Developing Strategic and Collaborative Community–Academic Partnerships to Improve Community Health, From Moving Upstream to Getting at the Root

Yvonne Anderson, MPA, BS, Renee Artis, BA, Mona AuYoung, PhD, MS, MPH, Quentin Ball, MPA, Ana Leon Bella, MA, Yelba Castellon-Lopez, MD, MS, Jack Cheng, JD, Ray Cheung, MBA, Elizabeth Cohn, RN, PhD, Louise Fonua, MS, Heng Lam Foong, MS, Judelysse Gomez, PhD, Krystal Griffith-Lloyd, MPH, Alana M.W. LeBrón, PhD, MSc, Julia Mangione, MSc, Mellissa McLeod, MPH, Keith Norris, MD, PhD, Leah Perez BA, Pam Pimentel, RN, Sora Tanjasiri, DrPH, MPH, Christopher Tenorio, BA, Amelia Vernon, BS, Michael Viera, Aziza Lucas Wright MEd, and Helena Williams, RN, BSN

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Community partners have experienced inequity and lack of transparency in funding practices. Funding for community partners is a critical component of community-engaged research, as it influences community trust and opportunities.

We compared contextual and site-specific factors at 2 centers (in New York City; Los Angeles and Orange Counties, CA) with different community-funding approaches, which influence institutional capacity to partner with and support community-based organizations. We describe community participatory and engaged research activities in two centers in a National Institute on Minority Health and Health Disparities–funded national consortium, describing each center's process for funding community-based organizations.

We present lessons learned from ongoing collaborative efforts between community-based organizations, community action boards, and research institutions. We discuss successes and opportunities for growth in our efforts to support community-based organization partners, resources to help sustain their health equity programs, the importance of long-term institutional investment to sustain this type of support, and the potential for institutional-level changes that increase trustworthiness and sustainable outcomes. We advocate for systemic changes in institutional focus and resource investment to better respond to community needs. (*Am J Public Health*. 2025;115(S2):S152–S163. https://doi.org/10.2105/AJPH.2025.308092)

Community-based organizations (CBOs) typically emerge to serve marginalized communities by providing essential resources and services as well as by addressing upstream drivers of their needs—especially in areas where governmental programs, health systems, and research institutions fall short.[1] CBOs are well positioned to bridge the gap between science and complex community health problems through social action and deep-rooted community engagement, yet they often face challenges in securing sustained financial support to strengthen infrastructure and expand reach. Academic institutions are uniquely positioned to provide access to grant funds and other support (e.g., skills development, statistics support) to aid CBOs to establish or sustain programs responding to health-related social needs.[2] In collaboration with CBOs, academic institutions can help develop and maintain infrastructure to transform conditions that shape local health priorities.[3–6]

We compare 2 supportive funding models developed by 2 US academic centers (Center A and Center B) in a National Institute on Minority Health and Health Disparities (NIMHD) consortium (hereafter "the consortium"). We developed these programs in response to conversations with our community partners to support the work of CBOs whose programming focuses on community-identified health priorities. Specifically, we describe contextual and site-specific factors at these institutions, which had different community-funding approaches, highlighting how regionally specific approaches influenced the capacity to support community-grounded work.[7] We have developed a model to inform institutional transformations for health equity by supporting strategic, bidirectional, and collaborative community–academic partnerships and providing financial and other support to backbone CBOs.

This essay's authors are engaged in health equity research and service as community grant recipients, academic researchers, academic staff, or direct service providers. We illustrate 2 examples of community–academic collaborations to develop community-responsive programs. Additionally, the community partners share a summary of their experiences of the process. Although the relationship-building, trust-building, and community engagement processes tied to this work are essential to understanding how this work was done, community engagement–specific details can be found in Capotescu et al.[8] and will be further described in a forthcoming article. Herein, we describe insights on (1) the development of 2 community grant–making processes that can be adopted to promote health equity, (2) the institutional challenges encountered, and (3) opportunities for institutional changes responsive to CBO and community priorities.[7,9]

Historically and contemporarily marginalized communities (e.g., communities of color, low-income communities) face health inequities, which are exacerbated by intersecting systemic oppressions such as racism, classism, xenophobia, ableism, sexism, and homophobia. Traditional public health frameworks not considering these intersecting factors fail to address the structural and social drivers of health, such as health care, financial resources, education, employment, policing, and housing.[10] Consequently, these frameworks are inadequate for achieving systemic, transformational changes to sustainably reduce health inequities. The White House's report "U.S. Playbook to Address Social Determinants of Health" outlines 3 pillars to improve health: expanding data gathering and sharing, supporting flexible funding for social needs, and bolstering the work of CBOs.[11] CBOs play a critical role in addressing complex public health challenges affecting marginalized communities, have deep roots in communities, and are often trusted messengers.[3,11–14]

Community-engaged research addresses health inequities by actively involving community members in research processes, thus ensuring that community voices, experiences, and needs are central to the development and implementation of health interventions and research.[9,12] Community–academic partnerships are a well-established approach for engaging marginalized communities in research and tackling complex health issues.[15–18] The National Academies of Medicine Assessing Community Engagement (NAM ACE) model emphasizes the importance of building trust, fostering collaborative partnerships, and promoting colearning between researchers and community constituents[9]; this model guides our work and that of the consortium.

