-90 minutes, and were be audio-recorded with a hand held devise. Each focus group began with the researcher reading a confidentiality statement to the participants. The statement emphasized that no names would be used in association with this study’s final report. The consent procedures were reviewed, and all participants signed and
completed a short demographic profile which asked participants to check their gender, age
category, race/ethnicity, and nativity. Most focus group participants entered both their current
age as well as checked the appropriate age category.

Summary

The initial aim for this study was to conduct a total of between 21-30 semi-structured key
informant interviews (7-10 per group) with the health department and the African American and
Latino communities. The target was met for the Latino community and health department staff,
but not for the African American community. Out of 31 individuals who were invited to
participate in a key informant interview, a total of 20 key informant interviews were completed.
Of the 20, seven were from the PHD, six from the African American community, and seven were
from the Latino community. There were a total of four male participants, and 16 female
participants. The mean age of participants was 44 years, ranging between 32-60 years of age.
Five of these interviews were conducted over the phone, and the remainder were completed in-
person (15). The average length of the interview was between 45-60 minutes.

Despite the goal of conducting a total of focus 4 groups, two with the African American
community and two with the Latino community, a total of three focus groups were held with 23
individuals ranging in age from 30-74 years of age. Nine participants were born outside of the
United States. The average length for the focus groups were between 60-90 minutes.

Only one focus group with members of the African American community was held.
However, this focus group was attended by 12 individuals. There were a total of four males and
six females in this focus group.
In total, there were 43 individuals that participated in either an interview or focus group representing a wide range of perspectives, experiences, and opinions about the subject of this study allowing for an in-depth exploration of the research questions.

Field Notes and Memos

Field notes were taken throughout each component of the study process including the collection and review of documents, the recruitment and completion of the key informant interviews and focus groups, and throughout the analysis phase. Field notes were kept in a single bound notebook. They included reflections on the process, researcher reactions, feelings, biases, and interpretations throughout the study. The notes were kept as free text and were not translated or uploaded onto a computer.

Memos were incorporated as part of the review and analysis process of the key informant and focus group transcripts. Memos were generated and filed in Atlas.ti. Memos were developed during the coding process and were used to help provide additional context and/or document emerging relationships between codes and concepts.

Data Management

Data was tracked and organized in one of several ways. First, all documents were collected and placed into a Microsoft word folder on both a laptop and home computer. Each document was logged and categorized into an excel spreadsheet and filed under the same documents folder. For example: minutes and agendas were categorized and reviewed together; reports were categorized and reviewed together, and so on. Next, a line listing of potential study participants as well as agencies that could serve as potential recruitment sites was logged into an
excel spreadsheet and kept under a folder titled “recruitment”. All voice recordings and word transcripts were kept in separate folders for key informant interviews and focus groups. Sub folders were created for each unit of analysis- public health employees, African American community, and Latino community. A data accounting log for key informant interviews and focus groups was kept in an excel spreadsheet (TABLE II). Each transcript was classified using a simple alpha numeric schema such as KI #1 L, KI #4 AA, dated, and kept on both a personal HP laptop and iMac desktop computer that are password protected. Each interview and focus group word document was uploaded into ATLAS.ti 7.5, qualitative analysis software used to both analyze and store transcripts. Field notes were kept in a separate notebook and referenced throughout the data collection and analysis phases of the study. Memos were developed and stored in ATLAS.ti 7.5. Finally, EndNote was used to track, log, and store both references and copies of all cited literature. Appendix F provides a data management overview.

**TABLE II: Data Accounting Log for KI and Focus Groups**

<table>
<thead>
<tr>
<th>Type of Data Collected</th>
<th>Format</th>
<th>Community</th>
<th>Date of INT/FG</th>
<th>ID Tracking No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>INT</td>
<td>Phone</td>
<td>L</td>
<td>1/24/2013</td>
<td>#1</td>
</tr>
<tr>
<td>INT</td>
<td>In person</td>
<td>PH</td>
<td>1/28/2013</td>
<td>#2</td>
</tr>
<tr>
<td>FG</td>
<td>Group</td>
<td>AA</td>
<td>..</td>
<td>#1</td>
</tr>
<tr>
<td>FG</td>
<td>Group</td>
<td>L</td>
<td>..</td>
<td>FG #2</td>
</tr>
<tr>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
<td>..</td>
</tr>
</tbody>
</table>
Data Analysis Plan

Data analysis was done in an interactive fashion occurring simultaneously with data collection. The analysis was conducted using the three major strategies of qualitative data analysis as outlined by Miles, Huberman, and Saldana (2014) that include data condensation, data display, and drawing and verifying conclusions. Data condensation refers to the process of organizing qualitative data by writing summaries, developing codes, and eliminating irrelevant information. Data display is the process of preparing data to assist in developing conclusions by displaying the data into tables, matrices, charts or other visual graphics. Drawing and verifying conclusions is done through early data analysis and the process of justifying conclusions from the data. Data analysis was done in a two-step process. In step 1, an independent and in-depth review of the all data about the case and subsequent subunits was completed, in step 2, a within and between case analysis (within/between subunit analysis) and cross case analysis (across units) was completed. The following provides an overview of the two-stage analysis process used in this study:

Step 1: Case and sub-unit description

The data from the case and each subunit was analyzed in the following steps:

1. **Document review:** All documents (e.g. community health assessment reports, minutes, agendas, contractual agreements) were reviewed using the conceptual framework and data table as a guide (Appendix A). Most archival records and documents were reviewed at least twice. The first review was conducted prior to the start of interviews and focus groups for a baseline understanding of the CHA development process and to determine the absence or presence of information to support each of the key constructs of community engagement
outlined in the conceptual framework. Each document was read and scanned using the control function option in both Microsoft word and Adobe PDF to find key words associated with each construct of interest in this study. Contextual information was also reviewed if it was found to be related to the construct being reviewed. A matrix was developed in excel to track the number of times key concepts and/or associated terms were used across all acquired documents. If none was found, a zero was entered for that document. TABLE IV provides a summary of results. The results of this analysis were compared to the results of the analysis of the interviews and focus groups.

2. **Field notes:** Field notes were both created and reviewed on an ongoing basis. For example, as documents were being reviewed, notes were being taken. These notes were used to give short summative descriptions of the outcome of the analysis of each type of qualitative data (documents, key informant interviews, focus groups).

3. **Line by line deductive and inductive individual coding:** For each case and subunit, semi-structured interviews and focus groups transcripts were reviewed using both a deductive and inductive coding schema consistent with an *a priori* and grounded theory approach. The deductive codes are those codes developed from the *a priori* conceptual framework and reflected in TABLE III. Inductive codes are those codes that emerged from the data and were added to the list of codes. These codes were terms that emerge consistently or often in the transcript text that were thought to be relevant to the study questions and phenomena. There were a total of 9 *a priori* codes, and 28 deductive codes. These methods are consistent with what Miles, Huberman, and Saldana (2014) refer to as “exploratory methods” which includes the concept of “provisional coding”. This approach begins with an initial list of codes that a researcher can modify as needed in a study. Figure 7 provides an alternative
view of the *a priori* and inductive codes. This figure includes two additional constructs for consideration in future studies, agency and co-learning.

**TABLE III:** Deductive List of Codes

<table>
<thead>
<tr>
<th><em>a priori</em> Codes</th>
<th>Sub-Codes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reasons for Assessment</td>
<td>Community initiated; PH initiated</td>
</tr>
<tr>
<td>Past History</td>
<td>High, Minimal, None</td>
</tr>
<tr>
<td>Knowledge</td>
<td>High, Minimal, None</td>
</tr>
<tr>
<td>Power</td>
<td>Community Led, PH led, Shared</td>
</tr>
<tr>
<td>Ownership of Action</td>
<td>Community, PH, Shared</td>
</tr>
<tr>
<td>Supportive Infrastructure for Action</td>
<td>Strong, Weak, None</td>
</tr>
<tr>
<td>Barriers</td>
<td>Staff skills, Trust, None</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Commitment, Funding, Leadership</td>
</tr>
<tr>
<td>Lessons</td>
<td>Flexibility, Time, Funding</td>
</tr>
</tbody>
</table>

* codes also served as code families in ATLAS.ti

**Figure 7:** Overview of community engagement constructs and factors

- 9 *a priori* codes/deductive
  (barriers, facilitators and lessons)
- 37 total (28 inductive)
4. **Modification of codes:** The list of deductive codes was expanded to include inductive codes that were added following review of subsequent transcripts and field notes. Field notes were used to document the rational for adding codes. These descriptions were useful and reflected in the coding dictionary developed to support the overall coding schema.

5. **Coding dictionary and protocol:** A coding dictionary was developed for all codes used in the analysis. In addition, a short protocol was developed to outline the process and rationale for coding segments of text (Appendix G). For example, no less than a sentence was coded. Several sentences could be coded together if having more than one sentence was useful to supporting a key concept.

6. **Inter-Coder Reliability:** A second coder with extensive knowledge of qualitative methods volunteered to code a sample of transcripts. A random sample of four transcripts was selected from a stack of printed transcripts. The coding was done by hand using the coding dictionary and protocol as guides. No direct access to the hermeneutic unit (HU) or analysis project containing source files was granted to the second coder. This was done to protect the confidentiality of the source files. Each transcript coded by the second coder was reviewed against the coding done by the researcher to determine differences and similarities. While some qualitative software allow for inter-coder reliability calculations, ATLAS.ti 7.5 does not include this feature. ATLAS.ti recommends the use of a free web tool called “coding analysis toolkit or CAT”. CAT enables the user to calculate a Kappa value, a measure of inter-rater agreement. After some discussion, it was determined that coding by hand was a more practical approach given the small sample of transcripts being reviewed. When comparing the coded transcripts, a few differences were noted and discussed. The major
change was in the addition of a new code, which led to a review of past transcripts and in some cases minor additional coding.

7. **Main/parent code:** Individual codes were organized into code blocks organized by category, or code family. In addition, each unit of analysis i.e. public health staff, African American, and Latino study participant transcripts were grouped into primary document families. This step is a done as a precursor to within and cross case analysis where similar categories, themes, or relationships between the case and subunits are examined for patterns, similarities, and differences. Parent codes are reflected in TABLE III.

**Step 2: Within, Between Subunit and Cross-Case Analysis: Drawing Conclusions**

Step 2 began with two types of analysis offered in ATLAS.ti. First, the query tool was used to calculate frequencies of responses by code for each group. Each unit of analysis was queried separately. The results of each query were downloaded into an excel spreadsheet to allow for ease in organizing and working with the data. For example, four out of seven public health staff interviewed responded that most community health assessments are community initiated. The frequencies of all responses were then compared across units using a data display and graphed using parent codes and sub-codes (Figures 8, 9, 10). Appendix H provides a high level summary of the within and cross case process used to identify cross cutting themes.

A checklist matrix was then developed to assess the presence or absence of the six main constructs associated with community engagement in relation to the case, within and across each subunit (TABLES V, VI). The matrix was used to aid in identifying patterns and relationships first in the key informant interview and focus group data and then compared against the documents and field notes (TABLE IX triangulation). The main categories for the case and
subunit were evaluated for variability, similarities and emergent themes or issues. The data displays along with the memos created during coding were established to support the researcher propositions and conclusions.

The second step in the analysis process was to evaluate co-occurring codes which allows for the examination of the association between concepts. In ATLAS.ti this is done with the co-occurrence tool. This tool generates a table with two numbers in a cell. For instance, if two codes co-occur, the output in a particular cell will show two numbers. The first is the frequency of co-occurrence, and the second is a c-coefficient which indicates the strength or intensity of co-occurrence. Generally, this number is somewhere between 0 and 1. However, in some instances the number may be larger than one. If this occurs for a particular cell, ATLAS.ti will indicate this with a yellow circle. While not as robust as qualitative statistics, this tool allows the researcher to learn something about how two concepts may be associated and therefore, may be useful in that it allows for deeper exploration in specific areas. In addition to the co-occurrence tool, network views were generated for comparison purposes with the co-occurrence outputs. Figures 12 and 13 are examples of two network views.

Lastly, side by side queries for specific codes and code families was done using the codes-primary table option. Like the query code, this analysis tool allows for queries of specific codes or code families and side by side comparisons by primary document families or in this case by the unit of interest.

In summary, the data collection table and protocol (Appendix A) was used to guide the analysis of each set of documents, interviews, focus groups, and field notes. Several tables and
matrices were used to examine the relationships and variabilities within and between each group. A summative table of triangulated findings is shown in the results section of this study.

**Trustworthiness**

Many frameworks and approaches exist to support rigor, validity, and reliability in qualitative research. Yin (2009) refers to four tests that “have been commonly used to establish the quality of any empirical social research” (p.40). They include construct validity, internal validity, external validity, and reliability. There also alternative frameworks with parallels to Yin’s for those who believe these concepts are reserved for quantitative research. Most notably, Guba and Lincoln (1985) outline four areas that qualitative research studies should address. They include:

- Credibility/validity-the degree to which the study accurately captures the phenomena being studied,
- Transferability-the extent to which the results can be generalized,
- Dependability/reliability- the ability to repeat the study in a similar context and obtain the same results,
- Confirmability- the extent to which the results of the study can be validated by others.

To address threats to construct validity, internal validity, external validity, and reliability, key “tactics” as noted by Yin, 2009, were used and applied throughout this study. These tactics reflect Yin’s recommendations related to both data collection and analytical techniques. They include:
• **Multiple sources of evidence:** This study included the collection of data from a variety of methods and sources including key informant interviews, focus groups, documents, archival records, field notes and memoing. The variety of data was key to illuminating a variety of experiences and perspectives related to the phenomenon being studied.

• **Data triangulation:** Multiple sources of evidence allowed for “converging lines of inquiry” (Yin, 2009, p.115) with the goal of “corroborating the same fact or phenomena” (Yin, 2009, p.116). This was done by comparing the results of the key informant interviews, focus groups, against the documents, field notes and memos.

• **Database development:** All documents including interview transcripts, focus group transcripts, documents, and memos were kept in folders and subfolders on both a laptop and home computer. Each document was labeled, and logged into an excel spreadsheet. The use of a database strengthens reliability because it provides an audit trail that links the data, analysis, and conclusions (Yin, 2009). This allows for the study to be repeated and yield the same results.

• **Chain of Evidence:** A case study data collection table was developed to guide the data collection and analysis phases of the study (Appendix A).

• **Coding Schema Review:** Inter-rater reliability was increased through the use of an independent second coder used to code a random sample of de-identified transcripts. A codebook was developed to support synchronicity between coders (Appendix G).

• **Member Checking:** Key informants and focus group participants were given the opportunity to review draft transcripts for accuracy and quality prior to data analysis.
In addition, study subjects were asked to contact the researcher if they were interested in reviewing the draft manuscripts prior to journal submission.

**Institutional Review Board (IRB) Approval**

Approval for this study was sought from three entities. First, the study research protocol and study interview and focus group guides were presented to the Santa Clara County Public Health Department Research Group. This group reviews and approves all research and abstracts conducted under the auspices of the health department. Second, approval was sought from UIC’s IRB. The study was determined to qualify for an expedited review process and approved on November 13, 2015 (Appendix I). Third, the research study was reviewed by the Health Services IRB of the Santa Clara Valley Health and Hospital System (SCVHHS) and approved on December 11, 2015 (Appendix J).

Although no identifiable information was collected that could be directly tied to a study participant and the risk posed to study subjects were expected to be minimal, the UIC IRB required more stringent requirements for confidentiality and security of information than either the PH research group or the SCVHHS IRB. This was most likely due to the categorization of African American and Latino study participants as “vulnerable populations”, thereby requiring explicit explanation of the outreach, enrollment, and security process in the research protocol. Recruitment for this study was done using a purposive sampling approach and was supported by the use of community gatekeepers. A waiver of informed consent for the gatekeepers was requested and granted for this study.

A formal consent and consent process was required for this study. The consent was essentially the same as the information sheet (Appendix E). The information sheet was sent to
each participant in advance where possible, and reviewed in detail prior to the start of an interview or focus group.

The voluntary nature of enrolling in the study was an important part of the recruitment process and was emphasized with each of the three groups. Public health employees were recruited by a gatekeeper to eliminate the chance of coercion. Gatekeepers were also used to recruit individuals from the African American and Latino communities.

Individuals participating in either an interview or focus group were also told they could end their participation in the study at any time. If this had occurred, both the recording and transcripts would have been destroyed. This would have been the case for a focus group as well. If one individual participating in a focus group would have withdrawn from the study, the entire focus group would have been eliminated from the study at the direction of the UIC IRB. All participants were provided with the name and contact information of the UIC IRB and SCVHHS IRB should they need to report any issues with this study.

IV. RESULTS

This single case study focused on examining the community engagement process between the Santa Clara County Public Health Department and two minority communities, African American and Latino, in the development of a CHA. The following information is intended to provide a high level summary of results for the main research and sub-research questions in this study. The three research questions guiding this study were:

- How do constructs of community engagement influence the planning and data collection process and implementation capacity association with community health assessment
activities between African American and Latino communities and the Santa Clara County Public Health Department?

- What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete?
- What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?

The information in this section provides additional context to the findings reflected in the subsequent manuscripts which are word limited. Information is provided for each group and across groups using the data collection protocol as a guide (Appendix A). The frequency of responses and the relationship between codes is also presented. A table summarizing the triangulation of all main data sources is also included (TABLE IX). Six key constructs associated with community engagement were reviewed across groups to determine their effect on the action phase of the assessment process, as well as on the expectations resulting from the engagement process. Facilitators, barriers, and recommendations for change were also assessed. These constructs and associated factors are reflected in the conceptual framework. They include:

1. **Shared understanding of purpose for a specific CHA** examined by asking participants questions and reviewing documents to understand the genesis or drivers for a CHA.

2. **History of collaboration or partnership** between the PHD and the specific community was reviewed by asking participants questions and reviewing documents to understanding the beliefs, attitudes and value systems of each group.
3. **Baseline knowledge of one another** prior to working together on a CHA was examined by asking questions about how information about each group is obtained, shared, and used either within the PHD or the community.

4. **Power/Authority.** An understanding of power/authority was revealed by asking questions about the decision making process, as well as who was involved and why. Documents were reviewed to ascertain a working knowledge of the leadership structure within each group, as well as an understanding of commitment and capacity of each group.

5. **Infrastructure to support implementation** was examined through a series of questions intended to support a better understanding of the community and PHD capacity with regard to time, skills, funding, leadership, authority, and ability to organize and commit long-term. Documents were reviewed in the same fashion.

6. **Shared responsibility for action** was reviewed by asking participants who they believed would be responsible for implementation of CHA recommendations and why. Documents were reviewed to determine how and if this concept was reflected, and whether implementation had taken place, as well as overall satisfaction with the process.

7. **Barriers, facilitators, and recommendations for change** were reviewed by asking participants to share successes, challenges, lessons learned, and recommendations to improve community engagement.

**Research Question 1:**

How do constructs of community engagement influence the planning and data collection process and implementation capacity association with community health assessment activities between
African American and Latino communities and the Santa Clara County Public Health Department?

The Role Purpose, History, Knowledge, Power/Authority, and Infrastructure has on Effective Community Engagement and Action

This question was examined by reviewing archival records, documents, key informant interviews and focus group transcripts. The concepts most relevant for this question are tied to those associated with effective community engagement and assumed necessary for implementation to occur. Each of these concepts was examined to determine which were in place before, during, and after the completion of a CHA. This information is important because it provides relevant facts about the process of community engagement between groups. It also provides clues about the probability of moving CHA findings into the action or implementation phase.

Archival Records and Documents:

A summary of findings from the review of 24 archival records and documents collected for this study are reflected in TABLE IV. Overall, the archival records and documents provided the basis for understanding the drivers and initiators for each of the community health assessments. The review also provided a window into the power differentials between the communities and the health department. For example, a document provided by a key informant from the African American community revealed that a consortium of African Americans had requested support from the board of supervisors for a multi-phased assessment. This document makes references to university partnerships suggesting some level of capacity within the
community prior to engagement with the PHD as well as clarity of vision and purpose. This
document also provides specifics about the role of the community in the assessment process as
well as goals for each specific assessment outlined in the document. In reviewing several
meeting minutes and agendas specific to the CHA development process between the PHD and
the African American community, there were several meetings where clarity of roles and
responsibilities were discussed as well as the option of developing a charter to memorialize
agreements. In addition, a formal agreement was developed with an African American CBO to
assist with data collection suggesting willingness to share responsibility or commitment. The
CBO was charged with recruiting, hiring, and training African American facilitators and note
takers for focus groups and key informant interviews.

A review of documents to determine the impetus for the Latino health assessment
revealed very little about the role of the community. Most of the documents examined were
public documents generated by the offices of elected officials, the PHD, or executive level
personnel which suggest possible challenges in leadership, community capacity, or commitment.
**TABLE IV: Results of Archival and Document Review**

<table>
<thead>
<tr>
<th>Data Category</th>
<th>Constructs Explored</th>
<th>PHD*</th>
<th>African American Community</th>
<th>Latino Community</th>
</tr>
</thead>
</table>
| Archival Records      | • Power  
                        • Ownership  
                        • Authority  
                        • Background/shared purpose | Community priorities reflected in reports; accepting of cultural frames; clear role within partnership with AA; shared power i.e. MOU with African American Agency for data collection | Community centered approach reflected throughout documents; acknowledgement of PHD partnership and its value (specific individuals named) | No clear commitment or substantial representation of Latino community in large assessment; passive role in smaller assessment. Elected officials or other professionals involved |
| Documents             | • Beliefs, values  
                        • Knowledge  
                        • Barriers: Trust  
                        • Ownership  
                        • Infrastructure: Time  
                        • Resources etc. | PHD staff flexible and open to community influence and leadership; attempts to clarify role early in process; cultural frame acknowledged | Leadership reflected throughout engagement with PHD; flexibility and open to suggestions from PH over time; biweekly meetings reflect commitment | Ideas generated for larger assessment directed at PHD and their role; no documented commitment from community |

* There were no PHD specific documents because a large portion of the 24 documents reviewed referenced the PHD or were generated by the PHD.

**Interviews and Focus Groups:**

The analysis of semi-structured interviews and focus groups provided a deeper understanding of factors that both contribute to or detract from effective community engagement and action. Meaningful and effective community engagement are terms used interchangeably to mean the same thing. Meaningful engagement is achieved when all parties have equal opportunity to share ideas, there is shared understanding of goals, decision making, co-benefits
are clear, mutual respect and understanding exists, and responsibility for action is shared.

Similar to the document review, interviews and focus group transcripts were reviewed with the following principles in mind which are reflected across the six main constructs examined in this study. They include:

- Active participation by community leads to trust, better outcomes, and shared leadership,
- Power sharing; communities initiate and direct action,
- Pre-requisites such as infrastructure and funding should exist, commitment to long-term investment, formalization of partnerships; organizational capacity; empowerment,
- Leadership or allowing communities to have a voice is important,
- Equity and flexibility, as well as an understanding of cultural frames are important concepts for communities.

