

BRIEF REPORTS

Nurturing Belonging, Reflection, and Responsiveness in Cross-Sector Partnerships: Exemplar From Community-Based Smart Health System Research

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The National Academies of Sciences, Engineering, and Medicine emphasizes the need for research about belonging so work across systems and sectors can more effectively address antiracism. The purpose of this article is to share insights regarding how we successfully co-developed safe and equitable co-learning between cross-sector partners and how this led to a sustainable partnership. The purpose for cross-sector partnering was to work together to prepare for the Community-Based Smart Health System (SHS) community-based participatory research (CBPR) initiative. The SHS CBPR addresses advancing health equity and health technology (techquity) among community dwelling older adults to detect early changes in chronic health conditions using real-time sensor-based monitoring in the home. The cross-sector partnership consisted of a public academic university, a non-profit Asian-based community health and service center, a government administration affordable housing authority organization, and a non-profit faith-based free healthcare clinic. Partners engaged in relationship work together to nurture a sense of belonging, reflection, and responsiveness while preparing to work together on the SHS CBPR initiative towards optimal health and well-being for all. Preparatory work included three participatory methodological processes: (I) adapting the Community Cultural Wealth Framework from a strength-based lens as a guide, including acknowledging that racism is a daily risk factor and knowing and using strengths can protect against racism; (II) co-developing cross-sector partnership agreements that included statements regarding the co-construction of a safe and brave space; and (III) infusing partners' voices into the co-design and other preparatory documents. In this article, we share insights about having exchanged knowledge and shared power in decision-making using authentic reflection that honored partners' perspectives and demonstrated responsiveness to challenges. We describe necessary actions taken to mitigate a power differential. We end with suggestions for how researchers and partnerships can learn from our experience to enhance future initiatives to nurture a sense of belonging within their partnerships, especially partnerships involving testing or using new smart health technologies and automated remote health monitoring.

Conducting community-based participatory research (CBPR) in the context of advancing health equity and health technology towards optimal health and well-being for all is vital. It is essential to ground preparatory work in a nurturing atmosphere to promote a sense of belonging, reflection, and responsiveness among partners. This includes exchanging knowledge and sharing power authentically among cross-sector partnerships with academic and community leaders and community health workers (CHWs) to improve sustainability of the partnership and the work of CBPR. Research focused on health equity in the context of health technology (we call this *techquity*) has potential to harm communities due to dual power differentials created through interaction with academia and community research and sophisticated home-based health monitoring technologies. Health technology research conducted without an equity lens could be experienced by communities as intrusive or even invasive, and this could result in decreasing trust and expanding inequities while increasing a community's isolation. Thus, careful attention to promoting a sense of belonging is critical to co-creating safe working spaces to advance techquity research and health equity ideals. This was emphasized by the National Academies of Sciences, Engineering, and Medicine (2021) in the context of research to promote antiracism (Nguyen-Truong et al., 2023). Authentic intention in nurturing belonging among partnerships is important in the strategic involvement of partners from different sectors interested in the innovative area of smart health technology research.

A growing body of literature discusses the intense effort that academic-community partnerships require to equitably collaborate and engage communities in CBPR. Considerable effort is required when representatives from different sectors work together to bring different strengths, resources, perspectives, and lived experiences to the partnership. Eliciting and utilizing these perspectives requires partners to commit their time, energy, effort, and trust. It also requires mutual understandings that many communities have experienced historical trauma and that language and cultures have varying needs and expectations ([Table 1](#)).

Despite these barriers, partnerships afford opportunities to obtain more meaningful, and arguably more evidence-based or evidence-informed, outcomes than research without stakeholder engagement (Goodman et al., 2020). For example, in one study, organizational partners (community health centers and universities) engaged immigrants as partners in research to study the complex physical and mental health conditions of immigrants. Consideration was given to the impact of language, culturally-based health approaches, and access logistics (Fritz et al., 2020; Nguyen-Truong & Fritz, 2018; Vaughn et al., 2017). In another study, cross-sector partners engaged with care team partners in permanent supportive housing (Schick et al., 2020). Community partners raised the question of how time-intensive research can be when ethically accomplished, given that resource imbalances often exist between community and academic partners (Goodman et al.,