By using community insights and strengths, community-engaged research can create more culturally relevant and effective health solutions, ultimately leading to equitable health outcomes. This approach has proven particularly effective for groups underserved by traditional public health initiatives.[9,12] Based on these principles, the consortium, which comprises 11 US research centers, was funded by the NIMHD under the Consolidated Appropriations Act of 2021 to address chronic illness inequities. The consortium aims to enhance equity in the prevention, treatment, and management of multiple chronic health conditions through these centers, especially their community engagement cores (CECs), who collaborate regionally with CBOs.[3,19,20]

ACADEMIC CENTERS

Our brief descriptions of the 2 academic research centers provide context for the grant-making approaches to support the work of CBOs. A comparison of the different approaches to community grants is illustrated in Figure 1, and Table 1 provides a summary of each center's CBO programming.

Center A is a collaboration across 5 New York City academic–medical institutions focused on reducing disparities in cardiovascular disease, cancer risk, and disease burden among Black/African American and Latinx/e/Hispanic New Yorkers. Table 1 provides a snapshot of the populations served.

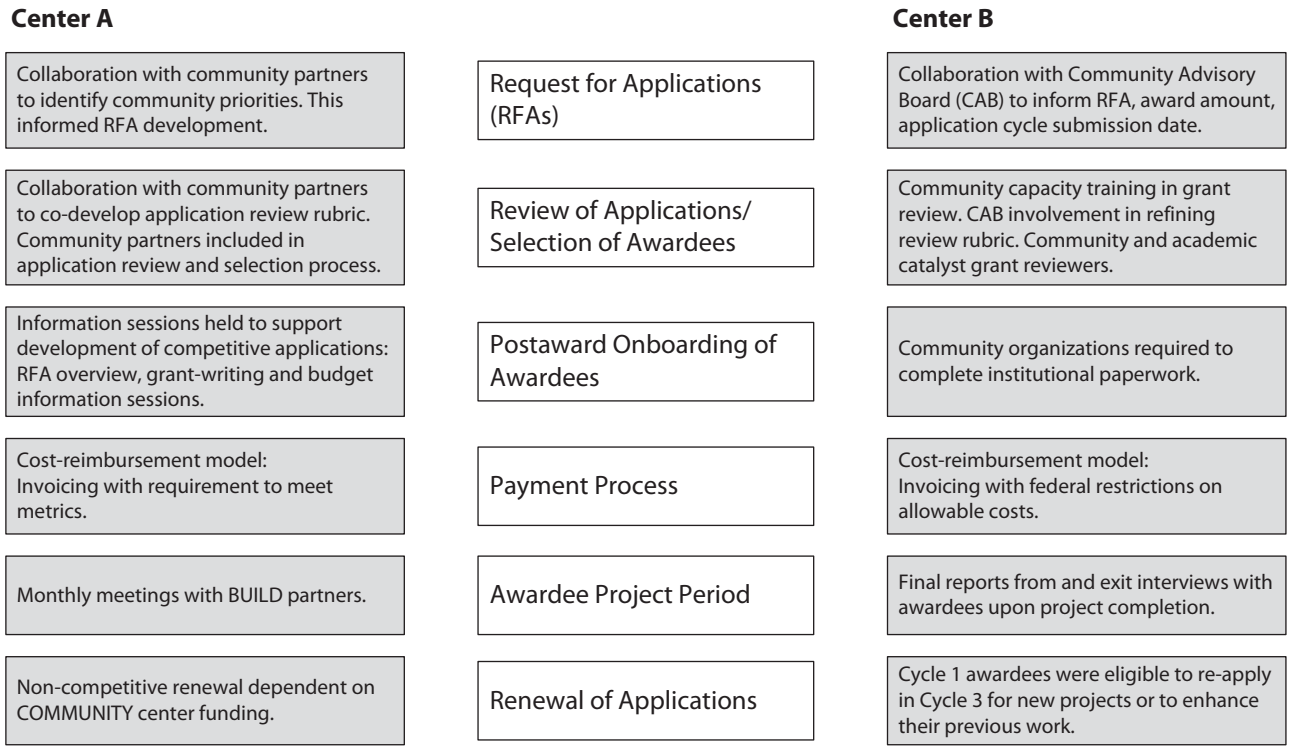

FIGURE 1— Comparison of the Capacity-Building Support Models of Center A's and Center B's Community-Based Organizations: New York City; Los Angeles and Orange Counties, CA