Findings for each construct by group is summarized below and discussed in more detail in the section on implications for public health leadership and practice.

Public Health Department:

*Genesis for CHAs*

All PHD employees interviewed for this study had experience conducting community health assessments in collaboration with community partners. The majority of PHD staff believed that all CHAs were done at the request of a particular community group, and that the role of PH was similar to that of a ‘consult’ or ‘technical expert’ or facilitator of a process, but not the sole owner of the outcome of the process. This perspective was corroborated, in part, by the document review. None of the public documents reviewed made reference to the role of the
PHD outside of data collection and reporting. There was no mention of PH’s role in implementation of CHA recommendations in any of the documents reviewed for this study.

Knowledge and History:

Participants acknowledged having little or no prior experience working with lay residents or leaders from the African American or Latino communities. One participant noted that requests from the Board of Supervisors had become so common that the approach to them had become ‘cookie cutter’. This same participant noted that this type of approach had been applied to the Latino CHA without issue, but that it had been rejected completely by the African American community. The participants who worked on the African American CHA spoke about the lack of skills and the frustration experienced in not understanding how to work within the cultural frame requested by the community. All PHD participants in this study spoke about the challenges of working within the one year time frame expected by the BOS. In other words, the PHD is expected to work with communities in the planning, data collection, and completion of a report within a one year period.

Power/Authority and Infrastructure:

During the interviews, many participants expressed frustration at being placed in a position of perceived authority with communities. One participant said that CHAs were “political”, and that staff assigned to completing CHAs were often placed in a position to represent the PHD without the skills necessary to engage appropriately with diverse communities, and without the authority to make commitments or decisions related to resource needs. Several participants noted that there had been no plans made with regard to how CHA
implementation would occur or how they would be funded. The document review did not provide sufficient insight into these concepts so they cannot be corroborated.

**Responsibility for Action:**

All PHD participants responded that they thought the PHD was at least partially responsible for supporting communities in the implementation phase of the CHA process.

**Barriers:**

There were several barriers identified by PHD participants. They include a lack of skills to engage with diverse communities, little knowledge of diverse community norms and frames, a mistrust of government institutions, reliance on select individuals within the department to make connections to minority communities, lack of funding, lack of leadership support for the action phase, politics, time, and the research approach to data collection. For example, the use of tested questions in surveys versus questions in the form that community would like them or need them was identified as problematic by Latino and PHD participants.

**Facilitators:**

Participants responded that having individuals within the department with connections or relationships with community leaders was important. A few responded that early and sustained commitment was important to the overall CHA process. Many respondents believed that their ability to remain open-minded and flexible had been an asset to the process. A review of public documents supports this assertion.

**African American:**
Genesis for CHA

Nearly all participants expressed strong feelings about the CHA and the need for it to be directed and facilitated by the community. One participant remembered being angry about the BOS’s decision to provide funding and support to the PHD to conduct the CHA. This was supported by the document review. One document clearly outlines the fund request and workplan for a multi-component comprehensive assessment of the African American community in Santa Clara County.

Knowledge and History:

Most participants had had no prior experience with the PHD. In fact, many were not familiar with the PHD and did not know what the PHD did. Given a deep sense of mistrust of government agencies, participants involved with the CHA demanded that it be conducted within an Afro-centric frame. An Afro-centric frame incorporates asking questions in the way and in places that connect best with African American communities. It also means that the people asking questions, facilitating discussions, analyzing, and translating data are all African American.

Power/Authority and Infrastructure:

Most participants expressed a strong sense of agency, leadership, and commitment to the outcome of the CHA. Most believed that the community had the infrastructure necessary to implement the recommendations. These concepts were supported by the document review.

Responsibility for Action:
Despite the early tension between the PHD and the community, respondents expressed a desire to continue to work with the PHD. In fact, they believed it was important to have the PHD co-lead the action phase of the CHA. One respondent commented to a PHD staff person who had worked on the CHA, “I learned more from you than you learned from me.” This statement illustrates the importance of reciprocal co-learning. While co-learning was not a construct incorporated into the conceptual framework for this study, it appears to be an important factor that should be incorporated as it most likely intersects with commitment and sustaining relationships.

Barriers:

Participants noted several barriers including lack of trust, lack of PHD staff that reflect the community; PHD approach to data collection, and a dependence of specific individuals within the PHD.

Facilitators:

Participants indicated that additional time granted for the completion of the CHA was helpful. In addition, the ability to work with specific individuals within the PHD was seen as asset.

Latino:

Genesis of CHA:

All Latino participants responded that the CHA had been requested by others outside of the community. This perspective directly links to community unwillingness or inability to take
responsibility for action. The documents reviewed for this study provide some support for this perspective.

Knowledge and History:

Latinos in this study acknowledge that despite the large size of the population, few had worked with the PHD prior to the CHA. For those that had, several responded that there had been little or no outcomes from prior collaborations. In fact, one respondent reported that despite being a strong advocate and ally of the PHD, she could not convince others to feel the same. The documents reviewed were not sufficient to deny or corroborate these assertions.

Power/Authority and Infrastructure:

Most participants expressed a sense of disempowerment, and a lack of resources necessary to implement any recommendations from the CHA.

Responsibility for Action:

None of the study participants responded that they felt ownership over the CHA conducted by the PHD. While Latino participants were acknowledged in documentation, there was not enough information to determine what role the individuals had in the process or if they committed to the action phase.

Barriers:

Notable barriers from Latino participants included a lack of leadership within the community, a lack of resources and infrastructure to support action; lack of knowledge or awareness within the community about the role community should play in the CHA process.
Facilitators:

Participants reported that the large size of the population presents individuals with opportunities to engage with the PHD. Many acknowledged the PHD for their continuous effort to engage members of the Latino community.

TABLE V provides a checklist summary of supporting conditions for effective community engagement and action identified from interviews and focus group participants. Overall, each group responded that they saw value in partnering despite having minimal or no history of collaboration prior to the community health assessment process. While study participants from the PHD acknowledged a “cookie cutter” approach to CHAs, they were open to suggestions for change from the communities. The African American study participants were more open to a partnership with the PHD, than Latino study participants. However, it should be noted many of these factors were absent at the start of the assessments. Therefore, this table should be interpreted to reflect positive factors or steps towards meeting an ideal state. A state where effective community engagement exists as a precursor to action or implementation of a CHA.

TABLE V: Supporting Conditions Related to Effective Community Engagement

<table>
<thead>
<tr>
<th>Construct/Condition</th>
<th>Presence of Supporting Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>PHD</td>
</tr>
<tr>
<td>Genesis of Assessment/Shared purpose</td>
<td>Open to community leadership</td>
</tr>
<tr>
<td>PH led</td>
<td></td>
</tr>
<tr>
<td>Community led</td>
<td></td>
</tr>
<tr>
<td>Prior history Past collaboration(s)</td>
<td>Recognition of importance of</td>
</tr>
<tr>
<td></td>
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</tbody>
</table>

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Despite the existence of several positive conditions that contribute to effective community engagement and action or implementation of recommendations from CHAs, study participants acknowledged that there were challenges and barriers to meaningful engagement and subsequent action (TABLE VI). First, despite knowing about each other, none of the groups in this study had worked together prior to the development of the CHAs. The beliefs and attitudes of the PHD, African American and Latino study participants was particularly important and provided a backdrop from which to understand the genesis or drivers for the CHAs. In general, PHD staff reported a high level of conceptual understanding of the important role of community in all aspects of public health practice including CHA development. However, in practice, PHD staff reported that they lacked community engagement skills and deep community knowledge necessary for effectively engaging with African American and Latino community members. Even when PH staff reported they felt prepared to work with minority communities, they reported a lack of organizational commitment and resources necessary to implement and sustain positive relationships with these communities.
**TABLE VI: Negative Conditions Contributing to Ineffective Community Engagement**

<table>
<thead>
<tr>
<th>Construct</th>
<th>PHD</th>
<th>African American Community</th>
<th>Latino Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Driver of Assessment</td>
<td>Political drivers for community engagement</td>
<td>Community leads, but expectations high for PH during action phase</td>
<td>PH Leads- does not include community</td>
</tr>
<tr>
<td>PH led Community led</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior history</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past collaboration(s)</td>
<td>No prior history of engagement with AA, Latino communities</td>
<td>Lack of trust</td>
<td>Lack of trust</td>
</tr>
<tr>
<td></td>
<td>for a CHA</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior Knowledge</td>
<td>Preconceived ideas of community; research frame</td>
<td>Distrust of Research Frame</td>
<td>Lack of understanding of PH research frame</td>
</tr>
<tr>
<td>Understanding of one another</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td>Lack of clear delineation of roles and expectations throughout process</td>
<td>Lack understanding about limitations, capacity of PHD</td>
<td>Lack understanding about limitations, capacity of PHD</td>
</tr>
<tr>
<td>Decision maker/ authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infrastructure to Support Action</td>
<td>Limited investment post assessment; heavy dependence on individuals</td>
<td>Weak or no infrastructure to support action phase</td>
<td>Weak or no infrastructure to support action phase</td>
</tr>
<tr>
<td>Responsibility for Action</td>
<td>Lack of long term commitment</td>
<td>Contingent on specific individuals</td>
<td>Implicit expectations about PHD</td>
</tr>
<tr>
<td>Post assessment</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Regardless of efforts to clarify roles, responsibilities or capacity of each group, there appeared to be confusion about when decisions were being made or how accountability would be handled across all groups. In many instances, Latino participants expressed an unwillingness to commit to follow up on recommendations from the CHA. This was because Latino participants did not feel connected to the process. They believed external forces had driven the development of the CHA for the Latino community.

In order to more deeply understand the relationship between constructs as well as similarities and differences between groups, each construct was reviewed in relation to the research question using quotes from the interviews and focus groups to support emerging
themes. TABLE VII contains quotes that support the lack of shared purpose and vision for CHAs between groups, as well as a lack of history of collaboration or partnership between groups. These facts are important because they demonstrate that these groups begin CHA development at somewhat of a disadvantage making implementation and action unlikely. They begin the process of CHA development from a different place of understanding, and there is little if any discussion about the intended outcome of each CHA. There is also no reflection from any of the groups about the actual process itself. No one asks, will this process lead to action? Is this the right process? A comprehensive table with supporting quotes for each construct reviewed in this study is found in Appendix I.

**TABLE VII: Constructs with Supporting Quotes by Group**

<table>
<thead>
<tr>
<th>Research Question 1: How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genesis for CHA</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Past History of Partnership/Collaboration</strong></td>
</tr>
</tbody>
</table>
Research Question 1: How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

“The health department never reached out... and you know the community they would work with officials.. more political officials.. and they were not aware of the PHD and what the capacity.. or even what the health department does.. I don’t even think they were aware of it all.. I don’t think that the health department .. they knew about the community but they never made the effort to reach out”. (African American participant)

“I think I would say.. I mean from like a grassroots level.. I definitely see and have heard of the involvement by the Latinos community in different surveys and focus groups and activities that are led by the department and then on a more stakeholder professional level.. I definitely see the groups .. the Latino community or stakeholders working with the health department but that I can .. name specific groups .. I apologize that I can’t”. (Latino participant)

Sub-Research Questions

- What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete?

- What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?

These questions were examined in the same fashion as the primary research question. The responses to these questions are reflected in TABLES V-VII. In essence, both the African American and Latino study participants responded that they expected the PHD to stay involved
in the action phase of the CHAs. When asked who should be responsible for the action phase of the CHA, an African American participant responded, “I think both the [the PHD] and the [community], even with disagreements and all that stuff, I think this makes this [work] about helping the community.” Latino participants, however, indicated that they thought the PHD was solely responsible for the follow-up of any of the assessments conducted by the department. Many Latino participants expressed frustration about the way the PHD works with their community. One participant said, “How does this work fit into an effective strategy? An assessment is not supposed to be a means to an end, it is supposed to be the beginning. So is the PHD getting the support from the county leadership to say, jump off the hamster wheel, and tell us exactly what the next steps are?, somewhere someone thought getting a community assessment for XY community is all you need, but no one ever said, what are we going to do now? have they?” Latino participants saw little value in the CHAs and thus, could not articulate a role for the community in their implementation. Alternatively, African American study participants expressed value in having the PHD co-lead or facilitate the action phase with the community.

All public health employees interviewed in this study expressed a desire and a commitment to shared ownership of the action phases associated with the CHAs regardless of how effective the community engagement with the communities had been. This was despite the barriers identified with respect to resources and infrastructure. Many of the individuals interviewed expressed a desire for training opportunities to learn how to effectively engage with communities throughout Santa Clara County. One PHD participant was asked about the commitment to these communities once CHAs were complete. The response was, “I feel that we are committed to them, I want to say that we are, but I think there is still a lot of work to be done
so that we don’t drop the ball after all this work, and that is very critical. We have become closer to these communities and now we are able to do some programming around what they need and if the ball drops it will be devastating to us because we have built some trust with them”.

*Relationship between Codes*

The relationship between codes was also examined to provide support for emerging themes and a response for each of the research questions. The top barriers identified through interviews and focus groups were the lack of understanding capacity/gaps for the African American and Latino study participants followed by lack of trust (Figure 7). Figures 8 and 9 reflect the distribution of codes for each of the six code families in this study which support emerging themes identified in response to the main research question. Latinos identify the PHD as the main driver of the CHA, had minimal history or knowledge of the PHD prior to the CHA, reported the PHD as having power, weak infrastructure, and expected the PHD to take action. African Americans identified the community as the main driver for the CHA, had minimal to no history or knowledge of the PHD prior to the CHA; were open to shared leadership and action, and indicated they had infrastructure to support action. Figure 10 provides information about the distribution of the most common facilitators to community engagement and action identified from interviews and focus groups. They include respect for community norms and cultural frame, on-going commitment, integration of community perspectives, the connection to specific individuals, awareness of one another, time, being patient with community, and flexibility.

TABLE VIII provides a summary of each of the constructs where co-occurring codes were demonstrated. This information is useful because it demonstrates the interconnectedness of the constructs and associated factors that are part of the community engagement process and
helps to illustrate the difference and similarities between groups. For example, as the PHD and the African American and Latino communities are coming together to develop a CHA, each of the communities brings with them their past experience, values, and beliefs which impact the engagement process. African Americans are connected through specific individuals they trust, but not far from their minds are past history of abuse, and a mistrust of research. Latinos see the reason for a CHA as directly linked to research that is done to them or about them by the PHD. A key barrier is the issue of mistrust across both communities which is acknowledged by the PHD. Infrastructure for action is connected to funding for the PHD and the African America group, but for Latinos it is connected to the diversity and skills of PHD staff, and capacity within the community. Figures 12 and 13 show the network views for both barriers and facilitators to community engagement/action along with key quotes that serve to illustrate the interconnectedness between concepts. Network views are visual diagrams of co-occurrence between codes which provide direction to the researcher for further exploration.
Figure 8: Distribution of barrier/challenge codes

Figure 9: Distribution of background/purpose, history, and knowledge codes
Figure 10: Distribution of power/authority, infrastructure, and action codes

Figure 11: Distribution of facilitator codes
**TABLE VIII: Top Co-Occurring Codes by Construct**

<table>
<thead>
<tr>
<th>Construct</th>
<th>PHD</th>
<th>African American</th>
<th>Latino</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genesis for CHA</td>
<td>Relationship with specific individuals Past history Research</td>
<td>Lack of Trust Community lead Respect for community norms</td>
<td>Research</td>
</tr>
<tr>
<td>Past History</td>
<td>Knowledge</td>
<td>Knowledge</td>
<td>Knowledge</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relationship with specific individuals</td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td>-</td>
<td>Past history</td>
<td>Past history</td>
</tr>
<tr>
<td>Power/Authority</td>
<td>Funding</td>
<td>Int/ext politics</td>
<td>PHD led Relationship with specific individuals Int/ext politics</td>
</tr>
<tr>
<td>Ownership of Action</td>
<td>-</td>
<td>Weak or no infrastructure Commitment</td>
<td>Weak or no infrastructure Commitment</td>
</tr>
<tr>
<td>Infrastructure for Action</td>
<td>Lack of trust Funding</td>
<td>Diversity/Staff skills Funding</td>
<td>Diversity/staff skills Understanding capacity</td>
</tr>
<tr>
<td>Barriers</td>
<td>Lack of trust Diversity/staff skills Mutual awareness</td>
<td>PH lead Lack of trust Mutual Awareness</td>
<td>Research Lack of trust Commitment</td>
</tr>
<tr>
<td>Facilitators</td>
<td>Time Respect for community norms Commitment</td>
<td>Patience with community Respect for community norms Infrastructure</td>
<td>Commitment Time Respect for community norms</td>
</tr>
</tbody>
</table>

* shown in priority order
**Figure 12:** Network view of barriers to community engagement and action

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**Quote:** “Everybody has their own agenda about what they feel is important from their own personal perspective as well as from their own community perspective and I think that sometimes there people have different philosophies, capacities in terms about what the overall goal should be and I think that those things can get into the way when people don’t find the common denominators.”

**Key Factors:** PHD and community capacity, trust, not integrating community frames, knowledge
Figure 13: Network view of facilitators to community engagement and action

**Quote:** “I think it was follow through, engagement, and relationship building… giving people tools… just a high level of engagement”

**Key Factors:** On-going commitment, respect for community norms/frame; integration of community perspectives; relationships
After critical examination of all data collected for this study, four salient themes across the three groups, African American, Latinos, and PHD employees, were identified in response to the research questions. Each theme is described here and examined in more detail in the manuscripts and in the discussion section of this study.

1. Different understanding about the purpose and drivers of CHAs across all groups

Participants expressed diverse opinions about the origin and need for a specific community health assessment. Some LHD employees reported acting on the request for a particular assessment from department leadership or the elected board. Many expressed concern over the way in which CHAs were being prioritized because of the vast “diversity of the county” and the many more communities that “should be assessed”. According to one respondent, unless communities understood the avenues for advocating for an assessment of their specific community, “it just puts them at a disadvantage right off the bat” which was especially troubling for communities already at some degree of disadvantage in the county. A few LHD participants said they felt that community health assessments were being done in a “reactive” manner rather than systematically in response to data and changing demographics.

While all Latino participants acknowledged significant disparities within the Latino community, they believed external forces outside of the community were responsible for the assessments. Several participants noted “politics” and “grant requirements” as reasons for assessment of the Latino community. The majority of Latino participants cited the LHD as the initiator of all assessment activities focused on Latinos. Several participants gave examples of how they became involved in a neighborhood assessment or CHA of the Latino community. For instance, one participant said “I remember the department coming to ask for assistance from the
promotoras” and another said “in my experience the community has not been really involved in the design of the research ... it’s been more of on the end... like getting data collected from them but not necessarily shaping the research process”.

Alternatively, African American participants described the community as the main driver of the CHA. One respondent said “We came up with an initiative to do a series of studies about the lives of African Americans in Silicon Valley.” Another participant said, “We need data and we need to accurately describe what we look like as a community...from our lens”. Several respondents emphasized the lack of existing data about the health and lives of African Americans and the importance of having data to support the need for resources and services in the community. One respondent summarized the perspective of most African American participants, the CHA was going to be “driven by the Black community” because “it’s about us and it’s for us”.

2. Lack of past history, distrust, and research approach to CHAs pose challenges to effective community engagement

All but one participant stated that they had not worked together in the past on a community health assessment project or activity (“It was all new to me.. so I wasn’t connected at all... I was very interested in being connected to them”). There was general consensus among all participants that they knew very little about each other prior to coming together to work on a CHA. This lack of past experience working together added to the general sense of “distrust” of the PHD. The lack of trust was identified as a barrier by both the African American and Latino community, but was strongly expressed as a challenge by members of the African American community. One participant said, “our start was tremendously rocky because the community just did not trust... here was a whole new group of people and they didn’t .. for a lot of reasons..
trust because there has never been any engagement… any effort to include them before. they were very suspicious”. Another person described initial meetings with the LHD as “contentious” and “tense”. Latino participants emphasized the need to have strong representation within with the PHD as a key factor in building trust. One person said, “I feel like the CEO’s and executives directors are not Latinos.. but the representatives they send are Latinos but at the administration level… we don’t have enough Latinos at the table.”

While LHD participants reflected on several barriers and challenges to CHA development and action such as time and cost, several participants’ emphasized problems associated with the use of traditional, systematic scientific approaches being applied to CHAs. One person gave an example, “I think sometimes it’s hard to approach [CHAs] from our public health lens… maybe the communities have a different approach. I know for other assessments, [they] had a different priority than us and trying to reconcile that is a challenge. So I think there’s kind of a back and forth relationship that can be a little tricky”.

Another said, “I saw that we were going along the same track we always do and that’s the only track I know… we go talk to the community and then we evaluate what they say and then you know… our standard way of doing things, but the community was adamant.. they were not having it”. A community participant explained it this way,

I think there is also a tension between the need to be evidence-based in order to do something.. we were going to benefit if the data or facts were good, but we already knew that people needed health insurance in this community … [we] didn’t need to study this in this survey… maybe we would have benefited from having facts and figures that someone outside of here would understand/believe, this is a normal tension. In many
instances… the people already know what the solutions need to be.. what we need.. but the people with money.. not only the PHD, but universities, funders want the data in certain ways which is very challenging for people”.

3. Lack of resources exists within the communities and the PHD to implement recommendations.

All participants were asked about the resources in place or planned to support recommendations or strategies that resulted from the CHAs. Virtually all LHD participants responded that the resources dedicated to the action phase of the CHA was “minimal” compared to the resources allocated to the CHA process and reports. Several others were not sure who from the LHD had been “assigned” to support the implementation phase. Many also expressed concern about the LHD’s ability to follow through. One respondent said, “I don’t always know if the movement to action is there, unless there’s a piece that the community really wants to happen. I’m not sure if I’ve really seen it operationalized here, and I don’t know who’s responsibility that is, and I don’t know how that would even happen. But it kind of feels like we write this big report then it just lives on our website”.

Most Latino participants said they were not aware of any action that may have resulted from the Latino CHA both in the community and in the LHD. One respondent said, “There is momentum in the community but not capacity to take these on”. Another said, “I think most of our community is hustling and trying to survive, to provide for their families .. I don’t think we are in the position to do that without actual support and the structure that the county provides...so I think that it is really essential that the county play a leadership role in convening Latinos to focus on health”.

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There were varying opinions expressed from African American participants about the ability to implement any of the recommendations from the CHA. Most participants said they thought the community was “very prepared” to lead the action phase. Others expressed even more confidence because of specific individuals and their continued involvement. One participant characterized it this way, “that group is not going away... they have been around for quite a while and they usually don’t take ‘no’... it is a group of fighters.. there is core group that … are like bulldogs…when they get on something… they don’t let go and so the community wants to see some things happen.. and I think this core group will keep pushing it... until it happens…as long as everybody remains healthy.. I see things happening and changing”. A few saw it differently. Some thought the community needed “guidance and support” in order to implement the recommendations. A few thought the community was “loosely organized” and might redirect their attention based on “other things that come up”.