Table 1. Barriers Encountered to CBPR and Our Solutions to Address

Barriers	Solutions
Time	Meet community leaders, staff, and members at their place of business or at their preferred location. Conduct trainings to improve efficiencies and invest in community by exchanging and co-creating knowledge.
Energy	Academic partners should put in more energy than their community partners. Be respectfully energetic.
Effort (human & financial)	Academic partners should lead by example and put in more effort than community partners. They should financially compensate community for their efforts. Shared decision-making on equitable compensation should occur before a grant application is submitted so the budget reflects community needs and honors their human and financial effort.
Community leadership changes	Maintain ongoing communications and identify one or two alternative community leaders who agree to be representative leader-partners.
Organizational leadership & staff changes	Maintain ongoing communications and discuss back-up or succession plans upfront and periodically revisit the plan.
Language differences	Continually assess the research partnership's language differences. Grow a representative partnership that reflects and speaks the languages of research participants and communities engage.
Cultural differences / expectations	Meet with community leaders from the start to co-create a safe and brave space to co-create shared understandings about cultural expectations.
Historical community trauma	Recognize historical trauma exists. Increase the research partnership's knowledge about the traumas of the communities served. Engage with community with openness, kindness, and from a position of wanting to learn rather than imparting knowledge.
History of unethical research in United States of America	Before engaging with communities, identify unethical historic studies impacting the engaged communities engaged. Reflect on individual and collective understandings. Be astute to distrust (verbal, non-verbal) and co-create safe and brave spaces to listen and reflect together as partners. As researchers, be open to adjusting and co-creating to increase a sense of belonging and trust.

2020; Hoekstra et al., 2020). In addition, research suggests effective participatory methods are needed regarding research processes aimed at reduce time and effort burden while building the partnership's capacity for research and partnership sustainability (Nguyen-Truong et al., 2017, 2018).

Our cross-sector partnership used CBPR principles, including building *mutual* trust and rapport, safety, humility, respecting, learning, and mentoring throughout the research process (Nguyen-Truong et al., 2023; Wallerstein et al., 2018). We embraced CBPR principles that emphasize equitable involvement of partners throughout the process (Sánchez et al., 2021; Wallerstein et al., 2018), including co-determining the extent of partners' involvement and co-discovering time and effort capacity (e.g., learning about partners' work schedules and other commitments). We worked to mitigate power differentials (Sánchez et al., 2021; Wallerstein et al., 2018) through nurturing a sense of belonging within the cross-sector partnerships, despite the challenges of navigating multiple partners' capacities. We aimed for a deeper understanding of organizational partners to safely exchange knowledge and share decision-making power regarding the community-based smart health system (SHS) CBPR initiative.

The primary purpose of this article is to share our insights about the participatory methodological processes used that gained relationship knowledge to prepare for co-engagement in the SHS CBPR initiative. We discuss three intentional participatory methodological processes that were co-designed and used to nurture a sense of belonging, reflection, and

responsiveness by all partners. (I) We recognized that racism is a daily risk factor. We adapted the Community Cultural Wealth (CCW) Framework from a strength-based lens as a guide. II) We co-developed cross-sector partnership agreements that grounded co-construction of a safe and brave space for sharing thoughts. III) Partners' voices were infused into the co-design. We exchanged knowledge and shared power in decision-making through authentic reflection that honored partners' perspectives and responsiveness to challenges. We describe necessary actions taken to mitigate a power differential. We describe these methods here and then suggest how researchers and partnerships can learn from our experience. Enhance future initiatives to nurture a sense of belonging within their partnership, especially if the partnership context involves the rapidly growing research area of smart health technology and automated remote monitoring towards optimal health and well-being for all.

The Washington State University Human Research Protection Program (Institutional Review Board [IRB]) approved the main SHS CBPR study that included the participatory methodological processes (#19135-001).