AJPH Supplement 2, 2025, Vol. 115, No. S2

Our work targets the social drivers of health by centering the voice of and power sharing with community members.[9,10,21,22] Our aim is to work with and support a growing number of New York City–based constituents using a coalition approach. Center researchers and staff collaborate with community partners to understand and address how health, health behaviors, and health care delivery are affected by multiple spheres of influence, such as biological and behavioral factors, built and sociocultural environments, and the health care system.[21,23]

Our mission is to develop and sustain strategic community–academic partnerships and address health-related social needs via the Building Upstream Infrastructure for Learning and Dissemination (BUILD) program.[7] The BUILD program provides seed funding and other capacity-building support to New York City CBOs whose work addresses these health-related needs (Table 1). Our ultimate goal is to develop a sustainable, scalable capacity-building support model to inform transformative institutional changes (e.g., health care delivery and health care system practices) to assist the work of CBOs, who are the primary recipients of social needs referrals from health care systems.

Center B is a collaboration between 2 California universities in neighboring racially/ethnically and socioeconomically diverse areas: the second (Los Angeles County) and sixth (Orange County) largest US counties, where the more than 13 million residents represent a third of California's population. Guided by the NIMHD research framework, the center focuses on multilevel risk factors contributing to cardiometabolic disease and its complications, particularly those disproportionately affecting low-income, minoritized, and other vulnerable groups.[21] In addition to the CEC, the Community Action Board (CAB) includes advisers from local organizations, national health advocacy organizations, and groups focused on cardiometabolic disease prevention and management or racial/ethnic minority health. The CEC's vision is to foster a transformative relationship between community and academia rooted in equitable conversations and guided by community expertise. We aspire to create partnerships in which community knowledge and perspectives are integrated at every stage of research, leading to more inclusive, meaningful, and effective outcomes for traditionally marginalized groups.

TABLE 1— Characteristics of the Centers and Community Grantees: New York City; Los Angeles and Orange Counties, CA

	Capacity-Building Initiative	Communities Served	Community Impact
New York City			
Center A	Building infrastructure for learning and dissemination program	Black (20%), Latinx/e/Hispanic (28%), ≥ 2 races (3.4%) New Yorkers[a]	
Center A, CBO 1	Fresh food distribution, health and wellness outreach	Low-income public housing residents of communities in New York City's Lower East Side; migrants, immigrants, and asylum seekers (recent arrivals)	More people and communities served, built organizational infrastructure, raised awareness of nutritional needs of public housing residents and asylum seekers, youth leadership development, expanded and strengthened relationships with key community and city leadership partners, dissemination via center events
Center A, CBO 2	Cocreation of course on trust, health, and equity	Systems-affected individuals and their families	Community-led and informed health equity curriculum disseminated to local community members; intergenerational village circle community conversations led by trusted messengers informed health and wellness clinic; programming served local community; programmatic quantitative and qualitative data showed community member satisfaction with programming and subjective improvement in health; dissemination via center events
Center A, CBO 3	Mobile teaching kitchen and school program on culturally relevant nutritious meals	Harlem youths and their families	Increased number of people and communities served; expanded food systems, agricultural and cooking lessons to youths in central Harlem; expanded mobile teaching kitchen and after-school programming; expanded hours and programming focused on growing culturally relevant foods via innovative techniques (e.g., hydroponics); dissemination via center events
Center A, CBO 4	Challenging the physical education curriculum, introduction to cycling, youth leadership and positive youth development	Hispanic (71%), Black (24%), other (5%) middle school students in Manhattan and the Bronx	Expansion of physical education curriculum; onboarded other schools in the New York City area; expansion of youth leadership opportunities (e.g., led gamification activities); collaboration with the New York City Department of Transportation on street and cyclist safety; dissemination via center events
Center A, CBO 5	Spanish-language curriculum development for fitness classes and teacher training of instructors who are Black, Indigenous, or other People of Color	Older Black, Latinx/Hispanic adults, including those with cancer or multiple chronic diseases	Training and certification scholarships for community members; culturally adapted the curriculum; expanded reach and dissemination to culturally diverse community members with multiple chronic conditions; dissemination of curriculum to Spanish-speaking elders; increased communities and community members served; health, emotional, and mobility improvements; expanded and strengthened partnerships with key hospital and community-based partners; dissemination via center events
Los Angeles and Orange Counties, California			
Center B	Reducing cardiometabolic disparities in racial/ethnic minority populations	Hispanic/Latino/x (49% and 34%), White (26% and 40%), Asian (15% and 22%), Black/African American (9% and 2%), American Indian/Alaska Native, 0.4% Native Hawaiian and Pacific Islanders (1.5% and 1.1%)[b]	