4. The PHD is expected to stay committed to the action phase.

Virtually all participants saw a role for the LHD in the implementation phase of the CHAs. LHD participants expressed feeling “stressed”, and “unsatisfied” about their ability to follow through with commitments made to these communities. One participant said, “We are starting to see that we are in this for the long haul with them… I feel that the department is starting to see that we are not off the hook.. so I feel like that there is a sense of commitment from the department to move forward and work with them”. Others however, said that the commitment to communities following the CHAs was based on “individuals” and not reflective of “department wide” commitment. Still, people felt a sense of obligation and welcomed being
held accountable. “We started something... maybe not because we planned it out to be that way... but we were asked to do something and I feel like we have a little bit of a responsibility to see it through or to help them see it through”.

Most Latino participants were in agreement that the LHD should play a leadership role in addressing the issues identified in the CHA or other assessments focused on Latinos. Some even expressed frustration with the idea of shared responsibility for action.

So the big push is community engagement and them somehow the community taking ownership of these issues and moving things forward. I don’t know which academic came up with that piece of crap.. because in order to engage with community you need to find a community that feels empowered and knows how to do something about it.. you know… I think that the whole issue of engaging the community to take action steps and ownership.. is very difficult.

Nearly all African American participants expressed a desire for shared leadership between the LHD and the community in advancing the recommendations from the CHA. One participant said, “We have an opportunity …to work together to create policies and practices that better serve the community because now we have a trusting relationship”. Another participant characterized the relationship between the LHD and the community as follows, “[public health] have resources and expertise we could use.. I think the marriage has to stay.. we can’t separate or divorce”.

New Constructs: Co-Learning and Agency

While data from this study strongly supports the four overarching themes, there were some data from the focus groups and interviews that suggest two additional factors should be
further considered, agency and co-learning. Agency is a sociological construct with varying definitions and ideological theories found in the literature. However, all of them include some variation of individual free will, personal control, ability to influence one’s surroundings, and capacity (Hitlin & Elder, 2007). For African American participants, the concepts of self-determination, leadership, and control were important and influenced the interaction with the PHD team and ultimately the direction of the CHA. An African American participant said,

Self-determination is critical.. the community who you are studying needs to be not just at the table with a couple of representatives but they need to have ownership of it..and they need to direct and work collaboratively with the department on direction.. and take a lead in the community too.. because we were leading this.. and here was the support team from the PHD.. instead of the other way around.. and trust that.. that it’s not only going to get better results.. but it’s also going to get engagement form the community .. when they take ownership of the process and the results.. I think it has an impact.. like I said.. the ripple effect in so many ways.. because I think community based.. you know.. community policy making… community based information gathering… policy, direction, programs.. is really what it’s going to take to improve outcomes and improve health of the community.

Alternatively, Latino participants often used terms such as “no capacity” or “lack of power” to describe their position and interactions with the PHD. One participant said, “I don’t feel connected to the process, or represented in it”. These different perspectives provide a window into the importance of agency and its influence and interaction with other contributing factors that support effective community engagement and action.
The idea of “co-learning” in the study may be seen as uniquely tied to the concept of power and also empowerment. Co-learning may be thought of as the exchange of skills, knowledge, capacity, and an acknowledgement that everyone can contribute in positive ways to relationship building (Glanz & Rimer, 2015). Elements of this concept were reflected throughout the study and should be considered relevant and important to meaningful engagement between and among groups. The PHD staff acknowledges learning from their experience with the African American community. One PHD participant said, “It was eye opening and we learned a lot especially with the African American assessment”. Despite general lack of satisfaction with how the PHD engaged the Latino community in CHA development and follow up, one participant welcomed the opportunity to work with the department to improve the process of engagement. “I would think the department wanting the Latino community to be part of a learning community, to determine how to engage the community to be part of the process.. and really understanding the culture, community values, perceptions.. everything or any of the activities that the health department is wanting to learn is good”. When asked what it would take for Latinos to work with and engage with the PHD, one participant said, “I think kind of like what [she] did... she invited me.. so identifying [Latinos] and reaching out to them.. Sometimes [Latinos] feel intimidated by PH.. so reaching out and inviting them.. so that they actually have a voice, and learn the process”.

**Results Summary**

TABLE IX reflects triangulation of all data sources as well as findings by each key construct in this study. Triangulating the data sources for each group in this study provided a deeper understanding of the complex factors associated with each construct, how they relate to one another, and how they affect meaningful engagement between the PHD and the communities
in this study. The analysis of all data sources found that the reasons or genesis for each CHA was different for each group. The PHD began the CHA development process with the African American and Latino community in the same fashion as it had with numerous other groups. It had been given a directive from leadership or an elected board office to conduct a community specific CHA and in the course of fulfilling the request engaged community stakeholders as normal practice. However, PHD participants in this study acknowledged knowing little about the communities and did not have experience working directly with the communities prior to the CHA. This meant that the groups did not have the benefit of building onto an existing partnership or past collaborative effort. Instead, representatives from the African American, Latino, and PHD came to the process with unstated expectations and a lack of vision for the CHAs.

African American study participants reflected on the community’s desire to lead a multi-pronged assessment process without the support of the PHD and in a manner consistent with their cultural frame, experience, and vision. They had little knowledge of the PHD and minimal interaction with the department prior to the CHA. However, despite a difficult start, they acknowledged the PHD for working through initial challenges by slowing the process, learning and listening to the community; and staying consistent. Despite a lack of trust and a desire to work only with African Americans, participants reported having built a relationship with the PHD through the CHA process which they believed would be beneficial to the implementation phase. Most participants reported that the community had the infrastructure (leadership, commitment, networks, funding) necessary to support next steps.
Latino participants indicated that the community had not requested a CHA. They reported little or no knowledge of the PHD and many reported they had not worked with the PHD previous to the CHA. A majority of participants responded that they did not trust government entities and they did not genuinely feel part of the development process for the Latino CHA. Most participants indicated that there had been little benefit to the community from the CHA or previous studies conducted by the PHD. The majority of participants emphasized a lack of leadership and infrastructure in the community that would be needed to implement recommendations from the CHA. Therefore, they indicated that the PHD should be responsible for implementing the recommendations.

The relationship between the PHD and the African American study participants was different compared to the Latino participants. While the PHD participants acknowledge beginning the engagement process in the same way for each community, the African American group already had a clear vision and approach for the CHA compared to the Latino group who did not feel well represented or committed to the process at any stage of the CHA process. Despite reservations for working together, the African American group and the PHD worked through issues by being flexible, open to suggestions, and responsive to each other’s needs. This relationship may support the long-term commitment needed for implementation even if both groups may not necessarily have the infrastructure needed to propel the work forward.

PHD participants reported investing in the planning and data collection phase of a CHA, but not for the action or implementation phase. A few participants indicated that because community members had requested a CHA, they should be responsible for the action associated with them. The majority of PHD participants responded that they felt responsible at some level
for the implementation of CHA recommendations regardless of whether a community had requested it or had the capacity to advance findings to action. However, despite the desire to support implementation of CHAs for each community, PHD participants indicated that there was a lack of clear support or commitment to this phase by the PHD and county leadership. This left both PHD and many Latino participants unfulfilled and questioning the value of CHAs. This is supported by the interviews, but no documentation was found that could support this assertion.

In summary, four cross cutting themes emerged from the analysis of documents, key informant interviews and focus groups that support a response to the research questions guiding this study. They were: 1) different understanding about the purpose and drivers of CHAs across all groups, 2) lack of past history, distrust, and research approach to CHAs pose challenges to effective community engagement, 3) lack of resources exists within the African American and Latino communities and the PHD to implement recommendations, and 4) the PHD is expected to stay committed to the action phase, regardless of challenges encountered throughout the process of CHA development and capacity for action. Two additional constructs were reviewed due to their likely influence on both the process of engagement and the action phase of CHA development, agency and co-learning. Individual and community agency is important throughout the process of engagement, but especially so at the beginning of CHA development. Likewise co-learning is important to the entire process as it supports compromise, openness, and trust building which are important factors to consider when working with minority communities. The results of this study suggest that there are opportunities for both the PHD and the communities to reframe the approach to the development of community health assessments to support capacity for collective action to achieve community health priorities.
<table>
<thead>
<tr>
<th>Research Question</th>
<th>Construct</th>
<th>Data Source</th>
<th>Summary from Interviews</th>
<th>Summary from Focus Groups</th>
<th>Summary from Archival records/Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?</td>
<td>Genesis of CHA</td>
<td>Community role important; Latino groups had a passive role; AA active role</td>
<td>Elected involved with both CHAs, mixed group involved in Latino CHA; AA actively involved in planning, data collection</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>History</td>
<td>Minimal to no prior history of working together; contribute to tension, trust issue</td>
<td>Not sufficient to support or deny past histories of collaboration or partnership</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>Knowledge</td>
<td>Little to no knowledge of each other, contributes to trust issues, cultural frames not well understood</td>
<td>Minutes and notes support no prior knowledge of each other</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Power/Authority</td>
<td>AA- power and authority within community; Latinos- power and authority with PHD, viewed as abusive</td>
<td>Not sufficient to determine who is truly in power or has authority. CHAs begin with letters by elected officials, except in the AA report.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Infrastructure</td>
<td>AA- some capacity but need continued support; Latinos have none; large barrier to action</td>
<td>Not sufficient to evaluate action phase; AA have backbone organizations, Latinos do not</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ownership of Action</td>
<td>AA- shared; Latinos- PHD</td>
<td>No documents available that support Latino role; AA- presentation to BOS on action steps to date; Shared with</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Research Question</td>
<td>Construct</td>
<td>Data Source</td>
<td>Summary from Interviews</td>
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<tr>
<td>What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete?</td>
<td>AA- shared responsibility for action and leadership with PHD</td>
<td>AA- split between community owns the responsibility alone, and PHD and community share the responsibility</td>
<td>Expectations high for PHD</td>
<td>Expectations high for PHD</td>
<td>PHD and AA working together on action phase</td>
</tr>
<tr>
<td></td>
<td>Latino- PHD solely responsible for action (PHD seen as researcher responsible for implementation of their study)</td>
<td>Latino- didn’t ask for the CHA, so PHD is on point for action</td>
<td></td>
<td></td>
<td>No clear responsible party outlined in the Latino CHA</td>
</tr>
<tr>
<td>What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?</td>
<td>Sense of responsibility for outcome of all CHAs, but feel community has a clear role. PHD role seen as supportive, advocate, facilitator, bridging</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td></td>
</tr>
</tbody>
</table>
Engaging Minority Communities in Community Health Assessment

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The findings and conclusions in this study are those of the author and do not represent the official position of the Santa Clara County Public Health Department.

The material is based upon a Dissertation, submitted in partial fulfillment of the requirements for the doctoral degree at the School of Public Health of the University of Illinois at Chicago
Abstract

Background:
Since 2010, the Santa Clara County Health Department has conducted annual community health assessments (CHA) of specific populations such as Vietnamese Americans and Latinos living within specific geographic boundaries of the county. While the reasons to conduct assessments may vary, it is common practice for the Department to leverage existing partnerships with public health system partners to fulfill requests for population specific community health assessments. Because CHAs may include recommendations or strategies aimed at improving the health and well-being of minority communities, public health departments must focus on factors that affect the process used to engage these communities as it may improve the probability of implementing recommendations that result from their development.

Objective: This study highlights how eight constructs associated with the community engagement process (purpose, knowledge, history, power/authority, infrastructure, ownership, community agency, and co-learning) contribute to differences in CHA outcomes for the African American and Latino communities.

Methods: In 2015 and 2016, a total of 20 semi-structured in-depth interviews and three focus groups were conducted with public health department staff, and members of the African American and Latino community in Santa Clara County, California who participated in the development of a CHA. Interviews and focus groups were recorded, transcribed, coded and analyzed in Atlas.ti software to identify common salient themes.

Findings: (1) a CHA process must begin with a shared understanding of goals, vision, process, and expectations, (2) The collaborative process is challenged by lack of previous history,
distrust, and the approach for CHA development chosen by the LHD. (3) Community and LHD capacity for implementation must exist prior to CHA development, and (4) The LHD is expected to have a role in supporting communities in addressing CHA recommendations.

**Conclusion:** Findings from this study suggest that while local health departments may integrate model community engagement practices into the development of community health assessments, these practices may not always be effective with minority communities. Opportunities exist for LHDs to apply new approaches, identify and address factors that influence the engagement process, and build capacity for more meaningful engagement of minority communities in the development of CHAs.

**Key words:** community health assessment, community engagement, African American, Latino, local health department
Background

In 2013, 42% of Local Health Departments (LHDs) reported that they were involved in formal partnerships when carrying out their community health assessment functions.\(^1\) Formal partnerships in public health are well known and have been written about extensively including those involved in community health assessment (CHA) or the support of other LHD assessment functions\(^2,3\). However, little information is available about the genesis and engagement process used with informal partnerships, particularly those involving residents from disadvantaged communities in the development CHA. Their participation in the planning, data collection, and action phases of a CHA presents both an opportunity and a challenge for LHDs.

Previous research has shown that ‘meaningful’ engagement of disadvantaged communities is necessary to improve health outcomes, a fundamental goal in the development of CHAs.\(^4\) Meaningful engagement begins with mutual respect and understanding. It is reinforced by practices that lead to shared ideas, decisions, common goals, decision making, and mutual co-benefits. When these elements exist, the responsibility for shared action between parties is made possible. While many of the community-based approaches used by public health departments are anchored in and build upon these and other important concepts such as capacity building and empowerment, operationalizing these concepts with communities is key.

Santa Clara is a county with 1.9 million residents. Its population is rich in diversity with 36% of residents born outside of the U.S., and over 100 languages and dialects spoken. Like many health departments around the nation, the Santa Clara County Public Health Department (LHD) in Northern California conducts community health assessments in partnership with community stakeholders representing academia, nonprofit hospitals, community-based and faith-
based organizations, education, and many other public health system partners to better understand the health needs of its population. In an effort to be responsive to the needs of its diverse communities especially those that experience health inequities, the LHD has applied a wide range of traditional assessment methods such as Mobilizing for Action through Planning and Partnership (MAPP) and Community-Based Participatory Research (CBPR) to its assessment and planning functions. Since 2010, the LHD has conducted annual CHAs of minority or ethnic communities. In most cases, the LHD has completed CHAs by leveraging existing partners and through the application of well-established models of practice for their development. Recently, CHAs have been developed with individuals from minority communities not associated with a traditional public health partner.

Little is known about the process of conducting meaningful engagement in conducting CHA processes in minority communities. The purpose of this study was to examine the engagement process used in the development of a CHA by the LHD and two communities, African American and Latino. These communities were selected for this study because of their consistently lower socioeconomic status compared to other county populations. Salient themes are described from the examination of eight constructs associated with community engagement (purpose, knowledge, history, power/authority, infrastructure, ownership, agency, and co-learning). LHD perspectives are also included. Lessons learned, recommendations, and implications for public health practice are discussed. Figure 1 provides the framework for this study.

Methods
This study applied a purposive sampling approach to recruit participants from the public health department, and African American and Latino communities in Santa Clara County, California who previously participated in a small or large-scale community health assessment between 2004-2014 conducted by the local public health department. This timeframe was selected to allow time for implementation strategies to be reflected across the range of assessment activities involving representatives from these two communities. Public health staff were eligible if they worked at least half time on the development of assessments focused on these communities. Community members were eligible if they self-identified as African American or Latino and if they had participated in the planning and development phases of a particular health assessment focused exclusively on the African American or Latino communities. All participants were enrolled in the study upon receipt of written informed consent. Participants who were involved in the planning, development, coordination, analysis, and reporting or implementation phases of an assessment were eligible to participate in a semi-structured key informant interview. Individuals who participated in an advisory capacity, but were not directly involved in the planning, coordination or implementation phase of community health assessment were assigned to a focus group.

Semi-structured interviews and focus groups were held between November 2015 and February 2016. Discussion guides were developed based on a literature review of community participation models and strategies used by local public health departments, and on lessons learned from engagement of minority communities in practice-based research. The guides covered the key domains associated with community engagement and partnership (e.g., genesis of collaboration, power/authority, accountability/ownership, capacity for action, commitment, successes, and barriers). No identifying information was collected from participants other than
self-identification of race/ethnicity, nativity, and age. All interviews and focus groups were conducted in English.

Interviews and focus groups were audio recorded and transcribed verbatim. Transcripts were coded and analyzed in an iterative fashion in Atlas.ti 7.5 qualitative analysis software, using both deductive and inductive approaches to coding, starting with an a priori framework based on domains associated with community engagement in the literature and adding additional codes via a grounded theory approach.\textsuperscript{15-17} A random sample of transcripts was independently coded by a second coder. Discrepancies in coding were resolved through discussion and consensus. Key concepts, themes and supporting quotations were organized using tables and matrices to support analysis within and across units. Salient themes across each of the domains and supporting quotations were identified. Similarities and differences between communities were noted.

The study protocol was reviewed and approved by the University of Illinois at Chicago institutional review board (IRB, protocol # 2015-0983).

Findings

A total of 20 interviews were conducted with stakeholders from the public health department (7), African American (6), and Latino communities. The mean age of participants was 44 years with a range between 32-60 years. In addition, three focus groups were conducted [African American (1); Latino (3)] with a total of 23 individuals ranging in age from 30 to 74 years of age. Of the 23 participants, 9 of them were born outside of the United States. Four major themes are described below.
Disparate Reasons for a CHA

Participants expressed diverse opinions about the origin and need for a specific community health assessment. African American participants described their community as the main driver of the CHA. One respondent said “We came up with an initiative to do a series of studies about the lives of African Americans in Silicon Valley.” “There was a very strong community voice” said one person when describing the community’s request for an African-American focused CHA. Several respondents emphasized the lack of data about African-American health and lives and the importance of having data supporting needs for community resources and. Alternatively, while Latino participants acknowledged significant health disparities affecting the Latino community, they believed forces external to the community were responsible for the assessments. Several participants noted “politics” and “grant requirements” as reasons for Latino community assessment. The majority of Latino participants cited the LHD as the initiator of all Latino-focused assessment activities.

Despite the varying degrees of understanding among the groups, LHD staff responsible for facilitating CHA development with the African American and Latino communities reported spending less time clarifying CHA goals with stakeholders compared to the discussion of methods, data collection tools, and reporting.

Key Factors Affecting the Community Engagement Process

Lack of Knowledge and Minimal History of Past Collaboration

Most community members and LHD staff stated that they had not worked together in the past on a community health assessment project or activity. A LHD employee said, “It was all new to me.. so I wasn’t connected at all… I was very interested in being connected to them”.
There was general consensus among participants that they knew very little about each other prior to working together on a CHA. Community members felt that the health department generally did a good job of working with agencies or systems of care serving the African American and Latino communities, but seldom worked directly with “residents or people being impacted by” an issue. A few participants stated that what they knew of each other came from knowledge of “disparities data” or “programs” offered by the local public health department. Community members acknowledge working with individuals within the LHD, but there were no formal partnerships in place with leading organizations within either community.

*Power, Trust, and LHD approach to Assessment*

While every participant expressed value in collaboration and partnership, participants from both communities expressed “distrust” at the beginning of the assessment process with the LHD. One participant said, “our start was tremendously rocky because the community just did not trust, here was a whole new group of people and they didn’t, for a lot of reasons, trust because there has never been any engagement, any effort to include them before... they were very suspicious”. Another person described initial meetings with the LHD as “contentious” and “tense”. Several participants stated the importance of having diverse representation within the LHD to building trust. A Latino participant reflected on the perspective of Latinos as the subjects of research. “people always think, . . .they are going to study us…here is the guinea pig thing again and we aren’t ever going to see them again”.

LHD participants acknowledged barriers such as length of time to complete an assessment or costs associated with CHA development; several noted challenges associated with the use of systematic models for assessment with communities primarily because many models
assume trust already exists. One person said, “Sometimes it’s hard because we have our approach to [CHA development] and maybe communities have a different approach”. LHD staff indicated that reconciling community and LHD priorities was challenging: “There is kind of a back and forth relationship that can be a little tricky A Latino participant explained it this way, “I think there is a tension between the need to be evidence-based while meeting the needs of the community. This is a normal tension, but in many instances the people already know what the solutions need to be, what we need, but the people with money, not only the LHD, universities, funders, want the data in certain ways... which is very challenging.”.

**Capacity for Action and Ownership**

All participants were asked about the resources in place or planned to support recommendations resulting from CHAs including a call for action. Virtually all LHD participants responded that the resources dedicated to the call for action were “minimal” compared to resources for the development of a CHA and report. LHD participants were unclear who had been “assigned” to support the implementation phase linked to the action call. Many expressed concern about the LHD’s ability to follow through. One respondent said, “It kind of feels like we write this big report then it just lives on our website”.

Most Latino participants said they were not aware of any action that may have resulted from the Latino CHA both in the community and in the LHD. There were varying opinions expressed from African American participants about the ability to implement recommendations from the CHA. Most participants said they thought the community was “very prepared” to lead the action phase. Others expressed even more confidence because of specific involved individuals and their continued commitment to working with the LHD. A few thought the
community was “loosely organized” and might redirect their attention based on “other priorities”, and emphasized the LHD’s important role in ensuring CHA followup action.

**Individual and Community Agency**

African American study participants noted several community strengths and capacities compared to Latino community participants. African Americans referred to the importance of community self-determination, as well the belief in the community’s ability to advocate for and lead change. Alternatively, Latinos in this study often referred to their community as ‘disempowered’, or lacking leadership, and other resources including a leading organization.

**High Expectations of the LHD**

Virtually all participants saw a role for the LHD in the implementation phase of the CHAs. LHD participants expressed feeling “stressed”, and “unsatisfied” about their ability to follow through with commitments made to these communities. One participant said, “We are starting to see that we are in this for the long haul with them… I feel that the department is starting to see that we are not off the hook.. so I feel like that there is a sense of commitment from the department to move forward and work with them”. Others however, said that the commitment to communities following the CHAs was based on “individuals” and not reflective of “department wide” commitment. Still, people felt a sense of obligation and welcomed being held accountable.

**Discussion**

Given the rapidly changing demographics, systemic health issues, emerging public health threats, and profound disparities, alongside limited resources, effective community engagement
is more critical today than ever to facilitate collective action toward health improvement and equity. The findings from this study underscore the importance of early engagement with minority communities in the conceptualization, design, and development of a CHA, perhaps even before a CHA is the focus of the partnership. Moreover, this study reveals the complex nature of the interactions among key factors affecting the working relationship between a LHD and minority communities.

A clear understanding of purpose, as well as shared vision, and goals is an important first step to effective community engagement\textsuperscript{12,18-21}. In the course of developing shared purpose, groups are likely to improve their knowledge of each other and respective assets and capacities that can be used as a catalyst for change, build trust and understanding, and improve communications. Knowing and understanding cultural frames, history, and norms is also important to effective community engagement\textsuperscript{22}. Participants in this study appeared to be starting at different places of understanding, which has implications for managing the process and expectations during and after the CHA. It may also have the negative consequence of further marginalizing already vulnerable communities.