Positionality Statement

We are aware that individuals and organizational partners' collaborators in the cross-sector partnership from the United States Pacific Northwest have unique identities based on their socio-cultural, work, and lived experiences, and these identities informed how our partnership learned and worked together. The academic partner and community organization partners' collaborators included the Chief Executives of Operations, Directors, Managers, and CHWs. The Co-Principal Investigator (Co-PI) is a Co-Founder and the PI is the Director and Founder of the Nurse Technology Enhanced Care at Home Lab (nurse-TECH.org Smart Home Solutions, 2024) at a nursing college of a public academic university. The mission of the lab is to develop and promote health technology addressing chronic conditions in adults and create a space to work together with community and health technology industry partners. The Co-PI is Vietnamese with a Guamanian Micronesian Islander background and has specialties in antiracism and CBPR, including working with organizational community leaders and CHWs from immigrant, refugee, and marginalized communities. The PI is White with Native American heritage (reported in stories handed down across generations about a Choctaw grandmother) and has specialties in developing health-assistive smart homes for older adults and the use of artificial intelligence in the delivery of healthcare and informatics-based information. The community organization partners and their missions consisted of (1) a non-profit Asian-based community health and service center that bridges cultures and a harmonious community of older Asian immigrants and refugees, including Chinese, Korean, and Vietnamese since 1981 (Asian Health & Service Center, 2024); (2) a government administration affordable housing authority organization serving residents who experience housing barriers due to income, disability, or special needs

since 1942 (Vancouver Housing Authority, 2024); and (3) a non-profit faith-based free healthcare clinic improving healthcare access for adults who are low-income, un-insured, or underserved since 2011 (Battle Ground Healthcare, 2023). We adopted the following definition of a CHW from the American Public Health Association (2024) CHW Section, “A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery” (para 2).

Sharing Our Three Methodological Processes

Adapted Strength Concepts of the CCW Framework

In our first participatory method process work, we adapted the CCW Framework because of its strength-based lens and it guided our work as it did Acevedo and Soloranzo (2021). We share the following examples, including insights, reflection, and discussion. We were cognizant that our work was being done in different communities during the COVID-19 pandemic and wanted to move away from a traditional deficit lens. We also recognized that racism (discrimination) can be a daily risk factor. For example, we learned from prior work with Hispanic and Asian-based community leaders and CHWs that escalating immigrant-hate and anti-Asian hate, discrimination, and the fear of backlash was a concern (Nguyen-Truong et al., 2024). The academic partners (i.e., the PIs and research staff) entered the cross-sector partnership from a position of centering community partners and intentionally highlighted numerous known strengths of each community and using strengths can be protective against racism (Acevedo & Solorzano, 2021). For example, from prior work together the diverse Asian community’s strengths included resilience, seeking of harmony, collective knowledge on adapting to new environments, and having a well-developed and well-organized cultural center with multiple social and health service offerings. The housing authority community’s strengths included having housing in multiple locations along public transportation lines (i.e., buses, train), well-maintained residential properties, well-planned events offered at each property, and publicly elected and appointed leadership committed to innovation and equity. The faith-based clinic’s strength included a commitment to caring for *all* persons’ physical, social, and spiritual well-being. To further embrace and illuminate strengths and build trust and rapport, we spent additional time getting to know one another as a cross-sector partnership. This was accomplished through multiple in-person meetings held at partners’ places of operations, or if requested by the partner, via videoconferencing. In these meetings, the PIs elicited aspirational capital – a concept relating to partners’ desires for communities; linguistic capital regards partners’ ability to communicate; navigational capital refers to

Table 2. CCW Framework's Strength Concepts and Cross-Sector Partnership Agreements

Community Cultural Wealth Framework's Strength Concepts	Cross-Sector Partnership Agreements
<i>Aspirational</i>	Aspirational agreement included having an affordable (low-cost) SHS and knowing that the goal for the SHS's features and functions was to assist community-dwelling older adults via a technology-augmented people-based system facilitating early detection clinically relevant changes chronic health conditions.
<i>Linguistic</i>	Linguistic agreement included (1) recognizing that each partners' communication style may be different from one another, (2) recognizing that some partners can communicate in multiple languages in addition to English, (3) highlighting CHWs communication strengths in describing the novel SHS technology and the associated nascent language needed to accurately describe it, and (4) the ability for CHWs to stay engaged in communications throughout the six-month study.
<i>Navigational</i>	Navigational agreement regarded keeping the connection among partners while being mindful of capacity and accommodating their various work schedules.
<i>Familial</i>	Familial agreement regarded being supportive as a collective.
<i>Social</i>	Social agreement regarded partners openly sharing their perceptions and experiences in our co-constructed safe and brave space.
<i>Resistant</i>	Resistant agreement regarded working with grit (i.e., bravery) and resolve (i.e., action oriented) where possible when facing challenges.

keeping the connection among partners; familial capital involves being there for one another; social capital relates to partners openly sharing; and, resistant capital refers to working together when facing challenges. Thus, these strengths are a foundation from which the work of our second and third participatory methodological processes built upon in nurturing a sense of belonging, reflection, and responsiveness in having prepared for the SHS CBPR.