Continued

TABLE 1— Continued

	Capacity-Building Initiative	Communities Served	Community Impact
Center B, CBO 1 (cycle 1)	Workshops on hypertension self-management and healthy eating	Black/African American and Hispanic seniors in South Los Angeles who have experienced homelessness	Reached 85 formerly unhoused community members to provide free blood pressure screenings, weekly monitoring, and free resources (e.g., educational materials and assistive mobility devices)
Center B, CBO 2 (cycle 1)	Cardiometabolic condition self-management through culturally tailored health tips	Chinese immigrant patients with cardiometabolic disease, many with limited English proficiency	Health tips available as text messages in English and Chinese (traditional and simplified); 91% agreed it encouraged them to eat healthy foods, and 88% agreed it helped them to communicate about healthy heart lifestyles with their families
Center B, CBO 3 (cycle 1)	Culturally tailored educational materials on cardiometabolic health	Spanish- and English-speaking youths and families	Project in progress
Center B, CBO 4 (cycle 1)	Cardiometabolic health screenings	Majority Hispanic/Latinx low-income, uninsured individuals	Project in progress
Center B, CBO 5 (cycle 2)	Cultural tailoring of MyPlate nutritional recommendations and recipes	Samoan community	Created culturally relevant nutritional resources and tools to support healthy living and prevent chronic disease; publicly available resources are rarely available for Native Hawaiian and Pacific Islander communities (e.g., Samoans)
Center B, CBO 6 (cycle 2)	Cultural adaptation of cardiometabolic intervention and capacity building of staff to lead it	Native Hawaiian and Pacific Islander community	Onboarding paperwork in progress
Center B, CBO 7 (cycle 3)	Urban farmer training program and free mercado al aire libre (farmers market)	Greater Los Angeles low-income residents including immigrants	Onboarding paperwork in progress
Center B, CBO 8 (cycle 3)	Educational seminars on cardiometabolic health and community health fairs for health screenings	Asian Americans, Pacific Islanders, other ethnic groups	Onboarding paperwork in progress

Note. CBO = community-based organization.
[a]Estimates are from https://popfactfinder.planning.nyc.gov/explorer/cities/NYC?compareTo=1.
[b]Estimates are from https://www.census.gov/quickfacts/fact/table/orangecountycalifornia,losangelescitycalifornia,losangeles.

CENTER A REQUEST FOR APPLICATIONS

Center A partnered with community and institutional partners to identify health priorities and inform the development of a request for applications for a community grant program (i.e., BUILD) to help support community-based programming addressing health-related social needs. Our work followed the Bay Area Regional Health Inequities Initiative model,[7] the NAM ACE model,[9] and the Spectrum of Community Engagement to Ownership model,[22] specifically the following steps: consulting, involving, collaborating, and deferring to community partners.

Our initial focus was on developing relationships, establishing trust, familiarizing community partners with the center's work, and familiarizing center researchers and staff with community partners' work. Together we identified community health priorities and opportunities for collaboration and formed strategic community–academic partnerships to codevelop solutions to these priorities.[7–9] For example, we co-led a town hall meeting with institutional and community-based partners focused on the importance of trust between community health workers, community members, and the health care system to discuss pressing health needs and how to address them.[23] This led to 2 photovoice projects in 2022 with 60 community health workers connected to community-based health agencies and hospitals across New York City.[8] These projects ultimately identified 5 health priority areas to inform the BUILD grant program's request for applications.

We initially proposed supporting 10 organizations per year at $10 000 each;

however, in subsequent institutional and community partner conversations, we determined that the greatest impact would involve fewer renewable awards for projects demonstrating program expansion and sustainability throughout the 5-year grant life cycle (contingent on fund availability). Recognizing the central role of CBOs in the community, BUILD grants provide funding ($25 000 per year) to support, strengthen, and sustain the programming of CBOs whose work addresses the multilevel drivers of health and health inequities. We shared the request for applications with more than 100 community partners and CBOs, focusing on small CBOs (i.e., those with operating budgets of less than $1 000 000 per year), which do not normally have access to federally sponsored funds. We held information sessions (on, e.g., program overview, grant criteria) and capacity-building sessions (on, e.g., grant writing, budget development) to reduce barriers for less-experienced organizations. Ultimately, we reviewed 22 applications.