The context in which the CHA process occurs is also significant. In Santa Clara County, the approach to community health assessment has been historically rooted in the scientific method where researchers ask questions collect data to address the questions, analyze and report data. Communities are engaged as means to an end, rather than in the conceptualization, design and approach to assessment. This is due in part because community health assessment is often the responsibility of epidemiologists who may lack an understanding of the principles and practices associated with community engagement. Public health departments whose goal is to
improve health in minority communities through effective community health assessment and engagement must rethink their approach to CHA. CHA models may need to be adapted or revised entirely to more strongly promote engagement toward action (e.g. asset mapping; identifying levers of change). Communities must be brought in early and be part of the design and call for CHAs where implementation of recommendations is a desired goal. African American and LHD participants indicated that although there was no relationship prior to the planning stage of the CHA process, the groups took time to develop shared goals, vision, and agreements. Detailed workplans for how the community planned to address recommendations from the CHA were subsequently developed.

Within this paradigm, the interconnectedness of the key factors of community engagement becomes even more essential for determining whether CHAs will move to action. Latino participants in this study indicated that none of the constructs and associated factors explored in this study were present during the CHA process between the LHD and the community. No action on the CHA’s recommendations had taken place. Latino participants reported no capacity to address community priorities. The LHD was viewed as ultimately responsible for community health improvements in the Latino community.

CHAs should not be the only reason communities and LHDs partner. LHDs must lay the groundwork with communities well in advance of planning a CHA. Even when CHAs are viewed as important to communities, they must reflect the priorities and capacities of both the community and the LHD if there is an expectation that they will lead to improvement.

**Study Limitations**
An important limitation to this study should be noted. The information collected through interviews and focus groups is self-reported, and not representative of the full relationship between African American and Latino communities and the Santa Clara County Public Health Department. It is possible that effective community engagement strategies are being utilized across other programs and areas of the LHD with these same communities.

**Lessons Learned and Implications for Practice**

This study contributes to the on-going discussion about the importance of engaging minority communities, and provides lessons learned to advance public health goals.

1. *The community engagement model used must fit the context.* The LHD has an important role in ensuring that model practices are consistent with the overall purpose and goal driving engagement. If the intent is for a CHA to lead to action, the engagement practice and model should be consistent with the overall intent of community action. This means reframing the approach to community health assessments to incorporate additional models or practices such as asset mapping for both community and the LHD in order to support clear, action oriented goals and activities. A process that has strong community commitment and support is more likely to lead to community action. Incorporating self-reflection as an important component of CHA planning may help generate important questions to support success, “Are we setting this process up for action? If so, how?” “Are there alternatives we haven’t thought of?” Otherwise, data collected for data’s sake, may not necessarily lead to action by any of the parties involved.

2. *Involve communities before planning a CHA.* While CHAs are important for LHDs to understand the health needs of the population, targeted communities must also see value
in a CHA. It is critical that communities be involved in all phases of CHA development, from the initial call, to design, data collection and reporting. *If communities are not involved in all phases of a CHA, they are less likely to commit to implementing the recommendations that result from them even when communities have the infrastructure, assets, leadership, and mobilization capacity to do so.* Without early and sustained commitment and buy-in from communities, the outcome of a CHA may be viewed as someone else’s responsibility. An unintended consequence of developing CHAs without meaningful community engagement is that LHDs may actually perpetuate the sense of betrayal and mistrust that exists within minority communities. A clear sense of shared purpose, goals, mutual benefit, and level of responsibility for any action associated with a CHA should be discussed and agreed upon by all parties involved before embarking in a CHA.

3. **Community and LHD capacity must exist in order to move findings to action.** LHDs and communities must take a pragmatic approach to CHA development. There must be capacity to move findings to action from both the LHD and the community. If community and individual agency, infrastructure, resources, funding, commitment, lack of vision, and leadership is missing, then it is highly unlikely that CHAs will lead to a positive impact.

4. **LHDs must build internal capacity to support deep meaningful relationships with minority communities.** Several opportunities exist to support capacity building for LHDs and minority communities to foster meaningful and lasting relationships built on trust, understanding, and commitment. One way is to create opportunities for knowledge exchange and shared learning. This can be done in a variety of ways such as creating a
community of practice (CoP) between LHD staff and residents in which shared goals are established and co-learning occurs, providing leadership training for PH staff and residents; or encouraging minority community leaders to sit on PH advisory boards or PH staff on community boards. LHDs and communities must also continue to look for opportunities to work together on shared goals and strategies to address health improvement and health equity that go beyond funders’ directives but rather reflect the actual needs and strengths of the partnership. LHDs can demonstrate their commitment to working with minority communities by offering training in facilitation, community capacity and engagement models and practices, and by diversifying the workforce to reflect the communities they represent.

**Conclusion**

Public health departments fulfill their assessment functions in a variety of ways. Community health assessments are one way to understand and address pressing community health issues. While there are mixed perspectives in the literature about the importance or impact of CHAs, there is a lack of information about the process or degree of community engagement used in their development and in the role that minority communities play. Findings and recommendations from this study help address this gap by providing different perspectives and recommendations for improving how LHDs address community health assessment requirements to align with organizational and minority community values, goals, and capacities. This study offers LHDs engaged in community health assessment an alternative perspective on the use of CHAs: CHAs may be used by LHDs as a tool for working towards the genuine
community engagement necessary for the elimination of health inequities and disparities in minority communities.

**Figure 1:** Conceptual Model for Effective Community Engagement

**References**


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Manuscript 2: African American and Latino Community Satisfaction with Participation in Community Health Assessment

Prepared for submission to the Journal of Immigrant and Minority Health
African American and Latino Community Satisfaction with Participation in Community Health Assessment

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The material is based upon a Dissertation, submitted in partial fulfillment of the requirements for the doctoral degree at the School of Public Health of the University of Illinois at Chicago
Abstract

**Background:** Community health assessments (CHAs) of African American and Latino communities were conducted by a local public health department (LHD) to identify priority health needs.

**Methods:** Three focus groups and 13 key informant interviews were conducted to explore participant satisfaction with the process to develop CHAs. Transcripts were coded using a priori and emergent codes using grounded theory and analyzed to identify similarities and differences between communities.

**Results:** Both groups reported the need for data as an important motivator to CHA participation. The groups differed in how they perceived their role in the CHA process, and also in their overall satisfaction with the process. African American participants reported a positive experience compared to Latinos.

**Discussion:** Community satisfaction is CHA development is linked to role, investment, and capacity to address issues that result from CHAs. LHDs must work to ensure that community involvement in meaningful and leads to tangible benefits.

**Key words:** African American, Latino, Community Health Assessment, Satisfaction, Engagement
Introduction

The racial/ethnic health disparities and inequities experienced by African Americans and Latinos in the United States are well documented [1-3]. African American and Latinos are more likely to have lower rates of health insurance, higher rates of certain chronic conditions, shorter life expectancies, lower rates of educational attainment, and are more likely to live in poverty compared to other groups [3]. For some of these reasons, they are also more likely to be the subject of special studies and recipients of public health interventions, programs, and services [4]. For public health practitioners dedicated to the elimination of health disparities and inequities, it is important to have an understanding of how the social determinants of health and other factors influence the health and well-being of minority communities as they create and evaluate strategies, policies, and programs to address them [5,6]. One way to understand the health of communities is through the systematic collection of data to monitor the health status of a population, sometimes referred to as a community health assessment (CHA) [7, 8]. Public health departments (LHD) are likely to engage representatives from multiple sectors in the development of CHAs as well as in the development of action plans to address issues that emerge from CHAs. The literature is rich with examples of successful partnerships between public health departments and academia, healthcare organizations, coalitions, community-based organizations, and many others in the development of CHAs [9, 10]. However, little is known about how lay residents are engaged in the process of developing CHAs and even less is known about how they perceive their engagement and role in the process.

In places like Santa Clara County, California where nearly a third (27%) of the population is Latino and 3% is African American, understanding the root causes of negative
health outcomes as well as community priorities is important especially when these communities are over represented in systems like foster care and juvenile justice and are the highest beneficiaries of public health care services [11, 12]. Developing partnerships and strong collaboration with these communities is a high priority for the LHD.

Barriers and facilitators to African American and Latino participation in research are well documented. They include factors such as negative opinions about researchers, lack of trust, feelings of betrayal, fear, community benefit, incentives, and lack of cultural frame [13, 14]. At first glance, these factors may seem irrelevant to the development of CHAs because CHAs are generally not developed with the goal of contributing to the science base. The CDC defines research as the “systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge” [15]. However, LHDs are government agencies whose assessment functions may be indistinguishable from research conducted by an academic institution.

These factors emphasize the need to reevaluate the CHA approach and the importance of deep and meaningful engagement when working with minority communities. When LHDs and minority communities come together to work on a project like a CHA, it is important to examine satisfaction (positive experience) with the process and outcome. Without this understanding, LHDs may inadvertently perpetuate the negative views associated governmental entities resulting in lack of participation by minority communities in future opportunities for collaboration.

This study presents data on the satisfaction of African American and Latino community members who participated in a CHA process with a LHD. Community perspectives and
experiences are presented which may help inform strategies to reduce barriers and challenges to community participation in CHAs.

Methods

Recruitment and Sampling

Purposive sampling was used to recruit county residents over the age of 18 who self-identified as African American or Latino and participated in a CHA with the LHD between 2004-2014 [16]. Key informant interviews were conducted with residents that were involved in the planning and development phases of a CHA. Residents who played an advisory role were assigned to a focus group. Upon written consent, participants were enrolled in the study. The interviews and focus groups were part of a broader study conducted in Santa Clara County that focused on exploring several key constructs of the community engagement process used by the LHD in the development of CHAs. Study procedures were approved by the Institutional Review Board at the University of Illinois at Chicago.

Data Collection

A total of 13 key informant interviews were completed with 10 women and 3 men. Interviews were conducted in English and lasted between 40-60 minutes. Three focus groups were held with 23 individuals, one with the African American community and two with the Latino community. Participants ranged in age between 32-74 years of age. No other identifying information was collected. Nine focus group participants stated they were born outside of the United States.
Interview and focus group guides were developed in English and included questions and prompts related to community engagement and perspectives about the partnership with the LHD such as the genesis for collaboration, role of community, past experiences with the LHD, community importance of partnering with the LHD, successes, and expectations from the community, as well as recommendations for strengthening partnerships with the LHD. Interviews and focus groups were audio recorded for accurate transcription.

Data Analysis

Interviews and focus group transcripts were translated verbatim. Transcripts were coded and analyzed in an iterative fashion using Atlas.ti 7.5 [17]. A priori and emergent codes using grounded theory were used to identify key themes and patterns. A random set of transcripts was independently coded by a second coder. Discrepancies in coding were resolved through discussion and consensus agreement. Key concepts, major themes, and supporting quotations were organized into tables and matrices to support analysis within and across groups (Table 1).

RESULTS

Data an Important Motivator to Participation

Study participants reported a variety of reasons for participating in a CHA process. One consistent theme across both African American and Latino participants was the importance of data to support building knowledge and support for community identified priorities. African Americans emphasized a personal commitment to their community, others participated at the request of community leaders, and others viewed their participation as uniquely tied to their professions. One participant said, “I had really wanted something like this to happen for a really
long time because I think African heritage populations kind of gets forgotten because it’s so small... I think sometimes we are invisible”. African American participants expressed excitement about participating in a process that was “community directed”. That is, the African American community would direct the planning, data collection, and reporting of the CHA in collaboration with the LHD. One participant said, “I have been here most of my life and I have never seen an assessment done of the African/African Ancestry population in this county”.

Latino participants reported participating in a CHA at the request of the health department, funder, or community-based organization. Acknowledging the health disparities and issues facing the Latino population in the county was viewed as an important precursor to resource and service needs. One study participant said, “We need numbers in order to make a case for our community if our community is going to get its fair share”. Another said, “sometimes I think we have been told what’s important to us... versus letting the facts speak for themselves and then letting the community say... well ‘yeah’... we have five things that are killing us or whatever but we decide this is the most important”.

**Community Role in CHA process**

African American participants reflected on the leadership of the community in the CHA process and in the direct benefits of taking an active role. A participant said, “I don’t want to underestimate how important that process was because I think it was very fascinating to watch it and to experience it... there was a very strong community voice”. The community’s sense of responsibility and ownership of the process was seen as important to community action and follow up. “When we go to the community with the report, we are talking to our community about it, the community is calling on those of us that were African people involved to say ‘come
tell us about it,’ I am accountable to my community. The community trusts that we did our best and that the information is more accurate and from our perspective. So I think when community is involved in it, I think the information is more valued”, and another participant said, “In this case because the community was so involved with it there is ownership to this document and pride in this document and I think it really sets it up for the community to own it and really push and move it forward.”

Participants reported momentum in the community to support implementation of recommendations from the CHA. “We are meeting with different department heads, doing presentations in the community, identifying resources from our own community”. One strategy mentioned by participants was the idea of forming strategic partnerships with the LHD and other community-based organizations especially those with resources such as foundations.

Unlike the African American community, Latino participants reported taking a passive role in assessments conducted by the LHD. “I don’t really see the community itself sitting at the table in some of the conversations that I have been part of… whether that is happening via the focus groups or individual interviews or whatnot.. I don’t see them in partnership at the table with CBOs… with professional stakeholders and so on”. Other participants expressed dismay at the lack of community priorities reflected in reports from the LHD or other assessment efforts. “I am also really tired of reading assessments… because I get a first look at a lot of these assessments… from funders, from universities and people who want my input on the first read.. I am really frustrated with recommendations that put the onus back on community members to make changes in their lives…I am constantly getting these things like people need to eat healthier or exercise more or find a child care center so their child can have a better quality
education... in none of these reports is there anything like we need to increase access, we need to have preschool for all regardless of documentation status, and so when I push back and I ask those questions nothing really comes from it, and so for me, then what’s the point?”.

Participants did not feel responsible for the outcome of the assessments including the implementation of recommendations that may result from them. One participant reflected on the lack of leadership in the community. “There has been a leadership vacuum...we are ginormous and who is that convener? I don’t know who that is”.

Different Levels of Satisfaction with the CHA Process

Little benefit to Latino community

Overall, Latino participants indicated little benefit from participating in a CHA process with the LHD. Several participants expressed disappoint about the way the LHD had engaged the community. One participant said, “I think that the LHD feels it collaborated because they have what they need, but we don’t have what we need... so I think a real collaboration will happen when we have what we need .. It’s not a true collaboration unless we get something as well. It’s collaboration when the work is done from the roots up”.

Many Latino participants reported feeling “used” and “cheated” once the assessment process was complete because once the assessments were done “nothing happened”. One Latino participant said, “the community is tired... they are being used to obtain what [they] want numbers etc., but these are people not numbers... the more [they] take from these people... the more unjust it is”. Another participant said, “I don’t want to be rude... but I would like to continue working with the LHD as long as there are solutions ... because that was the initial plan
but it never came to fruition… surveys were administered, facts were collected, data was collected, but there it ended and our people continue to be in the same state”.

Several participants wondered how the information from the Latino CHA was being used by the community and the LHD. One participant said, “I have heard people say… the health department creates all these reports and they do nothing about them”. Another said, “honestly, I don’t know what the community is doing with it or the LHD for that matter… I haven’t seen or heard anything… so probably nothing”.

Positive Relationship Built through CHA process

Despite initial mistrust of the LHD, African Americans participants described a positive experience with the CHA process primarily due to the way the data was collected. Data was collected in a manner consistent with the community’s norms and cultural frame. In reflecting on initial discussions with the LHD, a participant said, “once we started the conversations about the healthcare studies, the conversations were being done by people who weren’t Black” and another said, “we made it clear, this was going to be done from an Afro-centric frame”. An Afro-centric frame was used to develop questions, collect and report data, in a way that resonated with community members. Participants acknowledged the LHD as “responsive” and “open” to playing a support role to community. A participant said, “I think this [engagement] was a new way… in my experience… that the LHD had really reached out to get the perspective and hear the voices of the community in a way that I had not experienced before”. Another participant summarized their experience this way, “I think the trust has been established [with the LHD] but the community never fully lets go of distrust… right….because we have been hood
winked so many times ... you know and so there is still some apprehension, but we are in a better place than we were before”.

Discussion

This study found important differences in how African American and Latino communities perceive and experience their participation in CHA processes that are linked to overall satisfaction. While African American and Latino participants in this study agreed on the importance of generating data to highlight the needs of each community as a key motivator for participation in a CHA, there were differences in how they perceived their role in the assessment. The Latino community expressed assessment fatigue. The Latino population is large in Santa Clara County, and therefore, is likely to be asked to participate in multiple assessments above and beyond those facilitated by the LHD. The importance of maximizing the benefit to communities from participation in assessment activities is paramount. This study revealed that African Americans experienced higher benefit from their participation in a CHA process compared to Latinos. African American participants reported being more actively engaged in the design and process of CHA development compared to Latino participants. This is an important concept and is emphasized in other studies especially those that apply a community-based participatory approach [18, 19].

There were also culturally specific differences in CHA development and design found in this study. African American participants were enthusiastic and hopeful about the future benefits of the assessment process they felt reflected the needs and priorities of the community. This was primarily because the assessment had been “community driven” and developed within a culturally appropriate “afro-centric” approach and frame [20, 21]. In addition, participants
reported the existence of leadership and strong networks within the community which could support the implementation of recommendations from the assessments that could benefit the entire community.

Alternatively, Latino participants reported being involved in the CHA, but not in ways that were seen as beneficial to the community. Because of this, participants did not express a sense of ownership or commitment to the outcome of the assessments. Latino participants were not able to articulate whether the Latino CHA recommendations were being addressed by the community or by the LHD.

Findings from this study suggest that African American and Latino communities experience their involvement in a CHA process differently based in part on the role they play in their development. Their satisfaction with the overall process is likely a direct reflection of whether the engagement process was effective or not. Effective community engagement is likely hindered by several factors including lack of trust, lack of culturally specific approaches, leadership, lack of knowledge, and community and LHD capacity. While many studies focus on partnerships between minority communities and academic or clinical institutions, these factors are relevant to researchers from LHDs because a key principle of public health practice is to “work for the empowerment of disenfranchised communities”, which may be compromised if there is not true community participation and partnership in all aspects of a CHA. The use of community-engaged research models offer alternative approaches that should be further considered and explored by LHDs for CHA practices [22]. LHDs and communities should also consider co-development or adaptation of other non-research models and tools that promote engagement such as community mapping.
This study has several limitations which limit its generalizability. First, while common themes emerged across both groups, the number of focus groups was small and more may be needed for a deeper understanding of each community’s views. Second, the purposive sampling approach used in this study may not have provided the full range of perspectives, opinions, and experiences for each group. Therefore, the participants in this study may not represent the views and experiences of all African Americans and Latinos in Santa Clara County.

Conclusion

Results from this study suggest that community engagement strategies used to develop CHAs that are responsive to community needs and capacities contribute to higher satisfaction with the process. LHDs should work closely with community members prior to embarking on CHAs.

Table 1: Factors Associated with Positive Experience

<table>
<thead>
<tr>
<th>Supporting and Inhibiting Factors (N=13), and Focus Groups (N=23)</th>
<th>Support Factor</th>
<th>Inhibiting Factor</th>
<th>Select Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genesis for Assessment</td>
<td>Community Initiated Active Role</td>
<td>Government/LHD Passive Role</td>
<td>“The impetus came from community”.</td>
</tr>
<tr>
<td>Community Knowledge</td>
<td>Past Collaboration</td>
<td>No History</td>
<td>“[We] had minimal to no contact with the LHD before’.</td>
</tr>
<tr>
<td>Leadership</td>
<td>Lead Organization</td>
<td>Fragmented</td>
<td>“We need a face”.</td>
</tr>
<tr>
<td>Infrastructure/Resources</td>
<td>Community Assets</td>
<td>Minimal</td>
<td>“We have to create structure.”</td>
</tr>
</tbody>
</table>
References


based participatory research (CBPR) processes and outcomes. *Critical Sociology, 41*(7-8), 1045-1063.


V. DISCUSSION

A well-known definition of public health is “what we as a society do collectively to assure the conditions in which people can be healthy” (IOM, 1988). This definition has been institutionalized at all levels of public health practice and across the three core functions of public health: assurance, assessment, and policy development. Public health practitioners understand that a key tenet to fulfilling the goals and mission of public health centers on the ability to successfully engage across sectors with multiple, diverse stakeholders and communities. In places like Santa Clara County, the local health department has reinforced its commitment to community engagement and addressing health inequities and health disparities by incorporating them as priorities in its strategic plan. Community involvement in all aspects of public health activities including assessment are encouraged and expected. However, the majority of community interaction related to assessment has been through collaborations and partnerships with public health system partners rather than with direct community residents. To date, there is little in the published literature about the process and interaction between a local health department and minority groups in the development and implementation of CHAs.

Given the rapidly changing demographics, health care needs, new and emerging public health threats, effective community engagement is more critical today than ever. The findings from this study underscore the importance of early engagement with minority communities in the conceptualization, design, and development of a CHA. Moreover, this study reveals the complex nature of the interactions among key factors that contribute to an effective working relationship between a LHD and minority communities. Each community brings its own experience, history, perspectives, opinions, and priorities to the process which must be reconciled, honored, and
respected in order for the process to lead to a positive outcome for all involved. Data from this study suggest that the PHD should reconsider its approach and overall methodology for addressing its core assessment functions when working with minority communities. This department’s experience and lessons learned fill a gap in the existing literature and should be leveraged in support of other local health departments across the nation who face similar challenges in meeting their assessment core function in ways that result in tangible, actionable, benefits for all involved.

This case study examined the relationship and interconnectedness between six key constructs of community engagement as it relates to implementation of recommendations that are identified in CHAs: drivers for a CHA, the history of partnership and collaboration, community knowledge, power/authority, PHD and community infrastructure to support action, and ownership through document review, key informant interviews, and focus groups. Barriers and facilitators were also examined. In addition to these constructs, co-learning and agency emerged as relevant to the process of community engagement. Each of these constructs is important in achieving effective community engagement and believed to be precursors for implementation and action.

However, it is the process represented by these constructs that are critical to achieving the desired goal of implementing community identified priorities to achieve community health improvement. The context in which this process occurs is also significant. The SCCPHD’s approach to community health assessment has been historically rooted in the scientific method where researchers ask a question, collect data to address the question, analyze and report the data. Communities are engaged as means to an end in this process, rather than in the design and
approach to assessment. This is due in part because community health assessment is the responsibility of epidemiologists who may be exceptionally trained methodologists, but may lack an understand of the principles and practices associated with community engagement. Public health departments whose goal is to improve health in minority communities through effective community engagement and community health assessment must rethink the approach used to CHA development. Communities must be brought in early and be part of the design and approach to CHA development if implementation of recommendations is a desired goal. More importantly, CHAs must reflect the priorities and capacities of the community and the health department.