CENTER B REQUEST FOR APPLICATIONS

The initial community grant request for applications was based on Center B's proposal to fund 4 CBOs with onetime $10 000 awards each. The request for applications was intentionally flexible on proposal type (i.e., capacity building or programmatic support) and had self-defined metrics and minimal jargon to encourage smaller CBOs' applications. In response to a large proportion of regional Spanish-speaking communities and to promote language justice, CEC members developed bilingual English–Spanish materials for the first cycle, including technical assistance webinars conducted in English with live professional Spanish interpretation.[13] The CEC received 14 applications, including 1 in Spanish, which was reviewed by Spanish bilingual and bicultural team members.[24]

Moving toward a model of community consultation and involvement, Center B's newly formed center CAB reviewed and informed the proposed Community grant award request for applications and a scoring rubric for cycle 2 (Appendix A, available as a supplement to the online version of this article at http://www.ajph.org).[22] To make the application requests more community responsive, the CAB recommended an increased 1-time grant award of $20 000, an updated rubric more closely matching the application, and a disseminating request for applications through their networks. The center adopted these recommendations, switching to 2 awards of $20 000 each. Subsequent application requests were developed only in English owing to insurmountable institutional barriers that made translation and interpretation of preaward documentation impossible.[13] With center CAB dissemination support, the center received applications from 10 first-time applicants and 1 previously unfunded applicant.

APPLICATION REQUESTS REFLECTIONS

Both centers recognized the importance of gathering community feedback on the application process, eligibility criteria to optimize reach, and how grantees carry out their work. Center A engaged community partners throughout the grant-making process, including talking to partners about the need for the proposed program and identifying health priorities and an appropriate funding amount. Although community health priorities were developed with community members, consistent feedback was needed from CBO service recipients to ensure that priorities were aligned with their needs. As we have described, both centers incorporated community feedback to increase grant size to better match community needs while working in areas with high costs of living.

CENTER A GRANT AWARDEES SELECTION

Center A's BUILD grant process is a grassroots funding mechanism informed by and codeveloped with community partners. They invited 26 current community and institutional partners to serve as grant reviewers who had previous experience reviewing community grants, providing community-based services, or working closely with community members or CBOs. Of those invited, 19 participated as grant reviewers, including 8 center-affiliated staff members and 11 community partners. Three of the 11 community partners participated in 2 sessions to develop and refine the scoring rubric (Appendix A). Thereafter, all reviewers participated in an orientation and onboarding, which included rubric training. Subsequently, partner feedback identified that the rubric lacked an "overall score" category, which would more easily identify successful applications moving to discussion. All community reviewers were compensated for their time. After review and awardee selection, 4 CBOs were funded by the CEC subaward, and a fifth was funded by an institutional center–affiliated partner. As part of our capacity-building activities, we provided a written summary of reviewer feedback that included areas

for improvement to organizations not selected for funding (Figure 1).

CENTER B GRANT AWARDEES SELECTION

The scoring rubric (Appendix B, available as a supplement to the online version of this article at http://www.ajph.org) was informed by the traditional National Institutes of Health review processes (e.g., significance, feasibility) and numeric rating scale (i.e., 1 = exceptional; 9 = poor) and tailored to the call for proposals (e.g., focus on community capacity building). Later, center CAB member feedback led to modifications, such as avoiding certain terminology ("poor") in rating community projects. To promote an equitable review process, a trained community reviewer and an academic reviewer reviewed each application, each CEC member having equal scoring weight. The center invited community and CAB members to participate in paid grant reviewer training to learn about the review process and practice using the scoring rubric. All community reviewers were also compensated for reviewing the center's grant applications. We included reviewer feedback for all CBO applications regardless of funding outcome to provide capacity building and encouraged those not awarded to reapply for the next funding cycle.

GRANT AWARDEES SELECTION REFLECTIONS

Including community partners was essential to the review and award selection process. For example, Center A's budget had allocated 4 awards, but the review process identified 5 potential awardees. Additional review and subsequent reviewer discussion determined that given the importance and community impact of the organization's work, the center would try to identify additional institutional funding to cover the fifth organization, which it did successfully. Center A's process can be used as a model to inform advocacy for transformative institutional changes.

CENTER A GRANT OUTCOMES AND RENEWAL

Our outcomes and those of our partners align with capacity-building domains identified by Liberato et al.[25] We developed programming and educational opportunities tailored to support CBOs' capacity (e.g., professional and skills development, dissemination of BUILD programming to the broader public, a center conference). Moreover, we focused on facilitating and establishing strategic academic and community-based collaborations resulting in funding pathways. Additionally, we facilitated opportunities for partners to lead workshops and panels (e.g., organizational programming, nonprofit development). Lastly, we held monthly meetings with BUILD partners to discuss successes, challenges, and emergent issues related to sponsored programs, "cross-pollination" opportunities, and ongoing dissemination.