Working within this paradigm, the interconnectedness of the key factors of community engagement becomes even more essential for determining whether CHAs will move to action. Latino participants in this study indicated that none of the constructs and associated factors explored was present during the CHA process between the PHD and the community. As a result, both PHD and Latino study participants reported that no action had taken place or that they were not aware of any action that occurred as the result of the CHA. Alternatively, African American and PHD participants indicated that although there was no relationship prior to the planning stage of the CHA process, the groups took the time to develop shared goals, vision, and agreements. They reported that they had developed a shared workplan outlining action steps to address the recommendations from the CHA. Therefore, a first step to effective community engagement is a clear understanding of purpose, as well as shared vision, and goals. In the course of developing shared purpose, groups are likely to improve their knowledge of each other build trust and understanding, and improve communications. All of which are important elements to overall effective community engagement.
Despite the inherent challenges experienced by study participants in the course of developing a CHA, participants expressed a desire to build partnerships. For the African American and PHD participants, this was most likely a result of each other’s willingness to learn, be influenced, share power, and leadership. Over an 18-month period, this group became a cohesive team and worked together to both accomplish a CHA and workplan to address the most pressing community priorities. This group’s evolution may be categorized as having gone through the five stages of team development: forming, storming, norming, and performing (Tuckman, 1965). In the forming stage, the PHD and the African American community worked to identify the people who would work together to develop a CHA. In the storming stage, the groups encountered tension due to mistrust, lack of understanding, power differentials, individual styles, personalities and value systems, and implicit and unstated expectations. While this group remained in this stage for a substantial amount of time, working through each issue most likely led to a desire to sustain and build stronger partnerships. In the norming and performing stage, this group learned to appreciate and value each other’s contributions resulting in satisfaction with both the process and the outcome of the CHA. This group had become an effective team where each individual felt connected to the overall goal of improving health in the African American community. This group is likely to continue to partner in new ways in the future. The experience of Latino study participants was markedly different. While this group came together to develop a CHA, there was not enough interaction between them to develop the notion of team or partner through the process of CHA development. This group did not discuss a shared vision, expectations, priorities, or the design or approach to the CHA.

Community health assessment offers PHDs with the opportunity to interact, learn from, and build relationships with minority communities. Co-learning supports effective community
engagement. It also may help in building a strong foundation necessary for long-term partnerships. While co-learning was not specifically identified in the documentation, interviews, or focus groups, the process of co-learning is important and relevant to understanding deep and effective community engagement. Co-learning occurs when knowledge is shared and equally valued between people and groups. Co-learning occurs where there is trust and shared power. These are all elements associated with partnership and collaboration which are necessary for moving from planning, to action, and shared accountability. This study revealed that the PHD and each community had little knowledge of each other’s strengths, capacities, and histories. Developing time, and space and multiple ways to co-learn from one another will help foster deeper community engagement and relationship building.

Stuttaford, London, and Glattstein-Young (2015) link co-learning to agency. Agency is the belief if one’s ability or capacity for action. The author’s believe that knowledge is also essential to agency, and that agency is tied to power. Like co-learning, agency was not directly found in the data reviewed for this study. However, agency is likely an important contributor to the strong sense of vision, direction, and desired action illustrated by the African American participants in this study. Therefore, it is important to consider community agency when working to engage communities in CHA development and action.

All study participants indicated that they had learned something they considered beneficial as the result of the CHA development process. African American participants said they learned that the PHD could be a good partner to the community. Latino participants were more aware of the type of relationship they desired to have with the PHD. Lastly, PHD participants acknowledged a need to build capacity to address CHA requirements in
fundamentally different ways. This self-awareness of the need to change may be supported through self-reflection. PH professionals should be encouraged to be self-reflective as a way to support on-going improvements, capacity, and knowledge building that will foster meaningful engagement with minority communities.

VI. RECOMMENDATIONS

The results of this study suggest that the community engagement process used in the development of a CHA is as important, if not more so, than the impact of the CHA itself. To effectively engage communities, PHDs will need to give thoughtful consideration to the design and approach to CHA development, as well as to the capacity to adapt and align with community priorities, values, and expectations. The following recommendations are based on the study’s results, literature review, as well as researcher experience, and are offered in the spirit of supporting PHDs capacity to engage deeply with minority communities.

1. **Time, Proximity, Commitment.**

This study revealed that the PHD had no prior experience working with the African American or Latino community in the area of assessment. It is important to recognize that building relationships with minority communities takes time. Public health employees need flexibility and opportunities to work closer with communities without the constraints of timed deliverables or PH agendas. Strong relationships with communities must be cultivated and nurtured on an on-going basis by all staff in the Department, but most importantly by the leadership structure within the Department. Leaders must not abdicate their role in building strong community ties to staff particularly when organizational values and strategic priorities profess community building and community engagement as critical to meeting the mission of
public health. Leaders must model the commitment to minority communities through department and community wide actions and hold all staff accountable for the same.

2. **Design for Action.**

   If community and organizational action is expected from a CHA process, the process must incorporate an action planning model or practice at the onset. Community and organizational strengths and challenges must be acknowledged and incorporated into the planning process to identify both feasibility and probability for successful action. The PHD must engage communities in the development of CHAs with a clear understanding of organizational limitations, commitment, and resource availability. These must be made explicit as PHD employees engage with minority communities in this work. Likewise, communities have limitations and strengths that must be brought to the forefront in order to support community action. PHD’s can support and cultivate community capacity building by sharing and incorporating best practices, models, and strategies such as asset mapping, assist in building community networks, and facilitating civic engagement.

3. **Training, Education, and Leveraging Cross Disciplines.**

   Effective community engagement requires a deep understanding of a community’s history and cultural frame. Training and education is important to understanding the role and position of the PHD and how it may be perceived by members of minority communities. Public health employees should strengthen their skills in dialogue and facilitation which can be utilized to clarify purpose, roles, capacity, and expectations with community partners. In addition, all public health employees should take refresher courses on the ethical principles of public health practice which could help to differentiate and identify when public health engagement is “top-down” rather than “bottom-up” and the implications from each type.
PHD staff assigned to community health assessment functions should recognize and leverage the various skill sets available to them from work across disciplines. In Santa Clara County, the assessment functions are primarily assigned to epidemiologists. While epidemiologists have many strengths, community engagement and facilitation may not be one of them. Assessment functions could be addressed by leveraging the skills and strengths available to public health departments by pooling staff from across areas to address requests for populations specific CHAs. These staff may range from community planners, community workers, resident leaders, promotoras, health educators, nurses, and physicians.

4. **Diversify the PH workforce**

It is important that the PH workforce be representative of the diverse communities it serves. The community stakeholders in this study emphasized the importance of working with people who resembled their community. This was a major barrier identified for both the African American and Latino communities. African American study participants emphasized the importance of understanding the lived experience of African Americans, while Latino study participants felt underrepresented at higher levels of the PHD. While many PHDs are actively working towards this goal, it is important that diversity be reflected at all levels of the organization (from front line to executive leadership). There are many ways to achieve this important goal. One way is to mentor and facilitate upward mobility for emerging minority leaders within a public health department. PHDs can also work with their local school districts and university partners to expose students to public health careers.

5. **Build and Identify Adaptive Leadership Capacity at All Levels**

Community health assessments are intended to be used to develop strategies and action to improve community health. When CHAs are developed about communities without active
participation by those communities, the utility of CHAs and the reception by communities to new studies plummets. Public health departments must work together with communities to develop skills, and training that encourage and prepare residents to participate in public health activities (civic engagement). At the same time, leadership must be strengthened at all levels of public health practice, in order to defend, encourage, and support creative ways to engage and sustain non-traditional community partners in community health assessment and action. Leadership in public health departments should be *adaptive, systemic and pervasive* in order to fulfil the mission of public health and the promise behind community health assessment activities. Public health leaders must also recognize when CHAs are counterproductive or even damaging to communities and balance this reality within the complex environment in which these decisions are made. Leaders must be able to firmly object to directives that do not take into account community or organizational readiness to address recommendations that result from CHAs and offer alternative solutions. Leaders also have an important role in building knowledge and understanding of Public Health’s role in assessment and the role that communities play with elected officials, formal and informal community leaders. There are several resources available through the National Association of County and City Health Officials (NACCHO) that can support PHDs in achieving these goals. There are also many promising practices such as San Diego’s resident leadership academy which supports neighborhood level empowerment and community capacity building. PHDs can also support building leadership capacity especially adaptive leadership by establishing a community of practice. A community of practice brings together people with a shared interest and allows reciprocal learning and knowledge exchange which may support building bench strength for public health leadership now and into the future.
6. **Build Visibility and Advocacy for Public Health**

The general public is unaware of the important role that public health departments have in working to ensure the health and well-being of communities. Public health departments are often indistinguishable from other governmental entities. Public health practice has roots in social justice and equity movements that should be celebrated and shared widely especially with minority communities. While public health departments may not be resource rich, there are many opportunities to share best practices, lessons learned, and data with minority communities that can help support community capacity building efforts. The more the public understands about the role that the public health department plays in keeping communities safe and healthy, the more likely they are to advocate, support and defend public health. Moreover, when minority communities understand the value system of public health practice, they may be more open to collaboration and partnership with PHDs.

7. **Accountability**

Public health departments operate within complex political environments where needs often outweigh capacity. Despite this complexity, health departments must be accountable to the communities they serve. One way to do this in relation to their community health assessment role is to create transparency. Elected officials must understand that community health improvement does not start and end with data collection. Public health leaders must ask for comprehensive funding that includes and prioritizes the action phase. Communities should understand why CHAs are being done and how the data will be used. PHDs should continue to engage communities even after the CHA process is complete in order to gauge community understanding and action or inaction. This type of feedback loop will ensure that PHDs are
continuously learning and putting into action lessons learned in real time. This may mean radically changing the approach to community health assessments up to and including refusing to do CHAs that are not community driven or where no capacity exists to take CHA findings to action.

Importance of Reflection

One way to support PH practitioners to be accountable while building adaptive leadership skills and support on-going learning is to encourage and grant dedicated time for self-reflection. Without reflection, public health improvements in how CHAs are developed or how a PHD works with community may be slowed or not occur at all which may perpetuate past systemic abuses of already vulnerable communities. It may also result in an affront to the important role of being strong stewards of public funds when CHAs are completed, but do not lead to action or community improvement.

8. Support Action Phase

Even when deep meaningful engagement is experienced between a community and a PHD, there is no guarantee that a CHA will lead to action. Both the African American and PHD participants in this study reported high satisfaction with the process used to develop a CHA of the African American community in Santa Clara County. While there was optimism in the ability to advance CHA findings to action, no tangible action had been achieved at the time of this study. PHDs can support the action phase by leveraging its broad network of partners to support the action phase. This includes facilitating connection to funders or partnering with communities to prepare grant proposals or support communities in taking a phased approach to implementation.
Revised Conceptual Model

Findings from this study illustrate the interconnectedness among the six main constructs and 19 associated factors examined in this study. Each construct and factor was reviewed to determine whether it was present before, during, and after, the development of a CHA for each community and the PHD, respectively. While all constructs and factors are thought to be critical for effective community engagement and action, two additional constructs, co-learning and agency, are assumed to interact with other constructs throughout the community engagement process. Areas of potential interaction with these two additional constructs are as follows:

1. Construct: Genesis/background for CHA
   Factors: PH directed, community directed, overall experience with PHD

2. Construct: History [co-learning, agency]
   Factors: Attitude, beliefs, values

3. Construct: Knowledge [co-learning, agency]
   Factors: Trust, data obtained and used

4. Construct: Power/Authority [agency]
   Factors: Fairness, decision making, expectations

5. Construct: Infrastructure
   Factors: Time, resources, skills, leadership, commitment

6. Construct: Responsibility for Action [co-learning, agency]
   Factors: PHD, community, action to date

While co-learning and agency were not directly supported by the documentation, interviews or focus groups, these two additional dimensions likely contribute to the differences
observed among the PHD, African American, and Latino study participants. For these reasons, a revised conceptual model is proposed. The original conceptual model reflects the assumption that prior to working to develop a CHA, communities and the PHD already have knowledge of one another, believe in fair and equitable processes, trust one another, have power and understand the need to share it. All of these factors interact and are important starting points in the process of CHA development.

However, given that knowledge and power have been linked with both agency and co-learning in the literature, it is important that they be reflected and further considered in the conceptual model which provides the framework for this study (Pratto, 2016; Schultz, et al, 1998). As communities gain knowledge, the notion of power or empowerment experienced by the community is also likely to increase. It is therefore plausible to theorize that individuals or communities that are empowered also have a strong sense of agency. This observation was made when analyzing the perspectives and opinions of African American study participants. Many of these participants believed in the importance of community self-determination as evidenced by a strong desire to develop and lead a CHA process deeply rooted within their own cultural frame and community capacity. This community also expressed a strong commitment to the action phase of the CHA. There was also a strong belief in the community’s leadership and capacity to address the community’s concerns that resulted from the CHA. The process of co-learning is believed to contribute to continuous knowledge generation throughout the entire engagement process. This process is likely to be cyclical in nature rather than a linear process (Figure 14).
Figure 14: Relationship between agency, power, knowledge

Co-learning and agency are additional dimensions reflected in the updated conceptual model (Figure 15). This model reflects the ideal community health assessment scenario whereby effective community engagement occurs between a community and the health department leading to action and ultimate change. First, before the work of CHA development begins, there must be a discussion and on-going dialogue between a community and the PHD to understand each other’s attitudes, beliefs, history and experiences, perspectives about inclusion, power-sharing, commitment to shared ownership, and a sense of agency, in order to arrive at a shared understanding of goals and shared direction and design for a CHA. Second, during CHA development, the community and the PHD must have capacity and assets to move CHA priorities into implementation and action. These include human resources, skills, time, funding, leadership, commitment, authority, and ability to mobilize the community and the PHD to implement CHA recommendations. Third, communities and the PHD must work together to
support, build, and sustain a relationship throughout the implementation phase. Important to each of these phases is the importance of reciprocal learning or co-learning. In co-learning, everyone benefits from knowledge exchange, and everyone’s contributions are respected, valued, and viewed as beneficial to the overall process. Therefore, co-learning is a construct shown in the center area of the concept map where all three phases or rings overlap. Effective community engagement is thought to occur when all of these conditions are met increasing the probability of CHA implementation and action.

**Figure 15: Revised conceptual model**
Study Limitations and Challenges

Design and Generalizability

Using a case study research design has both strengths and limitations. While an important benefit of case study design is that it allows researchers to study a “contemporary phenomenon within its real life context “(Yin, 2009), it also means that the researcher has little control of the events and environment. This results in low statistical generalizability affecting external validity and to some extent construct validity. However, case studies are generally meant to contribute to theoretical generalization. Since this case study is explanatory in nature, generalizability to other contexts is limited. However, because a key aim of the study was to learn about the phenomena in more depth, findings from the study are expected to contribute to increased learning, discussion and further research that may support practice changes at both the system (health department) and community level in relation to health assessment as a core function of public health practice.

Another potential limitation of this case study lies in its design as a single case rather than a multiple case study design. The single case study design in this study was an appropriate choice because the Santa Clara County Public Health Department is not necessarily unique in how it applies community engagement to meet its health assessment core functions and therefore, may represent a typical health department. This rationale meets one of the five reasons outlined by Yin (2009) for carrying out a single case study.

Document Acquisition and Review

A total of 24 documents were collected and reviewed for this study. Minutes and agendas from meetings were provided by PHD study participants. A proposal to the BOS from the African American community for a multi-phased assessment was provided by an African
American participant. The remaining documents were found in the public domain mostly from county websites. Therefore, it is possible that other documents important to this study’s aims were not reviewed. It is also possible that important concepts and information may have been missed during the review of the documents that were collected. While many of the documents were short (1-15 pages), others were long (100+ pages) increasing the probability of error.

**Outreach and Enrollment of Study Participants**

Despite approval at three levels (PH research group, UIC IRB, SCVHHS IRB) and the support of three gatekeepers representing each of the groups in this study (PHD, AA, and Latino), outreach and recruitment was challenging. This was especially the case for the African American Community. The initial goal of this study was to hold two focus groups with the community and speak with 7-10 stakeholders. Despite receiving a letter of support from the African American Community Services Agency and active circulation of the outreach flyer, only one focus group was held and six interviews were conducted. Still those that did participate did so even if they were out on leaves or traveling. Nevertheless, it is not clear if adding an additional focus group and key informants would have changed the outcome of the study. This could have been due to the small population size of the African American community in Santa Clara coupled with the timing of the study’s approval in December.

PHD employees were allowed to participate in the study during work hours. All of the PHD employees were known to the interviewer. The consent was reviewed with every study participant, but an emphasis was placed on the voluntary nature and confidentiality of the study with PHD employees in order to encourage them to speak freely.
Regardless of the challenge with recruitment, the individuals that participated represented a broad range of perspectives, ages, and experiences which provide opportunities for rich exploration of the research questions.

*Interview and Focus Groups*

The interviews and focus groups were semi-structured and guided by questions specific to the group. While the questions were the same or similar across groups, many questions were left unanswered particularly if they did not apply to a specific group or individual. In some cases, individuals answered the same questions differently suggesting that the question was either unclear or a poor question. Some participants found a few of the questions redundant or the sequence confusing particularly those questions that asked specifics about what might have been in place before, during, and after the CHA process. These questions could have been structured differently or simplified.

*Coding*

A second coder helps improve reliability of qualitative studies. For this study, the original secondary coder who committed to supporting the study had to withdraw due to other commitments. Nevertheless, a second coder was identified with expertise in qualitative methods and experience with Atlas.ti. However, given the volume of transcripts, it was decided that she would code only a random sample of transcripts by hand. There are limitations with this method including that the sample of transcripts may not have been sufficient to ensure adequate reliability. Despite this limitation, her expertise in coding was valuable and her addition of codes resulted in going back to check and verify earlier transcripts.
VII. CONCLUSION: LESSONS LEARNED

This study contributes to the on-going discussion about the importance of engaging with communities to advance public health goals. Community engagement with minority communities in the development of CHAs is one important facet of this dialogue. The examination of six constructs and 19 factors associated with effective community engagement (purpose, history, knowledge, power/authority, infrastructure, and ownership) in addition to co-learning and agency has several important practice-based implications for public health practitioners tasked with community health assessment.

First, the community engagement model and the process inherent in the model are paramount to supporting an assessment process that effectively leads to action. The PHD is partially, if not wholly responsible for ensuring that model practices are operationalized in a manner consistent with the overall intent of community action. This means rethinking or reframing the approach to community health assessments to incorporate additional models, tools or practices such as asset mapping for both community and the PHD in order to support clear, action oriented goal and activities. If CHAs are developed with the intention of leading to action, then they must be developed from the beginning in a manner consistent with this goal.

PHD practitioners and community members involved in CHA development must see beyond the collection of data and think critically about the desired actions resulting from the process prior to engaging with communities. Data on the issues most prevalent in minority communities is important and one that the PHD participants of this study believed was paramount and directly aligned with the mission and value system of the PHD. But the reality is that data alone will not address the problems and issues confronting African American and Latino communities in Santa
Clara County. Incorporating self-reflection as an important component of CHA planning may help generate important questions to support success, “Are we setting this process up for action? If so, how, who, and by when?”, “Are there alternatives we haven’t thought of?” Otherwise, data collected for data sake, while important, may not necessarily lead to action by any of the parties involved.

Second, community involvement in the early planning stages of CHA development is critical. If communities are not involved in the design, planning and data collection phases of a CHA, they are less likely to commit to implementing the recommendations that result from them even when communities have the infrastructure, assets, leadership, and mobilization capacity to do so. Without early and sustained commitment and buy-in from communities, the outcome of a CHA may be viewed as someone else’s responsibility. An unintended consequence of developing CHAs without meaningful community engagement is that PHDs may actually perpetuate the sense of betrayal and mistrust that exists within minority communities. A clear sense of shared purpose, goals, mutual benefit, and level of responsibility for any action associated with a CHA should be discussed and agreed upon by all parties involved before embarking in a CHA.

Third, PHDs and communities must take a pragmatic approach to CHA development. There must be capacity to move findings to action from both the PHD and the community. If agency, infrastructure, resources, funding, commitment, lack of vision, and leadership is missing, then it is highly unlikely that CHAs will have a positive impact. Moreover, effective community engagement may not occur.
Lastly, several opportunities exist to support capacity building for PHDs and minority communities to foster deep meaningful and lasting relationships built on trust, understanding, and commitment. One way is to create opportunities for knowledge exchange. This can be done in a variety of ways such as creating a community of practice that includes residents, or providing leadership training for PH staff and residents, as well as encouraging minority community leaders to sit on PH advisory boards or commissions. PHDs and communities must also continue to look for opportunities to work together when no directive or grant requirement exists. PHD can demonstrate their commitment to working with minority communities by offering training in facilitation, community capacity and community engagement models and practices, and by diversifying the workforce to reflect the communities they represent.

Public health departments fulfill their assessment functions in a variety of ways. Community health assessments are one way to understand and address pressing community health issues. While there are mixed perspectives in the literature about the importance or impact of CHAs, there is a lack of information about the process used in their development and in the role that minority communities play in these processes. Findings and recommendations from this study help address this gap by providing different perspectives, opinions, and recommendations for changing and improving the approach to how PHDs address community health assessment requirements to align with organizational and minority community values, goals, and capacities. This study offers PHDs engaged in community health assessment with an alternative perspective on the use of CHAs. CHAs may be used by PHDs as a tool for working towards genuine community engagement important to the elimination of health inequities and disparities in minority communities.
Cited Literature:


VITA

ROCIO G. LUNA, MPH

EDUCATION

Drexel University, Philadelphia, PA  
Certificate in Epidemiological and Biostatistical Principles & Methods  
July 2006

University of North Carolina, Chapel Hill, NC  
Certificate in Field Epidemiology  
June 2006

San Jose State University, San Jose, CA  
Master of Public Health, Community Health  
May 1998

University of California, Los Angeles, CA  
Bachelor of Science, Physiological Sciences  
June 1992

PROFESSIONAL EXPERIENCE

Santa Clara County Public Health Department (SCCPHD), San Jose, CA  5/1999-Present

• Branch Director, Healthy Communities (1/2016- present)  
  Responsible for providing leadership over assessment, community planning, evaluation, chronic disease and injury prevention programs, and interventions.

• Division Director, Assessment, Planning & Health Policy (5/2010-present)  
  Responsible for providing leadership on the strategic direction of public health programs, policies and interventions.
• Director of Public Health Research, PH Planning & Preparedness Division (1/2004 – 4/2010)
  Responsible for the development of a data driven framework to help guide departmental direction.

• Health Program Specialist, Assessment & Quality Improvement Division (12/2001-12/2003)
  Providing leadership on performance based budget initiatives through performance management and evaluation initiatives.

• Senior Health Care Analyst, Research, Planning & Evaluation Division (12/2000-11/2001)
  PH representative leading and facilitating large community planning efforts in diverse communities.

  Assist with building the visibility and PH support for large evaluation initiative.

• Health Care Manager I, Health Promotion Division (9/1999-7/2000)
  Provide vision and direction on maternal & child health programs and interventions.

• Health Planning Specialist III, Health Promotion Division (5/1999-8/1999)
  Lead a multidisciplinary team in research study on elevated lead levels throughout the County.