CENTER B GRANT OUTCOMES AND RENEWAL

Reflecting our commitment to continuously improve our award process, Center B implemented grantee exit interviews, which informed onboarding process changes. Thus far, 2 exit interviews were conducted from the first funding cycle; the other 2 awardees faced project-funding delays related to institutional barriers. A primary challenge has been balancing longer-term funding grantee support and broader funding reach to more CBOs each year. In cycle 3, we invited previous awardees to reapply based on exit interview feedback, CAB recommendations, and CEC input (Figure 1). Center B follows a continuous refinement and improvement model for our request for protocols application, review, and awarding process to actively identify opportunities for greater community responsiveness and deeper collaboration with a goal for greater community impact.

GRANT OUTCOMES AND RENEWAL REFLECTIONS

Our approach to minimizing institutional barriers to funding aligns with the NAM ACE model's "improved health and health care programs + policies" pillar and the Bay Area Regional Health Inequities Initiative's downstream (i.e., health behaviors) to upstream continuum (i.e., social inequities).[7,9] As indicated in the Bay Area Regional Health Inequities Initiative model, addressing upstream root causes of health also includes intervening at the community and institutional levels (i.e., midstream), not just the structural and societal levels. The BUILD and Community grant award programs follow this approach to engage in community capacity building and address institutional inequities through strategic community–academic partnerships. One example is Center A's use of trust-based funding and grant renewal, renewing grants for organizations demonstrating program sustainability and expansion. If funding is not available, we connect partners and provide support for other funding streams.

We recognize that $25 000 is not nearly sufficient for CBOs to address

societal norms and structural determinants of health, nor should this be their task alone. However, these grants stoke change by investing in communities long overlooked and disenfranchised to provide services, education, and advocacy. Both centers have demonstrated that this money is what 1 grantee described as a "drop in the bucket" in helping organizations keep the lights on and respond to emerging community needs. Another grantee noted that organizations have to get creative with funding, especially considering the continued challenges faced by chronically underserved communities.

One BUILD-supported youth development organization was able to complete a full-year sports-based program with positive physical and social–emotional outcomes and then double the program's size the following year, which included more middle schools and programming that was focused equally on physical and mental health. A community grant awardee was able to directly respond to Samoan community members' need for previously nonexistent culturally relevant tools supporting healthy living and chronic disease prevention. Another CBO stated that this funding allowed "us to offer unique programs to communities that are often neglected." The grant also aided CBOs in keeping topics such as food insecurity relevant, with expenses associated with administering programs, staffing, professional and organizational development, and the myriad sustenance and growth needs of CBOs.

Community grantees noted that both programs helped bolster CBO credibility, opened doors to new funding opportunities, and supported increasing programmatic expansion accessibility and inclusivity in underserved communities. Outcomes reported by partners indicated that these programs enabled CBOs to address the evolving needs of diverse populations through initiatives such as instructor training, professional development, and new wellness programs. However, the uncertainty of continued funding poses challenges for CBOs' long-term financial planning. These awards offer CBOs flexible short-term funding, but the lack of guaranteed multiyear support requires identifying other funding sources for programming continuity. Academic institutions and health care systems are often the largest community employers; thus, they are ideally positioned to provide sustainable and accessible funding to CBOs responding to health and health care inequities.

INSIGHTS

We have critically reflected on the shared interests of CBOs and academic research centers, identified a potentially scalable model to promote and support community capacity building, and amplified CBO leadership in health equity initiatives.[23] CBOs work alongside communities to transform conditions producing health inequities and foster a more just society (Figure 2). Relatedly, academic health equity research centers focus on research that is effective in reducing health inequities and improving health justice. We discuss the impact of these 2 funding models and the potential for institutional-level, transformative systems changes as proposed in the NAM ACE model.[9] This community-partnered work provides evidence that sustained CBO investment can increase the community impact of research centers. This is especially relevant today as we face a backlash against health equity work and the dismantling of public health infrastructure. CBOs potentially face an even greater burden to address unmet community health needs, and more academic community partnerships may be needed although there are fewer funding opportunities.

Barriers and Challenges

Both the year-to-year and single-year grants pose challenges to short-term and long-term financial and programmatic planning. Subaward delays and restrictions limited the proposed work; for instance, the institutional preaward process felt like "jump[ing] through hoops" as a resounding pain point for our partners. Not all CBOs knew about recommended allowances for CBO staff time, which caused confusion, as covering staff time is critical for CBO service provision. Partners from both centers felt that these funder-specific requirements force development and subsidization of new infrastructure to deliver on those requirements (e.g., time and money for professional staff development and supervision). Minimizing funding barriers will support organizational and program longevity. For example, Center A's funding renewal criteria included CBO demonstration of scalability and program sustainability. In response to CBO feedback saying that continued funding is critical to sustain their work, we renewed all grants. This led to a different set of challenges: use of a cost reimbursement model, delayed funding owing to institutional infrastructure barriers, and budget cuts in the center.