The SCCPHD is part of a large health and hospital system dedicated to providing affordable, quality care to the county’s 1.8 million residents. Its mission is to prevent disease and injury and create environments that promote and protect the community’s health.

**Kaiser Permanente, Santa Clara, CA**
1/1995-4/1999

• Community Health Representative, South Bay Public Affairs Department (6/1996-4/1999)
  Assist in the development to solutions for complex policy issues impacting community health.

• Health Educator, Gilroy Medical Offices & Santa Teresa Medical center (1/1995- 5/1996)
  Lead instructor for prenatal, diabetes, and smoking cessation wellness courses for monolingual Spanish speakers.

Kaiser Permanente is the one of the largest integrated managed care and hospital systems in the United States. For several years, Kaiser Permanente has received top ratings for their health plans and prevention model of healthcare delivery.
Bonaventure Surgery Center, San Jose, CA  
7/1993-12/1994  
An affiliate of Alexian brother’s hospital located in the eastern part of the city; currently managed by the Columbia/HCA Corporation.

Alum Rock Union School District, San Jose, CA  
8/1992-6/1993  
Humanities teacher, Sheppard L. Fischer Middle School

PUBLICATIONS


PRESENTATIONS


**TEACHING**

San Jose State University, San Jose, CA 2002-2003
Health Sciences Division, Instructor
Appendix A: Data Collection Table and Protocol

**Main research question:** How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

**Sub-research questions:** (1) What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete? (2) What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?

<table>
<thead>
<tr>
<th>Sub-Construct</th>
<th>Concepts to Explore</th>
<th>Measures</th>
<th>Data Source</th>
<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairness</td>
<td>Community and LHD</td>
<td>• Reported level of participation in decision making throughout planning, data collection, strategy development, and implementation (either past or present experiences)</td>
<td>• Document review (assessment related agendas, minutes, MOUs etc.) • Key informant semi-structured interviews (21-30) 7-10 per community: LHD, Latino, AA • Public information available from funders, community groups, and LHD.</td>
<td>Thematic coding with ATLAS.ti using a hybrid approach: a priori framework / grounded theory Within case analysis; cross case analysis Perspective</td>
</tr>
</tbody>
</table>
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**Main construct:** Factors associated with effective community engagement BEFORE/PRIOR to assessment activities

<table>
<thead>
<tr>
<th>Sub-Construct</th>
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<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beliefs</td>
<td>Community and LHD</td>
<td>• Perspectives and demonstrated value/importance placed on maximizing community and LHD voice/position • Perspectives and demonstrated level of influence of community and LHD in decision making, priority setting • Alignment of process with community need/timing</td>
<td>• Document review (agendas, minutes, strategic plans MOUs etc.) • Key informant semi-structured interviews • Focus groups (total of 4; 2 Latino, and 2 AA) • Public information available from funder, community group, and LHD website</td>
<td>Thematic coding with ATLAS.ti Within case analysis; cross case analysis - Perspectives underlying themes</td>
</tr>
<tr>
<td>Knowledge</td>
<td>• Extent/degree of knowledge about</td>
<td>• Exchange of</td>
<td>• Planning documentation</td>
<td>Thematic coding;</td>
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<tr>
<th>Main construct: Factors associated with effective community engagement BEFORE/PRIOR to assessment activities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-Construct</strong></td>
</tr>
<tr>
<td>each other (community and LHD)</td>
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<tr>
<td>Trust</td>
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</tbody>
</table>
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Main construct: Factors associated with effective community engagement BEFORE/PRIOR to assessment activities

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<th>Analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Power</td>
<td>• Explore who is and who ought to be a decision maker in an assessment process/applied research activity? • What resources are or should be controlled by decision-makers? • What can decisions can or ought the decision-maker(s) control or not control?</td>
<td>• Boundary questions developed and integrated into the semi-structured interview questions • Level of influence reported by community and LHD • Committed resources</td>
<td>• Archival documents • Literature • Public documents • Key informant interviews, focus groups • Field notes, memoing</td>
<td>Thematic coding, within and cross case analysis</td>
</tr>
<tr>
<td>Ownership</td>
<td>• Perspectives on who owns the research project from planning, data collection to action</td>
<td>• Demonstration of shared responsibilities/ownership/accountability • Expectations outlined and clarified • Level of support for acting on community</td>
<td>• Planning documents (meeting notes, MOUs, project charters, meeting agendas • Public information (board meetings, reports, financial reports). • Key informant interviews,</td>
<td>Thematic analysis, within and cross case analysis</td>
</tr>
</tbody>
</table>
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| **Main construct:** Factors associated with effective community engagement BEFORE/PRIOR to assessment activities |
|---|---|---|---|
| **Sub-Construct** | **Concepts to Explore** | **Measures** | **Data Source** | **Analysis** |
|  |  |  | or LHD priorities | focus groups |
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**Main construct:** Factors related to effective community engagement DURING assessment activities

<table>
<thead>
<tr>
<th>Sub-construct</th>
<th>Concepts to Explore</th>
<th>Measures</th>
<th>Data Source</th>
<th>Analysis</th>
</tr>
</thead>
</table>
| Time          | • Level of flexibility/adaptability to address community identified needs/priorities  
• Decision making and planning process done in a timely way | • Time lapse between initial engagement, planning, data collection, and implementation  
• Time lapse between decision points  
• Time between start/end for each implementation activity/recommendation/strategy | • Documents (charters, agendas, minutes, report drafts)  
• Key informant interviews, focus groups  
• Field notes | Thematic coding; cross case and within case analysis |
| Resources     | • Resources (quantifiable, in-kind) allocated to entire process through implementation and sustainability/maintenance | • Funding  
• Human resources  
• Infrastructure supports | • Documents (charters, finance reports; infrastructure)  
• Key informant interviews | Thematic coding; cross case and within case analysis |
| Skills        | • Knowledge and skills of individuals | • Experience levels of | • Documents (CV/resume, | Thematic |

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**Main construct:** Factors related to effective community engagement **DURING** assessment activities

<table>
<thead>
<tr>
<th>Community Organization</th>
<th>Community control, empowerment, awareness of changes needed</th>
<th>Past/present experiences; community histories</th>
<th>Documents (charters, finance reports; infrastructure)</th>
<th>Thematic coding; cross case and within case analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Linkage, community cohesion</td>
<td>Community leaders</td>
<td>Key informant interviews</td>
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<tr>
<td></td>
<td></td>
<td>Number of community specific channels</td>
<td>Field notes</td>
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<td></td>
<td>Thematic coding; cross case and within case analysis</td>
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<tr>
<td>Community Mobilization</td>
<td>Shared vision, priority, needs</td>
<td>Existing networks-scale and penetration</td>
<td>Documents (CV/resume, contracts, professional background; public documents; websites)</td>
<td>Thematic coding; cross case and within case analysis</td>
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<tr>
<td></td>
<td>Reinforcement of community network/cohesion</td>
<td>Past experiences/histories</td>
<td>Key informant interviews</td>
<td></td>
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<td></td>
<td></td>
<td>Supportive</td>
<td>Field notes</td>
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</table>

| | participants by skill type (management, organizing, finance, research building relationship – people skills) | contracts, professional background) | Key informant interviews, focus groups | Field notes | Thematic coding; cross case and within case analysis |
| |                                                                 | |                                               |                                               |                                               |

| | | | | | |

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<table>
<thead>
<tr>
<th>Community Leadership</th>
<th>Community Commitment</th>
<th>Authority</th>
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</thead>
<tbody>
<tr>
<td>Recognized leader(s) [people/organizations] of effort, movements, initiatives</td>
<td>Community buy-in/ representativeness</td>
<td>Decision making</td>
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<tr>
<td>Number and type of leaders</td>
<td>Collective action</td>
<td>Influence</td>
</tr>
<tr>
<td>Community recognition of leaders</td>
<td>Shared accountability</td>
<td>Process measures of decision making</td>
</tr>
<tr>
<td>Definition of community leaders</td>
<td>Past/present histories</td>
<td>Types of influence</td>
</tr>
<tr>
<td></td>
<td>Span of influence – networks</td>
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<td></td>
<td>Supportive networks [politicians, elected, other stakeholders]</td>
<td></td>
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<tr>
<td>Documents [charters, CVs]</td>
<td>Documents [charters, CVs]</td>
<td>Documents[ meetings, agendas]</td>
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<tr>
<td>Key informant interviews</td>
<td>Key informant interviews</td>
<td>Key informant interviews</td>
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<tr>
<td>Focus groups</td>
<td>Focus groups</td>
<td>Focus groups</td>
</tr>
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<td>Public information- websites, directors, newspaper, journal articles</td>
<td>Public information- websites, directors, newspaper, journal articles</td>
<td>Thematic coding; cross case and within case analysis</td>
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<tr>
<td>Thematic coding; cross case and within case analysis</td>
<td>Thematic coding; cross case and within case analysis</td>
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**Main construct:** Factors related to effective community engagement AFTER assessment activities

<table>
<thead>
<tr>
<th>Sub-construct</th>
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<th>Measures</th>
<th>Data Source</th>
<th>Analysis</th>
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<tbody>
<tr>
<td>Community Support</td>
<td>• Formal and informal networks</td>
<td>• Number of partnerships/collaboratives by sector</td>
<td>• Documents (grants, MOUs, charters, contracts, minutes, agendas)</td>
<td>Thematic coding; cross case and within case analysis</td>
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<tr>
<td></td>
<td>• Infrastructure</td>
<td>• Financing</td>
<td>• Key informant interviews</td>
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<td></td>
<td>• Capacity to implement and sustain recommendations</td>
<td>• Infrastructure</td>
<td>• Focus groups</td>
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<td>• Public websites- literature review</td>
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<td></td>
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<td><strong>Assigned to:</strong> implementation</td>
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<tr>
<td>Community Networks</td>
<td>• Resources</td>
<td>• Types and amount of resources</td>
<td>• Documents (grants, MOUs, charters, contracts, minutes, agendas)</td>
<td>Thematic coding; cross case and within case analysis</td>
</tr>
<tr>
<td></td>
<td>• Partnerships</td>
<td>• Level of participation by community members/ types of membership</td>
<td>• Key informant interviews</td>
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<tr>
<td></td>
<td>• Civic engagement</td>
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<td>• Public websites- literature review</td>
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**Main research question:** How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

**Sub-research question:** (1) What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete? (2) What are the expectations and perceptions of the Santa Clara County Public Health Department about the level of engagement expected from African American and Latino stakeholders once community health assessments are complete?

<table>
<thead>
<tr>
<th>Main construct: Factors related to effective community engagement AFTER assessment activities</th>
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<tbody>
<tr>
<td>Long-term Investment</td>
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<tr>
<td>• Sustainability and maintenance of effort</td>
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<tr>
<td>• Infrastructure</td>
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<td>• Resources</td>
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Appendix B. Semi-Structured Interview Guide for the SCCPHD

Introduction, explanation of the process and consent review:

Thank you for taking the time to talk with me today. I am meeting/talking to public health staff who have worked on previous health assessments both large and small with members of the African American or Latino community to learn more about how the health department engages these communities in this work. During today’s call or in person interview, I will be asking you a series of questions on the topic of community engagement that may take approximately 60-90 minutes. Have you ever participated in an interview before? Interviews are one way to collect information from leaders, professionals, and residents who have knowledge about a specific topic.

Please keep in mind that all of your responses will be kept strictly confidential. Your participation will not affect your employment status, or relationship or collaboration with the African American or Latino communities. No responses will be associated with names in my report. If there is something you say, which could be directly attributed to you, that I would like to include in my findings, I will ask your permission ahead of time.

Your participation in this interview and in this study is completely voluntary. You may withdraw your participation at any time. If I have collected data, it is my responsibility to destroy the information and I will not use it in my study. You can stop the interview at any time. You do not need to talk about anything you do not wish to discuss with me.

I will be recording this interview to ensure that I accurately capture your responses. Once the interview is complete, I will transcribe the recording into a word document which I will share with you so that you can validate its accuracy. Once the transcript is complete, I will destroy today’s recording. No names or other identifying information will be recorded. I will ask that you share a few demographic indicators with me including your gender; I will ask that you choose an age category, and whether you were born in the United States.

Do you have any questions for me? Are you willing to participate in today’s interview?

Great, if you are ready to ready to begin, the first question is…
<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td>Background</td>
<td>Profile of KI</td>
<td>• What is your ethnicity or ethnic background?</td>
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<td></td>
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<td>• What is your gender? Are you in the 18-35, 36-55, or over 56 years of age category?</td>
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<td></td>
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<td>• Were you born in the U.S or outside of the U.S.?</td>
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<td>• What is your position in the organization? Title?</td>
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<td>• What are your primary roles/responsibilities?</td>
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<tr>
<td>Genesis for working in partnership with AA/Latino community (contextual)</td>
<td>1. Please tell me how work with the AA or Latino communities to conduct health assessment activities began. Probes:</td>
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<tr>
<td></td>
<td></td>
<td>• How did they start?</td>
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<td>• Who was involved?</td>
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<td></td>
<td></td>
<td>• What was your role?</td>
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<td></td>
<td></td>
<td>• Were there agencies, organizations, or informal networks involved?</td>
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<td>• What catalyzed or instigated this work – what helped make it happen?</td>
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<td>• (mandated, political context, timing, strategic alignment, community inspired etc.)</td>
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<td>• Was the work formalized via an MOU, charter?</td>
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<td>• What was your experience working in these communities before the assessment related work?</td>
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<tr>
<td>BEFORE/PRIOR</td>
<td>Trust</td>
<td>2. In what ways has the PHD previously worked with these communities? Probes:</td>
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<td></td>
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<td>• What were some of the reasons/rationale for working with these communities?</td>
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<td>• How often does the PHD work with these communities? Details (number and type of collaboratives/partnerships)</td>
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<td>• At what level of the PHD, is this work initiated?</td>
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<td>• What are some of the drivers/reasons for working with the communities?</td>
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<td>• Specific to assessment, how often and in what capacity does the PHD work with these communities?</td>
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<tr>
<td>Beliefs</td>
<td></td>
<td>3. How important is it to the health department to be able to work with the AA and the Latino communities? Probes:</td>
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<tr>
<td>Domain</td>
<td>Construct</td>
<td>Question</td>
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</table>
|        |           | • How much value does PHD place on working with these communities? Explain  
|        |           | • In what other areas /capacities has the PHD department worked with these communities?  
|        |           | • How does the PHD integrate the views/perspectives of these communities into its operations? Give examples  
|        |           | • Who, in your opinion, best represents these communities in SCC? When you think about working with these communities, who do you think of first? i.e. a group, a CBO, a specific individual or groups of individuals?  
| Knowledge | 4. | What did you know about these communities before the assessment activities?  
|          | Probes: | • How was this information obtained?  
|          |          | • How is this information used?  
|          |          | • Are there specific people assigned to work with representatives from communities? Explain.  
| Fairness | 5. | At the start of the assessments, how did the health department address decision making and expectations with the AA and Latino communities?  
|          | Probes: | • Was a charter developed?  
|          |          | • What role, if any, did members of the targeted communities play in the decision making process involved in this work?  
|          |          | • What structure, model, or framework for decision-making was used for each community?  
|          |          | • What helped/facilitated this discussion (s), including discussions about expectations, during this phase of the work?  
|          |          | • What were some of the barriers in having the discussion? In this phase of the work?  
| Power | 6. | In your opinion, who has been the decision maker in past assessments or other related PH work that has involved these or other underrepresented communities?  
|        | Probes: | |
## Local Health Department Semi-Structured Interview Guide

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<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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<tbody>
<tr>
<td></td>
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<td>• Who ought to be the decision maker in health assessment work that involves representatives from various communities? Why?</td>
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<td>• Who has controlled the resources that go into health assessments? Why?</td>
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<td>• In your opinion, who should control the resources that go into health assessments? Why?</td>
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<td></td>
<td>• How are decisions made about who controls the resources in health assessments?</td>
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<tr>
<td>Ownership</td>
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<td>7. Who do you think is responsible for following up on the priorities and subsequent strategies outlined in a health assessment?</td>
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<td>Probes:</td>
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<tr>
<td></td>
<td></td>
<td>• Tell me why you think that.</td>
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<td></td>
<td></td>
<td>• If you have had past experiences working with these communities in assessment related activities, what has happened after the assessment is done?</td>
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<td></td>
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<td>• What do you think were some of the successes in following up?</td>
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<td>• What do you think were some barriers?</td>
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<tr>
<td>DURING</td>
<td>Time, Resources, Skills</td>
<td>8. Tell me about the time, resources, and people dedicated to working with these or other similar communities during and after a health assessment or related activity.</td>
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<td></td>
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<td>Probes:</td>
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<td></td>
<td>• Time from initial engagement to completion of assessment.</td>
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<td>• What factors influence the time, resource, and people given/allocated to these assessments?</td>
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<td>• How are the people identified or assigned to working on the health assessments?</td>
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<tr>
<td>LHD organization</td>
<td></td>
<td>9. In your opinion, how prepared is the PHD to work with underrepresented communities like the AA/Latino community in assessment related work such as a health assessment, or another</td>
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### Local Health Department Semi-Structured Interview Guide

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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<tbody>
<tr>
<td>LHD leadership</td>
<td></td>
<td>applied research project?</td>
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<tr>
<td>LHD commitment</td>
<td>Probes:</td>
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<tr>
<td></td>
<td>- Tell me more about why you think that.</td>
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<td></td>
<td>- What type of structure exists now to support this work?</td>
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<tr>
<td></td>
<td>- What type of structure is needed to support this work?</td>
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<td></td>
<td>- Can the PHD engage with these communities easily? Why or why not?</td>
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<tr>
<td>Authority</td>
<td>10. Who makes or controls decisions on health assessment work when it includes members of the AA/Latino communities?</td>
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<td></td>
<td>Probes:</td>
<td></td>
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<td></td>
<td>- How do the experiences, positions, like titles, etc. influence the process? (positional leadership)</td>
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<td></td>
<td>- How does change happen in these communities after an assessment or similar project?</td>
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<tr>
<td>AFTER</td>
<td>LHD support</td>
<td>11. What do you think is the commitment by the PHD to the community once the assessment work is complete?</td>
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<td></td>
<td>Probes:</td>
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<td></td>
<td>- What type and amount of resources is there to support the community once the assessment ends?</td>
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<td>- What are the barriers or facilitators to this support?</td>
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<td></td>
<td>- Who decides what type of support is provided?</td>
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<tr>
<td>LHD network</td>
<td>12. Please describe what other kinds of support the PHD provides to the communities at the end of the assessments:</td>
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<td>- Is this done formally or informally? Explain.</td>
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<td>- How is this decided?</td>
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<td>- For how long?</td>
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<td>- If there is no further engagement with communities, tell me why you think that is.</td>
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### Local Health Department Semi-Structured Interview Guide

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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<tbody>
<tr>
<td>Ownership</td>
<td>13.</td>
<td>What has the PHD done to address the community identified strategies or priorities in completed assessments to date?</td>
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<td>Probes:</td>
<td>- Are implementation workplans developed and assigned?</td>
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<td>- How is this monitored?</td>
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<td>- How does the PHD work with the communities during this phase of an assessment?</td>
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<td>- How is accountability addressed?</td>
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<td>- What are some challenges, barriers, or facilitators in this phase?</td>
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<tr>
<td>Summative Questions:</td>
<td>14.</td>
<td>What do you think are the major successes of engaging communities like the African American and Latino communities in health assessment work?</td>
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<td>Probes:</td>
<td>- What worked well or as expected?</td>
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<td>- What were some highlights of the process?</td>
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<tr>
<td>Summative Questions:</td>
<td>15.</td>
<td>What do you think have been some challenges of working with communities to conduct health assessments?</td>
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<td>Probes:</td>
<td>- What would you say are the major lessons or things to think about when doing this work?</td>
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<td>16.</td>
<td>What recommendations would you have for other health departments about engaging vulnerable or minority communities in this work?</td>
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</table>
ID Tracking Pseudonym: __________________ (Example: 1KI, 2KI)

Date of KI: ________________(mm/dd/yyyy)

Mode: ___ In person ___ Phone

Recorded: ___ Yes ___ No

Start Time: _______________ End Time: ____________________ Duration:__________

Ethnicity: ___ Latino _____ African American ____ Mixed _____ Other ___ Refused

Nativity: ________ U.S. born, _________ Born outside U.S. ________________ Refused

Gender: ___ Male ___ Female

Age: ___ 18-35 years old ___ 36-55 years old ___ 56+_________

Signed consent and dated consent: ___ yes ___ no (do not begin without)
Appendix C. Semi-Structured Interview Guide for African American & Latino KIs

Introduction, explanation of the process and consent review:

Thank you for taking the time to talk with me today. I am meeting/talking to members of the African American and Latino Community who have participated in past health assessment activities with the Santa Clara County Health Department to learn more about how the health department works with the communities in this area. During today’s call or in person interview, I will be asking you a series of questions on the topic of community engagement that may take approximately 60-90 minutes. Have you ever participated in an interview before? Interviews are one way to collect information from leaders, professionals, and residents who have knowledge about a specific topic.

Please keep in mind that all of your responses will be kept strictly confidential. Your participation will not affect current or future partnership or collaboration with the Santa Clara County Public Health Department. No responses will be associated with names in my report. If there is something you say, which could be directly attributed to you, that I would like to include in my findings, I will ask your permission ahead of time.

Your participation in this interview and in this study is completely voluntary. You may withdraw your participation at any time. If I have collected data, it is my responsibility to destroy the information and I will not use it in my study. You can stop the interview at any time. You do not need to talk about anything you do not wish to discuss with me.

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Do you have any questions for me? Are you willing to participate in today’s interview?

Great, if you are ready to ready to begin, the first question is…
**African American and Latino Community Semi-Structured Interview Guide**

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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</table>
| Background | Profile of KI | - Tell me a little about yourself?  
- Are you affiliated with an organization(s)? If so, what is your role there?  
Probes:  
  - What is your ethnic background?  
  - What is your gender?  
  - What age category would you say you belong to? 18-35, 36-55, or 56+?  
  - Were you born in the U.S? If born outside of the U.S., ask how long they have been in the U.S. (if appropriate).  
  - Tell me more about your organization/entity? |
| Genesis for working in partnership with the SCCPHD (contextual) | 1. | Please tell how work with the SCCPHD to conduct health assessment work in the AA / Latino community began.  
Probes:  
  - How did it start?  
  - Who was involved?  
  - What was your role?  
  - Who initiated working with the PHD? Was an agency, organization involved or an informal network?  
  - What catalyzed or instigated this work – what helped make it happen? (community request, mandate, politics, funding requirement, etc.)  
  - Was the work formalized via an MOU, charter?  
  - What was your experience working with the PHD before working with them in assessment related work? |
| BEFORE/ PRIOR | Trust | 2. In what ways has the AA/Latino community previously worked with the SCCPHD?  
Probes:  
  - What were some of the reasons/rationale for working with the PHD in the past?  
  - How often does the community work with the PHD? Details (number and type of collaboratives/partnerships that are known to KI)  
  - With whom have you worked with at SCCPHD? (note staff titles, backgrounds if known) i.e.educators, planners, executive leaders, epidemiologist  
  - What are some of the drivers/reasons for working with the |
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<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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<tr>
<td></td>
<td>PHD?</td>
<td>Specific to assessment, how often have you worked with the PHD on assessments with a focus on your specific community?</td>
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<tr>
<td>Beliefs</td>
<td>3.</td>
<td>How important is it to the AA/Latino community to be able to work with the SCCPHD?</td>
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<td></td>
<td>Probes:</td>
<td>How much value does the community place on working with the Department? Explain</td>
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<td>In what other areas/capacities/ways has the community worked with the Department?</td>
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<td>In what ways do you think about working with the PHD? Give examples</td>
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<td>Who, in your opinion, are the people in the health department that you should be working with? Why those people specifically? (skills, ethnicity/race, leadership, change agents)</td>
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<tr>
<td>Knowledge</td>
<td>4.</td>
<td>What did you know about the PHD before working with them on assessment activities?</td>
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<td>Probes:</td>
<td>How did you obtain the information?</td>
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<td>How was the information used? explain</td>
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<td>Fairness</td>
<td>5.</td>
<td>At the start of the assessments, how did the community address decision making and expectations with the PHD?</td>
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<td>Probes:</td>
<td>Was a charter developed?</td>
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<td>What role, if any, did members of the PHD assessment team play in the decision making process involved in this work?</td>
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<td>What structure, model, or framework for decision-making was used by the PHD?</td>
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<td>What helped/facilitated this discussion (s), including discussions about expectations, during this phase of the work?</td>
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<td>What were some of the barriers in having the discussion? In this phase of the work?</td>
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|              |           | If this did not occur, why do you think decision making was
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<th>Domain</th>
<th>Construct</th>
<th>Question</th>
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<td></td>
<td>Power</td>
<td>6. In your opinion, who has been the decision maker in past assessments or other related PH work that has involved your specific community?</td>
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<td>Probes:</td>
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<td></td>
<td>• Who ought to be the decision maker in health assessment work that involves your community? Why?</td>
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<td>• Who controlled the resources that went into the health assessments? Why?</td>
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<td></td>
<td>• In your opinion, who should control the resources that go into health assessments that are focused on your community? Why?</td>
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<td></td>
<td>• How were decisions made about who controlled the resources in the health assessments that involved your community?</td>
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<td></td>
<td>Ownership</td>
<td>7. Who do you think is responsible for following up on the priorities and subsequent strategies outlined in a health assessment that is focused on your community?</td>
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<td>Probes:</td>
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<td></td>
<td>• Tell me why you think that.</td>
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<td></td>
<td>• If you have had past experiences working with the PHD in assessment related activities, what has happened after the assessment is done?</td>
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<td></td>
<td>• What do you think were some of the successes in following up?</td>
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<td></td>
<td>• What do you think were some barriers?</td>
</tr>
<tr>
<td>DURING</td>
<td>Time, Resources,</td>
<td>8. Tell me about the time, resources, and people from your community dedicated to working with the PHD during and after a health assessment or related activity.</td>
</tr>
<tr>
<td></td>
<td>Skills</td>
<td>Probes:</td>
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<td></td>
<td>• Time from initial engagement to completion of assessment.</td>
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<td>• What factors influence the time, resource, and people given/allocated to this work from your community?</td>
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<td>Domain</td>
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<td>Question</td>
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<td></td>
<td>• How are people identified or assigned to working with the PHD on health assessments?</td>
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<tr>
<td>LHD organization</td>
<td></td>
<td>9. In your opinion, how prepared is the AA/Latino community to work with the PHD related to work such as a health assessment, or another applied research project? An applied research project is a project that has practical benefits to a community.</td>
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<td></td>
<td></td>
<td>Probes:</td>
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<tr>
<td></td>
<td></td>
<td>• Tell me more about why you think that.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What type of structure exists now in the community to support this work?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What type of structure is needed to support this work?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Can the community engage with the PHD easily? Why or why not?</td>
</tr>
<tr>
<td>Authority</td>
<td></td>
<td>10. Who makes or controls decisions in health assessment projects when it includes members/staff from the PHD?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Probes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• How do the experiences, positions, like titles, etc. influence the process? (positional leadership)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What change do you see from the PHD after an assessment that involves your community is done?</td>
</tr>
<tr>
<td>AFTER</td>
<td></td>
<td>11. What do you think is the commitment by the PHD to the community once the assessment work is complete?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Probes:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What type and amount of resources is there to support the community once the assessment ends?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• What do you see as barriers or facilitators to this support?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Who do you believe decides what type of support is provided to the community?</td>
</tr>
<tr>
<td>LHD support</td>
<td></td>
<td>12. Please describe what other kinds of support is provided to the community by the PHD at the end of the assessments:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Is this done formally or informally? Explain.</td>
</tr>
</tbody>
</table>
### African American and Latino Community Semi-Structured Interview Guide

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
</tr>
</thead>
</table>
| investment | • How is this decided?  
• For how long?  
• If there is no further engagement with your community, tell me why you think that is. |

| Ownership | 13. What has the community done to address the community identified strategies or priorities in completed assessments to date?  
Probes:  
• Is implementation of any of the recommendations under way? How are they organized? By whom?  
• How is this monitored?  
• How does the community work with the PHD during this phase of an assessment?  
• How is accountability in the community addressed?  
• What are some challenges, barriers, or facilitators in this phase? |

| Summative Questions: | 14. What do you think are the major successes of engaging the PHD in health assessments that focus on your community?  
Probes:  
• What do you think worked well or as expected?  
• What were some highlights of the process? What stands out to you about the process or your experience in working with the PHD? |

15. What do you think have been some challenges of working with the PHD in conducting health assessments of your community?  
Probes:  
• What would you say are the major lessons or things to think about when doing this work? for the community and for the PHD. |

16. What recommendations would you have for other communities |
African American and Latino Community Semi-Structured Interview Guide

<table>
<thead>
<tr>
<th>Domain</th>
<th>Construct</th>
<th>Question</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>about working with/engaging the PHD in this type of work?</td>
</tr>
</tbody>
</table>

ID Tracking Pseudonym: ______________________ (Example: 1KI, 2KI)

Date of KI: _________________ (mm/dd/yyyy)

Mode: ____ In person   ____ Phone

Recorded: ____ Yes   ____ No

Start Time: _______________   End Time: _______________   Duration: _______________

Ethnicity: ____ Latino   ____ African American   ____ Mixed   ____ Other   ____ Refused

Nativity: _______ U.S. born, ________ Born outside U.S. _____________ Refused

Gender: ____ Male   ____ Female

Age: ____ 18-35 years old  ____ 36-55 years old  ____ 56+__________

Signed consent and dated consent: ____ yes   ____ no (do not begin without)
Appendix D: Focus Group Semi-Structured Interview Guide

Introduction, explanation of the process, and consent overview:

Welcome and thank you all for agreeing to have a conversation with me. My name is Rocio Luna and I am talking with members of the African American and Latino Community who have participated in past health assessments with the Santa Clara County Health Department to learn more about how the health department works with your communities in this specific area. Have any of you participated in a focus group before?

Focus groups are one way to gather information from individuals who may have specific knowledge or expertise on a topic of interest. There are no right or wrong answers. I am here to learn from you. I will be asking you a series of questions on the topic of community engagement that may take approximately 60-90 minutes.

Your participation in this focus group and in this study is completely voluntary. You may withdraw your participation at any time. If I have collected data, it is my responsibility to destroy the information and I will not use it in my study. You do not need to talk about anything you do not wish to discuss with me.

Please keep in mind that all responses will be kept strictly confidential. Your responses will not affect current or future relationship/collaboration with the Santa Clara County Public Health Department. No responses will be associated with any names in my report. If there is something you say, which could be directly attributed to you, that I would like to include in my findings, I will ask your permission ahead of time.

I will be recording today’s conversation so that I can accurately capture your responses. I will then transcribe the recordings into a word document. I will share the transcript with you so that you may validate its accuracy. I will not use any names or any other identifying information in my transcript. Once the transcript is complete, I will destroy today’s recording. If anyone would like me to stop recording, please let me know and I will stop recording.

Before we begin, I would like to go over a few ground rules. First,

- The information shared in the focus group must be kept confidential.
- Please allow everyone to participate.
- Please be respectful of the experiences and opinions of others. Everyone’s experience is different, and I am asking that we honor those differences today.
- Place your cell phones on silent/vibrate please. If you must take a call, please step outside of the room to take it.
Would anyone like to add any other ground rules? [add them if applicable]

**Logistics:**

The restrooms are down the hall.

Feel free to help yourselves to refreshments.

*Does anyone have any questions before we get started? [Answer them first]*

If you are ready to begin, let’s start with…

**Focus Group Discussion Questions**

1. Before we begin, I would like to learn a little about each one of you. Can you please state your name, your background, any affiliation with an organization or group? **DO NOT AUDIO RECORD.**
   - **Probe/Clarification:** Ask about age range (if appropriate)

2. In what ways were you involved in the recent assessments conducted by the health department on the status of African American and Latino health? **AUDIO RECORDING BEGINS NOW**
   - **Probe/Clarification:** How did you first learn about the assessments? Did someone from the community tell you about it? Did someone from the PHD contact you about the assessment? Why did you decide to get involved? At what level were you involved? What role did you play?

3. What was your experience in working with the health department staff in the assessment?
   - **Probe/Clarification:** Was this the first time you were involved? If you were involved in previous health assessments/studies, tell me a little about your experiences with those. Has anyone from the department contacted you to let you know what happened once the assessments were done?

4. In what ways were you involved in the decision making processes about the assessments in your community?
   - **Probe/Clarification:** Were any of you involved in the planning phase? In the data collection phase? In developing recommendations to address the findings of the assessment? Describe.
5. How important is it for your community to work with the health department?
   - **Probe/Clarification:** In what ways? Explain.

6. Most health assessments conducted by the PHD have a set of recommendations associated with them to advance the health and well-being of the community. Who do you think is responsible for implementing or taking action on those recommendations?
   - **Probe/Clarification:** Tell me why you think that?

7. In what ways should the community contribute to advancing/taking action on those recommendations?
   - **Probe/Clarification:** Tell me why you think that?

8. What do you think the PHD can do to work closer with your community on future health assessments that focus on your community?
   - **Probe/Clarification:** What recommendations come to mind? Tell me more about those.

9. What do you think community leaders can do to take action on recommendations that come from health assessments focused on your community?
   - **Probe/Clarification:** What recommendations come to mind? Tell me more about those. What part can you play to spark action in this area?

10. What do you think is needed to implement the recommendations in past studies of the community? (African American or Latino)?
    - **Probe/Clarification:** What type of resources, structures, systems need to be in place both from the community and the PHD? Tell me more about that.

11. Do you know what happens after the completion of health assessments like the ones you were involved in?
    - **Probe/Clarification:** Where did you learn/hear that? What information is important for you to know once the assessments are done? What is the best way to communicate that to you? Who should the communication come from and why?

12. Is there anything else you would like to share with me about your experiences in working with the health department or members of your community to conduct health assessments?
ID Tracking Pseudonym: ____________________ (ex: #1FG AA, #2 FG LL)

Date of Focus Group:

Location of Focus Group:
Start Time: ___________ End Time: _______________
Duration: ___________
Recorded: ____ Yes _____ No
Ethnicity: ____ Latino _____ African American _____ Mixed _____ Other ___

Counts only in aggregate:
• Gender Profile: ____________ (ex: 3M, 3F)
• Age Profile: ____________(ex: 2 18-35 years old, 2 36-55 years old, 2 ____, 56+)
• Nativity: ______________
Appendix E: Information Sheet

Informed Consent Document

University of Illinois at Chicago (UIC)

Research Information and Consent for Participation in Social Behavioral Research

Community Engagement as a Key Determinant in Building Implementation Capacity of Local Health Department Health Assessments: A Qualitative Study

You are invited to participate in a research study about how community engagement between a health department and the African American and Latino community in health assessment activities may influence moving beyond data to the implementation of recommendations, strategies, and interventions intended to benefit the health and well-being of these communities. Please read this form carefully and ask any questions you may have before agreeing to take part in this study.

Researchers are required to provide a consent form such as this one to tell you about the research, to explain that taking part is voluntary, to describe the risks and benefits of participation, and to help you to make an informed decision.

Why am I being asked?

You are being asked to be a subject in a research study about the community engagement process that takes place during public health department assessment activities and its relationship to implementation capacity within a public health department and the African American and Latino community in Santa Clara County.

You have been asked to participate in the research because you have been involved with a community health assessment process involving the African American or Latino community conducted by the Santa Clara County Public Health Department. Your participation in this research is completely voluntary. Your decision whether or not to participate will not affect your current or future employment status, partnership or collaboration with the Santa Clara County Public Health Department or with UIC. If you decide to participate, you are free to withdraw at any time and for any reason.

Approximately 70 subjects may be involved in this research.

What is the purpose of this research?
This research explores various elements associated with the concept of community engagement to determine how they influence the planning, data collection and implementation process associated with community health assessment activities between the African American and Latino communities and the Santa Clara County Public Health department.

This research will also explore the experiences, perceptions, and opinions of Public Health Department staff, and members of the African American and Latino community about the level of engagement expected from each other once community health assessments are complete.

**What procedures are involved?**

This research will be performed either over the phone or in person at a location convenient to the participant. Each interview or focus group will take approximately 45 minutes to 1 hour to complete. The interviews and focus groups will be audio recorded to ensure accuracy of the collected information. All interviews and focus groups will be transcribed into transcripts that you will be able to review and edit.

The questions will explore the concepts of trust, past experience, inclusion/exclusion, power, ownership, resources, organization, commitment, support, authority and long-term investment, as well as recommendations and lessons learned.

**What are the potential risks and discomforts?**

The things you will be doing have no more risk of harm than you would experience in everyday life. You may be inconvenienced by taking time out of your normal day to participate. Focus group participants may feel uncomfortable sharing experiences and opinions in a group setting. There is also a risk of a breach of privacy because focus group participants will know that subjects are participating in research. There is also a risk of breach of confidentiality for both focus group participants and those participating in an interview from accidental disclosure of identifiable data.

**Are there benefits to taking part in the research?**

You may not directly benefit from participation in this research. However, you may enjoy the opportunity to share your experiences, and opinions with me, the researcher.

Results of this study will provide knowledge to public health practitioners that may help inform a practice change and approach to how local health departments conduct health assessments when working with minority communities. This study may provide perspectives from public health practitioners and community stakeholders from the African American and Latino communities about ways in which community health engagement can support the translation of data into action.
What other options are there?

You have the option to not participate in this study.

What about privacy and confidentiality?

The principal investigator, Rocio Luna, will know that you are a research subject. If you participate in a focus group, others in the focus group will know who is a research subject. Your information will not be shared with others without your written permission, or if necessary to protect your rights or welfare (for example, when the UIC Office for the Protection of Research Subjects or Illinois State Auditors or Dr. Eve Pinsker, as the faculty advisor monitors the research or consent process) or if required by law.

Confidentiality will be maintained by assigning a code number to all records. Your name will be not used in any of the information received in this research study or in any of the research reports. When the study is completed, I will destroy the list that shows which code number is assigned to you. There is a risk of a breach of confidentiality for both focus group participants and those participating in an interview from accidental disclosure of identifiable information.

Written notes, transcribed audio recordings, and consent forms will be kept in a locked filing cabinet in the office of the researcher. Transcripts will also be kept on two separate computers, a personal computer and laptop, that are both password protected.

Audio recordings, interview and focus group notes will be destroyed at the end of the study. Focus group participants will be given an opportunity to review a preliminary analysis of themes that arise from their specific focus group. My contact information will be made available to study participants at the end of each focus group with instructions to contact me if they would like to see the preliminary analysis.

When the results of the research are published or discussed in conferences, no information will be included that would reveal your identity.

Although I will ask everyone participating in a focus group to respect everyone’s privacy and confidentiality, and not to identify anyone in the group or repeat what is said during the group discussion, please remember that other participants in the group may accidentally disclose what was said.

What are the costs for participating in this research?

There are no costs to you for participating in this research.

Will I be reimbursed for any of my expenses or paid for my participation in this research?

You will not be offered payment for being in this study.
Can I withdraw or be removed from the study?

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. If you provided data to the researcher during an interview, it will be destroyed and not used in the analysis or reports. If you participate as part of a focus group, all data associated with that focus group will be destroyed and not used in the analysis or reports.

I also have the right to stop your participation in this study without your consent if I feel it is in your best interest not to participate.

Who should I contact if I have questions?

Contact the researcher, Rocio Luna, DrPH candidate, at 408-612-7965 or Rluna5@uic.edu or Rociogluna@gmail.com, or Dr. Eve Pinsker, UIC School of Public Health, Professor, at (773) 802-4802 or epinsker@uic.edu

- if you have any questions about this study or your part in it,
- if you have questions, concerns or complaints about the research.

What are my rights as a research subject?

If you feel you have not been treated according to the descriptions in this form, or if you have any questions about your rights as a research subject, including questions, concerns, complaints, or to offer input, you may call the Office for the Protection of Research Subjects (OPRS) at 312-996-1711 or 1-866-789-6215 (toll-free) or e-mail OPRS at uicirb@uic.edu.

Permission to audio record:

☐ I give my permission to be audio recorded.

☐ I do not grant permission to be audio recorded, and understand that I am no longer eligible to participate in the research study.

Remember:

Your participation in this research is voluntary. Your decision whether or not to participate will not affect your employment, current or future partnership or collaboration with the Santa Clara County Public Health Department. If you decide to participate, you are free to withdraw at any time without affecting that relationship.
Signature of Subject:

I have read (or someone has read to me) the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I have been given a copy of this consent, signed and dated.

______________________________  ____________
Signature                                Date

______________________________
Printed Name

______________________________  ____________
Signature of Person Obtaining Consent    Date (must be same as subject’s)

______________________________
Printed Name of Person Obtaining Consent
### Appendix F: Data Management Table

<table>
<thead>
<tr>
<th>Data</th>
<th>Why</th>
<th>How</th>
<th>Where</th>
<th>Security</th>
<th>Duration</th>
<th>Identifiers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Archival records, and documents logging</td>
<td>Logging, categorizing</td>
<td>Excel</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Until study end.</td>
<td>Broad categories only- i.e. workplan, public health strategic plan, agency strategic plan, etc.</td>
</tr>
<tr>
<td>Archival records, and documents</td>
<td>Study Data, categorizing</td>
<td>Word file folder</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Until study end.</td>
<td>May vary because these are actual documents that will be kept in electronic form in one place to support analysis and conclusions. No individual identifiers will be kept.</td>
</tr>
<tr>
<td>Individual and agency names with contact information found via web or referral</td>
<td>Initial recruitment tracking</td>
<td>Excel spreadsheet</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Until end of study/</td>
<td>Name, email, address</td>
</tr>
<tr>
<td>Interview participants</td>
<td>Tracking by category: PHD, AA, Latino</td>
<td>De-identified information in excel</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Duration of study.</td>
<td>None- generic alpha numeric coding only: KI #1, 2, by category</td>
</tr>
<tr>
<td>Interviews</td>
<td>Study Data</td>
<td>Recordings with consent</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Duration of study.</td>
<td>Alpha numeric coding, ethnicity/race, age range, nativity</td>
</tr>
<tr>
<td>Focus groups participants (if known)</td>
<td>Tracking by category: PHD, AA, Latino</td>
<td>Excel spreadsheet</td>
<td>Personal and home computer</td>
<td>Password protected</td>
<td>Duration of study.</td>
<td>Alpha numeric coding: African American Focus Group Participant #1, 2, 3, etc.</td>
</tr>
<tr>
<td>Focus group discussions</td>
<td>Study Data</td>
<td>Recordings with consent</td>
<td>Personal laptop and home computer</td>
<td>Password protected</td>
<td>Duration of study.</td>
<td>Alpha numeric coding, ethnicity/race, age range, nativity (as applicable**)</td>
</tr>
</tbody>
</table>

* This type of data may not be readily captured in a focus group setting. Participants will be asked to say something about themselves, and only these types of data will be captured, as applicable. Any additional identifiers will be eliminated from the final transcript.
### Appendix G: Code Dictionary Key Informant Interviews and Focus Groups