Evaluation Metrics

Two concerns with funder-required metrics are salient. First, CBOs need multiple funders to fully support their budgets, but each funder typically has

	Community-Based Organizations	Academic Research Centers Focused on Health Equity	Areas of Shared Interests for Community-Based Institutions & Academic Research Centers Focused on Health Equity
Goals	Work alongside communities in transforming the conditions that produce health inequities, foster a more just society	Conduct research that has an impact on reducing health inequities & working towards health justice	• Collaborative research & action that has an impact on community health & health equity • Sustain & scale up community-based initiatives that foster health equity • Share resources • Develop & sustain deep & wide relationships that can be called upon (e.g., public health emergency, community priority or crisis)
Strengths & Areas of Expertise	• Local knowledge of community history, strengths, needs, priorities, solutions • Community trust & relationships • Community power building • Initiatives (e.g., consciousness-raising, advocacy, addressing structural & social determinants of health)	• Research methods, data analysis • Research & administrative infrastructure • Training next generation of practitioners & scholars • Sustained access to federal, state, regional, & local funding • Major local employer • Relationships with local institutions	**Transformations to Collaborate with & Support Capacity Building of Community-Based Institutions & Academic Research Centers Focused on Health Equity** • Recognize the importance of relationship-building & community priorities in guiding community-academic collaborations • Develop a collaborative model that builds relationships & honors community knowledge as expertise • Invest in community capacity-building ○ Create processes for communities to guide vision for & details of capacity-building process ○ Develop sizable seed funding initiatives that invest in a few smaller community-based organizations leading community-responsive health equity efforts ○ Think creatively to support mission-aligned work (e.g., pool funding) ○ Sustain flexible funding over multiple years ○ Facilitate connections between CBOs & funders in academic institution's networks to open doors for more funding opportunities ○ Develop capacity building opportunities that are relevant to local context, are desired, & fill a gap ○ Share scores/comments from grant reviews • Invest in capacity-building of academic institutions ○ Streamline bureaucratic processes to be less legalistic & reasonable in scope & timeline ○ Recognize & redress power dynamics ○ Increase structural & cultural sensitivity
Pressures	• Respond to community needs & priorities • Continual pursuit of grants to sustain & augment work • Systemic exclusion from institutional power • Universities request community support to advance university-driven research & teaching agendas • University bureaucratic processes (e.g., onboarding, subawards, invoicing, reporting requirements) are legalistic, unclear, time-consuming & delay project start/payment, not responsive to community needs	• Research approaches (e.g., community-based participatory research) differ from dominant research approaches that are misunderstood by administrators & funders • Secure research funding • Meet funder requirements & unclear funding commitments • Teaching and service demands • Fiscal constraints & transformations of higher education • Limited bureaucratic & administrator-level capacity to support community-engaged research	

FIGURE 2— Ecological Context of Community-Based Institutions and Academic Research Centers and Transformations to Collaborate With and Support Community Capacity Building: New York City; Los Angeles and Orange Counties, CA

its own evaluation requirements. One BUILD awardee has the burden of administering 5 different required surveys for their participants, some that are more than 12 pages long. Second, most funders expect CBOs to use advanced databases to capture data, but those systems require a great deal of funding to purchase and time to train staff and maintain them.

Funding Process Challenges

Although there is no single established best practice for community–academic partnerships,[26] academic partners can address known challenges of funding CBOs and create infrastructure to support this level of community engagement. Academic institutions have infrastructure that supports sponsored funds for research (e.g., paying community-based consultants) but need infrastructure for academic community–sponsored initiatives, which involve many considerations, as described in this essay. Not doing so can erode trust and make it difficult for researchers to build community partnerships.

Generally, universities and health care systems depend on 1 of 2 mechanisms to fund CBOs. For example, a memoranda of understanding applies when services rendered meet the goals of the overall sponsored program and the CBO is paid either as a consultant (if payment is below a specific amount) or as an independent contractor, which creates funding delays because of required vendor onboarding, additional procurement and accounts payable review, in-house lawyer approval, and funding justification. Without a streamlined process or grantee guidance, CBO staff face a significant and usually unpaid burden. For example, Center B's institutional form required the name and signature of an institutional research official although most CBOs do not have one. Executive directors eventually sign to prevent delays but do not feel comfortable legally signing this way. Organizations without nonprofit 501 (c)(3) status need a fiscal sponsor to receive the funds.

Awardees also need a unique entity identifier from SAM.gov to process award federal grant paperwork; for 1 awardee, a months-long delay for a new unique entity identifier after an organizational name change also delayed their award paperwork. Center A's transition from a public university to a health care system changed how

funds were disbursed. Institution-specific contracting idiosyncrasies delayed fund disbursement (4 months to more than a year), which forced a default to an onerous cost reimbursement funding structure, placing a significant financial burden on CBOs to cover program expenses (sometimes borrowing funds) just to meet established project milestones. As noted by 1 partner, "Cost reimbursement is killing us!"

Overcoming Barriers and Future Directions

CBOs and their academic partners are successful when funding and other capacity-building supports are adequate to meet the goals and outcomes of their programming and shared deliverables. As we have shown, it is imperative that institutions minimize barriers and that research partners consider long-term investment in CBOs to avoid program interruption and build on principles of trust. This can be accomplished by allocating funds to CBO partners at the time of initial research-based grant application. However, at the time of this writing, the new presidential administration plans severe National Institutes of Health funding cuts that will have a devastating impact on the work of our community partners and the centers' continued ability to provide funding support.

CBOs and academic research centers have unique and synergistic strengths and pressures in their health equity efforts. Building on these factors, we identified 4 key transformations to collaborate with and support the capacity building of CBOs and academic research centers focused on health equity (Figure 2). First, foundational to partnering in community capacity building, centers must recognize the importance of relationship building and community priorities in guiding community–academic collaborations. This takes time, ongoing discussion, and critical reflection on power dynamics between academic institutions and communities.[27] Second, centers can develop collaborative models that build relationships and trust and honor community expertise in guiding the design of community capacity-building initiatives.[28]

Third, centers can create pathways for communities to guide the vision and mission of their community-based programs and processes, such as developing sizable seed funding initiatives that invest in smaller CBOs; thinking creatively about ways to support mission-aligned work; sustaining funding over multiple years; facilitating connections between CBOs and other funders; developing relevant, desired capacity-building opportunities filling community-identified gaps; and sharing feedback with applicants not selected for funding. Fourth, it is imperative to invest in the capacity building of academic institutions to partner with CBOs, for example by training staff on community engagement principles and minimizing barriers to institutional and sponsored funds.[12]

To build on the progress made through these CBO award programs, creating additional funding pathways is crucial. Practical strategies include developing a resource manual of aligned funders and facilitating new funder introductions. Offering CBOs opportunities to present at funder events and pursue partnership recommendations could further expand their visibility and financial support. Institutional leadership should self-assess their own readiness to partner with CBOs by investigating institutional pathways for funding before embarking on this endeavor. By demonstrating adaptability and aligning funder missions with CBO focus areas, institutions can support CBO revenue diversification to advance sustainable health equity and community well-being. AJPH

ABOUT THE AUTHORS

Yvonne Anderson and Helena Williams are with the Gailen and Cathy Reevers Center for Community Empowerment, Los Angeles, CA. Renee Artis, Elizabeth Cohn, and Judelysse Gomez are with Northwell Health, Institute of Health Systems Science, Feinstein Institutes for Medical Research, Manhasset, NY. Mona AuYoung, Krystal Griffith-Lloyd, and Keith Norris are with the Department of General Internal Medicine and Health Services Research, David Geffen School of Medicine, University of California, Los Angeles. Quentin Ball is with I Challenge Myself, New York, NY. Ana Leon Bella is with Teachers College, Graduate School of Education, Columbia University, New York, NY. Yelba Castellon-Lopez is with the Department of Biomedical Sciences, Cancer Research Center for Health Equity, Cedars-Sinai Medical Center, Los Angeles, CA. Jack Cheng is with the Chinatown Service Center, Los Angeles, CA. Ray Cheung is with Breathium, Los Angeles, CA. Louise Fonua, Heng Lam Foong, Leah Perez, Christopher Tenorio, and Amelia Vernon are with the Asian Pacific Islander Forward Movement, Los Angeles, CA. Alana M.W. LeBrón, Julia Mangione, and Sora Tanjasiri are with the Department of Health, Society, and Behavior, Program in Public Health, University of California, Irvine. Mellissa McLeod is with Harlem Grown, New York, NY. Pam Pimentel is an independent consultant, Irvine, CA. Michael Viera is with Artists.Athletes.Activists, New York, NY. Aziza Lucas Wright is with Charles R. Drew University of Medicine and Science, Los Angeles, CA.

CORRESPONDENCE

Correspondence should be sent to Judelysse Gomez, PhD, Associate Investigator, Northwell Health, Institute of Health Systems Science, Feinstein Institutes for Medical Research, Manhasset, NY (e-mail: Jgomez38@northwell.edu). Reprints can be ordered at https://www.ajph.org by clicking the "Reprints" link.

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ORCID iDs:
Renee Artis https://orcid.org/0009-0002-2245-0902

Ana Leon Bella https://orcid.org/0009-0006-7816-4023

Alana M.W. LeBrón https://orcid.org/0000-0003-0964-4673

Mellissa McLeod https://orcid.org/0000-0001-5291-5673

Pam Pimentel https://orcid.org/0000-0002-8136-0838

Sora Tanjasiri https://orcid.org/0000-0002-8829-9363

CONTRIBUTORS

The authors contributed equally in the development of this essay.

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