<table>
<thead>
<tr>
<th>Code name</th>
<th>Code Type</th>
<th>Definition</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Reasons for Assessment</td>
<td>Code Family</td>
<td>Drivers for CHA</td>
<td></td>
</tr>
<tr>
<td>1.1 Community initiated</td>
<td>Sub-code</td>
<td>Community directed</td>
<td>“it was always going to be resident driven…”</td>
</tr>
<tr>
<td>1.2 PH initiated</td>
<td>Sub-code</td>
<td>PHD directed</td>
<td>“My sense is that it always comes from our BOS making a request”</td>
</tr>
<tr>
<td>2. Past History</td>
<td>Code Family</td>
<td>History of collaboration; partnership</td>
<td></td>
</tr>
<tr>
<td>2.1 High past history</td>
<td>Sub-code</td>
<td>High history of collaboration; partnership</td>
<td>“I was very well aware of the role of the PHD… the agency that I work in has always collaborated very closely with the PHD”</td>
</tr>
<tr>
<td>2.2 Minimal past history</td>
<td>Sub-code</td>
<td>Little to no history of collaboration; partnership</td>
<td>“Uhm.. prior to this study… [agency] and me in this role.. uhm… had almost minimal to no contact with the PHD”</td>
</tr>
<tr>
<td>2.3 No past history</td>
<td>Sub-code</td>
<td>No history of collaboration; partnership</td>
<td>“with the AA... it was all new to me.. so I wasn’t connected at all”</td>
</tr>
<tr>
<td>3. Knowledge</td>
<td>Code Family</td>
<td>Knowledge between groups prior to CHA</td>
<td></td>
</tr>
<tr>
<td>3.1 High knowledge pre-assessment</td>
<td>Sub-Code</td>
<td>High, extensive knowledge of each other</td>
<td>“It validated what I knew.. because I worked in the community for so many years and I have seen a lot of things..”</td>
</tr>
<tr>
<td>3.2 Some knowledge pre-assessment</td>
<td>Sub-Code</td>
<td>Minimal knowledge of each other prior to CHA</td>
<td>“I wasn’t too familiar with the county.. but little by little I started learning about the epi team, these assessments, and the nutrition program..”</td>
</tr>
<tr>
<td>3.3 No knowledge pre-assessment</td>
<td>Sub-Code</td>
<td>No knowledge of each other prior to CHA</td>
<td>“…here was a whole new group of people..and they didn’t .. for a lot of reasons.. because there has never been any engagement.. any effort to include them before”</td>
</tr>
<tr>
<td>4. Power/ Authority</td>
<td>Code Family</td>
<td>Decision maker</td>
<td></td>
</tr>
<tr>
<td>4.1 Community led</td>
<td>Sub-Code</td>
<td>Community group makes decisions, sets direction for CHA</td>
<td>“I think the decision making was great.. because what was different about these decisions that were made .. they were the communities decisions”</td>
</tr>
<tr>
<td>4.2 PH led</td>
<td>Sub-Code</td>
<td>PHD makes decision, sets direction for CHA</td>
<td>“I would say most of the decision were getting made by the consultant… and us… on the assessment”.</td>
</tr>
<tr>
<td>4.3 Shared leadership</td>
<td>Sub-Code</td>
<td>PHD and community group make decisions together</td>
<td>“we shared a decision making diagram with them.. I think it worked initially.. they agreed to it.. we made some modifications to it..”</td>
</tr>
<tr>
<td>Code name</td>
<td>Code Type</td>
<td>Definition</td>
<td>Example</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>5. Ownership of Action</td>
<td>Code Family</td>
<td>Party responsible for implementation of CHA recs.</td>
<td></td>
</tr>
<tr>
<td>5.1 Community responsible</td>
<td>Sub-Code</td>
<td>Community group is lead on implementation</td>
<td>“I think that has to be the community.. because they are the ones that are asking for help from us..”</td>
</tr>
<tr>
<td>5.2 PH responsible</td>
<td>Sub-Code</td>
<td>PHD is lead on implementation</td>
<td>“I think it should be PH .. if PH as an agency is collecting that data.. and is the gatekeeper for all that data”</td>
</tr>
<tr>
<td>5.3 Shared ownership</td>
<td>Sub-Code</td>
<td>PHD and community group share responsibility for implementation</td>
<td>“I think the entire community.. I think together...”</td>
</tr>
<tr>
<td>6. Supportive Infrastructure for</td>
<td>Code Family</td>
<td>Resources, supports in place for implementation</td>
<td></td>
</tr>
<tr>
<td>Action</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.1 Strong community infrastructure</td>
<td>Sub-Code</td>
<td>Community group resources, supports are high for implementation</td>
<td>“I think we are very prepared because we have a working relationship...”</td>
</tr>
<tr>
<td>6.2 Weak community infrastructure</td>
<td>Sub-Code</td>
<td>Community group lacks or has no resources, supports for implementation</td>
<td>“There is momentum in the community but not capacity to take these on…”</td>
</tr>
<tr>
<td>6.3 Strong PHD infrastructure</td>
<td>Sub-Code</td>
<td>PHD resources, supports, are high for implementation</td>
<td>“I don’t know about all the recommendations but some are moving forward .. yes “</td>
</tr>
<tr>
<td>6.4 Weak or no PHD infrastructure</td>
<td>Sub-Code</td>
<td>PHD lacks or has no resources, supports for implementation</td>
<td>“No because we don’t have the resources to stick around..”</td>
</tr>
<tr>
<td>7. Barriers</td>
<td>Code Family</td>
<td>Challenges to community engagement</td>
<td></td>
</tr>
<tr>
<td>7.1 Funding</td>
<td>Sub-Code</td>
<td>Finances/funds</td>
<td>“money and manpower”</td>
</tr>
<tr>
<td>7.2 Int/Ext Politics</td>
<td>Sub-Code</td>
<td>Gov’t entity; policies; activities; electeds</td>
<td>“I would say the political climate here.. I think a lot of people see it as PH’s role and they are unwilling to budge and unwaver on that view”</td>
</tr>
<tr>
<td>7.3 Lack of trust</td>
<td>Sub-Code</td>
<td>Feelings, experiences of dishonesty, betrayal</td>
<td>“that they didn’t trust us because of their experiences in the past”</td>
</tr>
<tr>
<td>7.4 Language: Research</td>
<td>Sub-Code</td>
<td>CHA process-epidemiological process vs. community frame</td>
<td>“We don’t know how to talk to the community, how to approach them, how to present our methods, scientific methods to the community so that they will accept it. We don’t know the lingo”</td>
</tr>
<tr>
<td>Code name</td>
<td>Code Type</td>
<td>Definition</td>
<td>Example</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>-----------</td>
<td>--------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7.5 Sense of betrayal, past history</td>
<td>Sub-Code</td>
<td>Feelings of being abused; used</td>
<td>“so people feel cheated .. at some level.. because they participated too.. and in the end nothing happened..”</td>
</tr>
<tr>
<td>7.6 Time</td>
<td>Sub-Code</td>
<td>Time to complete CHA</td>
<td>“it took a very long time.. .. I think that was a challenge…”</td>
</tr>
<tr>
<td>7.7 Understanding capacity/gaps</td>
<td>Sub-Code</td>
<td>Limitations and assets of each group</td>
<td>“I don’t think we’re that prepared for a lot of people here. I feel like my preparation mostly comes from graduate school, which isn’t really real life- it’s like its own- I took coursework in like community based participatory research and I kind of like generally- but day to day I feel like my experience now has come from just being thrown into it essentially”</td>
</tr>
<tr>
<td>8. Facilitators</td>
<td>Code Family</td>
<td>Factors that support effective CE</td>
<td></td>
</tr>
<tr>
<td>8.1 Commitment</td>
<td>Sub-Code</td>
<td>Dedication between groups</td>
<td>“you need to have an ongoing relationship ongoing commitment towards the community”</td>
</tr>
<tr>
<td>8.2 Flexibility</td>
<td>Sub-Code</td>
<td>Open to change, influence</td>
<td>“something is working well but how can we look at it different to incorporate other aspects.. the quality of health.. health and well-being and how can we do that in all the different groups.. “</td>
</tr>
<tr>
<td>8.3 Specific relationship/people</td>
<td></td>
<td></td>
<td>“The people assigned to it from the PHD .. as an African person.. I think it was very helpful that they were also people of color”</td>
</tr>
<tr>
<td>8.4 Time</td>
<td></td>
<td></td>
<td>“it was like this breath of fresh air.. maybe it was the right time at the right place. I remember a lot of excitement”</td>
</tr>
<tr>
<td>9. Recommendations</td>
<td>Code Family</td>
<td>Suggestions for improvement of CE</td>
<td></td>
</tr>
<tr>
<td>9.1 Be patient with community</td>
<td>Sub-Code</td>
<td>Work based on community’s time</td>
<td>“It takes patience.. you can’t give up.. the first time”</td>
</tr>
<tr>
<td>9.2 Integration of community perspectives; opinions</td>
<td>Sub-Code</td>
<td>Incorporate community opinions, ideas, priorities</td>
<td>“you have to go where the community is.. and in order to understand them.. you have to involve them.. you have to have them participate”</td>
</tr>
<tr>
<td>9.3 Mutual</td>
<td>Sub-Code</td>
<td>Learn about each</td>
<td>“I would say awareness, on both sides.</td>
</tr>
<tr>
<td>Code name</td>
<td>Code Type</td>
<td>Definition</td>
<td>Example</td>
</tr>
<tr>
<td>-----------------------</td>
<td>-----------</td>
<td>-----------------------------------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>awareness</td>
<td>other</td>
<td></td>
<td>So the PHD- so the AA community becoming aware of what the PHD does and what services we provide and then for us being able to engage the community”</td>
</tr>
<tr>
<td>9.4 Respect for</td>
<td>Sub-Code</td>
<td>Understand each community’s unique lens, approach, priorities; appreciation different type of knowledge</td>
<td>“listen to the community.. and not feel like you have all the answers..”</td>
</tr>
<tr>
<td>community norms,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>culture, frame</td>
<td></td>
<td></td>
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</tbody>
</table>
### Appendix H: Within/Cross Case Analysis Matrix

<table>
<thead>
<tr>
<th>Community Engagement Components*</th>
<th>SCCPHD</th>
<th>African American Community</th>
<th>Latino Community</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>K I</td>
<td>F G D O C S N M</td>
<td>K I F G D O C S N M</td>
</tr>
<tr>
<td>Trust</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prior history</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Loyalty</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some trust</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beliefs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Values equitable partnership</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Open to being influenced</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2-way comm.</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Respect of community knowledge</td>
<td>x</td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>Role clarity</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fairness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear decision making structure</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear purpose</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clear roles, responsibilities</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Power</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equitable</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community control</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Shared decision making</td>
<td>x</td>
<td></td>
<td></td>
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<tr>
<td>Ownership</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community owns implementation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Joint responsibility for</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PHD owns implementation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resources</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Sufficient resources</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Supports</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Community leadership</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community systems exist to support implementation</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>PHD commitment to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>implementation</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Authority</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Profile of community members</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>involved in process</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive change in community</td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and PHD after assessment</td>
<td>x</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**KEY:**  
K I = key informant, FG = focus group, DOCS = documentation, N = Field Notes; M = reflective memoing  
*= this is for illustrative purposes only, and does not include all categories from the study’s conceptual model
### Appendix I: Select Quotes by Research Question

**Research Question 1:** How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

<table>
<thead>
<tr>
<th>Category</th>
<th>Quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genesis of Assessment</td>
<td>“I guess most of these assessments come to us from the BOS...especially the Latino Health Assessment came from the BOS.. they were the ones who got it started for us” (LHD participant)</td>
</tr>
<tr>
<td></td>
<td>“We came up with an initiative to do a series of studies about the lives of African Americans in Silicon valley. The first study was supposed to be education. We took this initiative to the BOS.” (African American participant)</td>
</tr>
<tr>
<td></td>
<td>“I guess it was always deemed as something necessary to have the data.. because we were always throwing around these things in the office about the how the community wasn’t doing well.. the stuff we always knew.. but we definitely wanted the numbers to make the case “(Latino participant)</td>
</tr>
<tr>
<td>History</td>
<td>“I am just trying to think previous to working in this county.. too if I had any experience.. I would say  very limited actually” (LHD participant)</td>
</tr>
<tr>
<td></td>
<td>“The health department never reached out.... and you know the community they would work with officials.. more political officials.. and they were not aware of the PHD and what the capacity.. or even what the health department does.. I don’t even think they were aware of it all.. I don’t think that the health department .. they knew about the community but they never made the effort to reach out”. (African American participant)</td>
</tr>
<tr>
<td></td>
<td>“I think I would say.. I mean from like a grassroots level.. I definitely see and have heard of the involvement by the Latinos community in different surveys and focus groups and activities that are led by the department and then on a more stakeholder professional level.. I definitely see the groups .. the Latino community or stakeholders working with the health department but that I can .. name specific groups .. I apologize that I can’t”. (Latino participant)</td>
</tr>
<tr>
<td>Knowledge</td>
<td>I grew up in Santa Clara County, so I knew a little bit. I didn’t know much about the African American/African Ancestry community just because it’s like 2% of the population it’s so small- I knew a decent amount of the Latino community here just because just from growing up here...but never worked directly with them”. (LHD participant)</td>
</tr>
</tbody>
</table>
|                  | “I think the community was really focused on social services...and the
**Research Question 1:** How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

<table>
<thead>
<tr>
<th>Constructs</th>
<th>Quotes</th>
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</table>
| **Judicial System** | *and not so much on the health of the community.. and when I first mentioned the health department.. the response was.. don’t they go to restaurants.. and check out restaurants to see if they are clean or not.... And then I said no.. and I explained to them what the health department does.. and I don’t think they ever heard of PH... [PH] is just not as visible in the community..”* (African American participant)  

> “Well from my own experience, a lot of times [PH] reaches out to providers or leaders to speak on behalf of Latinos so with public health initiatives there is sometimes a disconnect with connection to actual residents and people that are being impacted by issues” (Latino participant) |
| **Power/Authority** | “I think the decision making was great.. because what was different about these decisions that were made .. they were the community’s decisions.. we allowed them to make their own decisions and facilitated the things to happen”. (PHD participant)  

> “I think it was very clear.. and I have to say.. that it wasn’t always agreed upon.. so I think there were some negotiations that happened.. there was some well.. you know this is my mandate.. well this is my mandate.. so you know.. I don’t want to underscore how important that process was because I think it was very fascinating to watch it and to experience it.. there was a very strong community voice and through that process it was very clear that there was not one kind of side and charge...but it was really a collaboration but there were distinct roles that each had and being able to navigate and negotiate where the boundaries were for those roles .. I think it was a very open process that I had not experienced before in collaboratives with the PHD.. so it was very exciting for me to see that”. (African American participant)  

> “Hmm I think yeah.. it’s been like the PH leadership.. in my experience the community has not been really involved in the design of the research .. it’s been more of on the end.. like getting data collected from them but not necessarily shaping the research process”. (Latino participant) |
| **Infrastructure** | “I think during the assessment... of course we have the resources to ensure that we get the assessment completed.. after.. I don’t .. see so much.. I don’t .. I think going back to past experiences.... there was nothing.. it was just completely like we are done ... move on.. and we are done.. but I felt a sense of responsibility.. because I was put out there in that community and I felt...” |
### Research Question 1: How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

<table>
<thead>
<tr>
<th>Ownership of Action</th>
<th>“I think we as the PHD have a responsibility. To do an assessment and then to do nothing with the data that you collect from the assessment is a disservice to the community. So I think you know we’re on the hook for doing it, but I also think that again our job is to work with the community, with community leaders to get it done. So it’s not that PH has to do everything, but we need to be able to coordinate with the community-you know whoever it is”. (PHD participant)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“I think both… us and the PHD”. (African American participant)</td>
</tr>
<tr>
<td></td>
<td>“I would say Public health just because I feel like public health is in a sense took the lead on it and the way I see it … It’s PHD”. (Latino participant)</td>
</tr>
<tr>
<td>Agency</td>
<td>“Self-determination is critical.. the community who you are studying needs to be not just at the table with a couple of representatives but they need to have ownership of it..and they need to direct and work collaboratively with the department on direction.. and take a lead in the community too.. because we were leading this.. and here was the support team from the PHD.. instead of the other way around.. and trust that.. that it’s not only going to get better results.. but it’s also going to get engagement form the community .. when they take ownership of the process and the results.. I think it has an impact.. like I said.. the ripple effect in so many ways.. because I think community based.. you know.. community policy making... community based information gathering... policy, direction, programs.. is really what it’s going to take to improve outcomes and improve health of the community”. (African American participant)</td>
</tr>
</tbody>
</table>
**Research Question 1:*** How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

<table>
<thead>
<tr>
<th><strong>Co-Learning</strong></th>
<th>“So the big push is community engagement and them somehow the community taking ownership of these issues and moving things forward.. I don’t know which academic came up with that piece of crap.. because in order to engage with community you need to find a community that feels empowered and knows how to do something about it”.  <em>(Latino participant)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-research Question:</strong> What are the expectations and perceptions of African American and Latino stakeholders about the level of engagement expected from the Santa Clara County Public Health Department once community health assessments are complete?</td>
<td>“I don’t think it’s been done yet.. it’s a process.. we will see.. we are meeting with people... we are starting to meet with the BOS.. we will be asking the county for.. resources, dollars, cents, partnerships and so on... PHD will be involved”.  <em>(African American participant)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Co-Learning</strong></th>
<th>“It was eye opening and we learned a lot especially the African American assessment”.  <em>(PHD participant)</em></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-research Question:</strong></td>
<td>“I would think.. the department wanting the Latino community to be part of a learning community, ... how to engage the community to be part of the process.. and really understanding the culture, community values, perceptions.. everything or any of the activities that the health department is wanting to learn.. what the objectives and the outcomes of these types of processes”.  <em>(Latino participant)</em></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Co-Learning</strong></th>
<th>“With PH, I think kind of like what [she] did.. she invited me.. so identifying [Latinos] and reaching out to them.. Sometimes [Latinos] feel intimidated by PH.. so reaching out and inviting them.. so that they actually have a voice, and learn the process”.  <em>(Latino participant)</em></th>
</tr>
</thead>
</table>

| **Sub-research Question:** | “Both the PHD and the county should be involved.. continue to be involved throughout the process.. you can’t rely on the politicians because they are going to be here today and then they will move onto something else.. it’s important to have a mechanism that makes the county be held accountable to the reports that it is producing”.  *(Latino participant)* |

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Research Question 1: How do constructs of community engagement influence the planning and data collection process and implementation capacity associated with community health assessment activities between African American and Latino communities and the Santa Clara County Public Health department?

“With the African American Assessment, we haven’t let go.. I think because we have a very active group.. of community partners who I don’t think will let us go that easy.. with the Latino Health Assessment.. I feel like we did it.. and I don’t know.. I don’t think we have anybody holding us accountable for that one.. no one is asking what are you doing next.. We need to circle back to them”. (PHD participant)

“I think that there is still work to be done.. so that people don’t drop the ball after all this work.. and that’s very critical.. that we have gotten this close to the community and we are able to do some programming around what they need and if the ball drops I think the whole thing.. it would be devastating to PH.. because the trust is already there now”. (PHD participant)

“Change doesn’t happen.. with us.. PH can’t.. we don’t have the resources, we don’t have the power, we don’t have the bandwidth.. or any of that.. to really make some of these changes happen.. so the community need to be well in the know.. that they need to be the ones advocating.. they need to be the ones going to the BOS.. we can’t even go and advocate to the Board or whomever it might be.. so they need to understand that.. so that’s really important.. they need to shape it.. after it’s theirs.. if we spent a big % of our time doing just that what about the other 99 communities?”. (PHD participant)
Appendix J: IRB Approval (UIC)

UNIVERSITY OF ILLINOIS
AT CHICAGO

Office for the Protection of Research Subjects (OPRS)
Office of the Vice Chancellor for Research (MC 672)
203 Administrative Office Building
1737 West Polk Street
Chicago, Illinois 60612-7227

Approval Notice
Initial Review (Response To Modifications)

November 16, 2015

Rocio Luna, MPH, BS
Institute for Health Research and Policy
9774 Golden Sky Way
Gilroy, CA 95020
Phone: (408) 612-7965

RE: Protocol # 2015-0983
“Community Engagement as a Key Determinant in Building Implementation Capacity of Local Public Health Assessments: A Qualitative Study”

Dear Dr. Luna:

Your Initial Review (Response To Modifications) was reviewed and approved by the Expedited review process on November 13, 2015. You may now begin your research.

Please note the following information about your approved research protocol:

Protocol Approval Period: November 13, 2015 - November 12, 2016
Approved Subject Enrollment #: 70
Additional Determinations for Research Involving Minors: These determinations have not been made for this study since it has not been approved for enrollment of minors.
Performance Sites: UIC, African American Community Services
Agency, Valley Health Center East Valley
Sponsor: None
PAF#: Not applicable
Research Protocol(s):
   a) IRB Research Protocol-Community Engagement and Health Assessment; Version 3; 10/23/2015
Recruitment Material(s):
   a) Recruitment/Screening Phone Script F/U to Email; Version 2; 09/19/2015
Informed Consent(s):

a) Informed Consent Document; Version 4; 11/09/2015
b) Waiver of informed consent granted [45 CFR 46.116(d)] for the identification of potential subjects in the recruitment phase of the research (for referrals from community leaders); minimal risk, written consent will be obtained at enrollment.
c) A waiver of documentation of informed consent has been granted under 45 CFR 46.117 and an alteration of consent has been granted under 45 CFR 46.116(d) for recruitment purposes only; minimal risk; verbal consent to screening/eligibility questions will be obtained; written consent will be obtained at enrollment.

Your research meets the criteria for expedited review as defined in 45 CFR 46.110(b)(1) under the following specific category(ies):

(6) Collection of data from voice, video, digital, or image recordings made for research purposes., (7) Research on individual or group characteristics or behavior (including but not limited to research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.

Please note the Review History of this submission:

<table>
<thead>
<tr>
<th>Receipt Date</th>
<th>Submission Type</th>
<th>Review Process</th>
<th>Review Date</th>
<th>Review Action</th>
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<tbody>
<tr>
<td>09/23/2015</td>
<td>Initial Review</td>
<td>Expedited</td>
<td>09/30/2015</td>
<td>Modifications Required</td>
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<tr>
<td>10/28/2015</td>
<td>Response To Modifications</td>
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<td>11/05/2015</td>
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<tr>
<td>11/11/2015</td>
<td>Response To Modifications</td>
<td>Expedited</td>
<td>11/13/2015</td>
<td>Approved</td>
</tr>
</tbody>
</table>

Please remember to:

➔ Use your research protocol number (2015-0983) on any documents or correspondence with the IRB concerning your research protocol.

➔ Review and comply with all requirements on the enclosure, "UIC Investigator Responsibilities, Protection of Human Research Subjects" (http://tigger.uic.edu/depts/ovcr/research/protocolreview/irb/policies/0924.pdf)
Please note that the UIC IRB has the prerogative and authority to ask further questions, seek additional information, require further modifications, or monitor the conduct of your research and the consent process.

Please be aware that if the scope of work in the grant/project changes, the protocol must be amended and approved by the UIC IRB before the initiation of the change.

We wish you the best as you conduct your research. If you have any questions or need further help, please contact OPRS at (312) 996-1711 or me at (312) 355-0816. Please send any correspondence about this protocol to OPRS at 203 AOB, M/C 672.

Sincerely,

Alison Santiago, MSW, MJ
Assistant Director, IRB # 2
Office for the Protection of Research Subjects

Enclosure(s):

1. UIC Investigator Responsibilities, Protection of Human Research Subjects
2. Informed Consent Document(s):
   a) Informed Consent Document; Version 4; 11/09/2015
3. Recruiting Material(s):
   a) Recruitment/Screening Phone Script F/U to Email; Version 2; 09/19/2015
   b) Recruitment Script-Email; Version 3; 10/23/2015
   c) Recruitment/Screening Phone Script f/u to Referral; Version 3; 10/23/2015
   d) Recruitment/Screening Phone Script; Version 3; 10/23/2015
   e) Recruitment Flyer: Focus Groups; Version 3; 10/23/2015

cc: Robin J. Mermelstein, Institute for Health Research and Policy, M/C 275
    Eve C. Pinsker (Faculty Advisor), School of Public Health, M/C 923
Appendix K: IRB Approval (SCVHHS)

DATE: December 11, 2015
TO: Rocio Luna, Public Health Department, Santa Clara County
FROM: Kakoli Banerjee, Ph.D.
Chair, Health Services Institutional Review Board
Santa Clara Valley Health & Hospital System
RE: Community Engagement as a Key Determinant in Building Implementation Capacity of a Local Health Department Health Assessment: A Qualitative Study

The Health Services IRB reviewed your proposal entitled- Community Engagement as a Key Determinant in Building Implementation Capacity of a Local Health Department Health Assessment: A Qualitative Study- and has concluded that it meets the necessary protections for human subjects discussed in the research protocol. The IRB voted to approve the project as presented.

On behalf of SCVHHS Health Services Institutional Review Board, I am sending you an approval letter with your IRB number:

Your IRB number is 15-08

This IRB approval is valid until December 10 2016. If this study will continue beyond one year, you will need to submit a request for an extension prior to the expiration date, indicating changes, if any, in the approved protocol.

Any change in the research project which significantly alters the procedures or risks must be submitted for review by the IRB prior to the implementation of such change, including a change in investigators. Any complications should be reported at once to the IRB before continuing with the project.

Please keep the IRB Committee informed of the project’s progress on a regular basis over its duration. At the end of the study, please provide the IRB with a report of the findings or copy of any published articles.