Co-Developed Cross-Sector Partnership Agreements

We co-developed agreements on how we wanted to learn and work together as a cross-sector partnership as the second participatory method work that built upon the work of the first participatory method. This discussion work was accomplished during two synchronous one-hour meetings times and follow up emails. In the agreement documents, we reflected back to one another (1) the illuminated strengths, (2) alignments with organizational missions, and (3) experiences working with the served populations as it related to the SHS CBPR initiative. We did this by centering partners' voices where we deeply listened to for gaining shared understandings about academic and communities' desires. Deep listening included listening to understand without distraction, making eye contact as appropriate per cultural norms, attentiveness to non-verbal communication, and asking thoughtful questions and responsive, and actively setting aside biases (reflexivity) and keeping an open curious and growth mindset. All agreements aligned with the CCW Framework's strength concepts and were embedded on a single comprehensive agreement document ([Table 2](#)).

Infusing Partners' Voices in the Co-Design

We took four important actions to infuse partners' voices in the co-design partnership discussion and the resulting documents as the third participatory method work that built upon the work of the second participatory method. First, we engaged in an initial discussion in listening to infuse partners' voices in the co-design as a cross-partnership. Second, while we worked on co-developing cross-sector partnership agreements (described earlier), we also used this time to complete the initial co-design discussion. Third, we shared that we recognized that academic and community partners bring different strengths, resources, perspectives, and lived experiences, and that we honor these experiences the perspectives each bring. Fourth, we engaged in a bidirectional knowledge exchange where each partner took turns sharing what they knew about smart health technology and its use in the populations they serve. For example, the Asian-based community partners reflected on a prior engagement with the PIs regarding the influence of culture on adoption smart homes for health monitoring.

During these discussions, the PIs centered themselves in humility to optimize the probability that they would not come across as being *THE* bearer of the knowledge of smart health technology unilaterally but rather as co-remembering and sharing knowledge. To reduce power differential impacts, we referred to previously co-developed cross-sector partnership agreements that promoted a de-centering for successful bilateral knowledge exchange. This methodological process opened space for two critical discussions to occur (about money; about the idea of *home*).

The first critical discussion regarded the PIs goal for older adults to trial a low-cost SHS (\$400 or less in United States dollars) during the SHS CBPR initiative. Participant inclusion/eligibility criteria was discussed that led to cross-sector partners sharing that health and technology costs were concerning issues for their constituents. We understood that *techquity* was mostly not occurring in partnering communities. For example, we learned that participants may not have internet due to affordability. Organically emerging in the discussion was one partner's knowledge of a government free internet program – the Affordable Connectivity Program (ACP). The information was shared with the rest of the community organization partners who had similar concerns and all benefited from this knowledge. Multiple partners began telling their constituents about the ACP program. The PIs pivoted from requiring participants to have internet to be included in the study to using hotspots (a mobile cellular-based data transmitter).

The second critical discussion regarded the meaning of *home* to participants. We heard that home was a special place where there was a feeling of safety, privacy, and independence. We also heard that an older adult's home may have multiple meanings in the context of physical spaces in multigenerational homes. The home could be the entire home's footprint (floorplan, all rooms and spaces of the residence), and it could be just the bedroom of the older adult. For example, their room with attached bathroom

could be considered their home with the bedroom door in essence being the front door to their home. This discussion substantively informed prototype design.

In a third discussion, the PIs co-facilitated and used a participatory plus/delta method to discuss the pluses that are strengths and the deltas as areas to improve (O'Connell & Vandas, 2015) with community organization partners' representatives. The discussions, consisted of three one-hour videoconferencing sessions that were scheduled to accommodate work schedules, led to an in-depth co-design. The study protocol, flyer, participant consent form, and Health Insurance Portability and Accountability Act (HIPAA) authorization form were shared and discussed. The Co-PI represented the public academic university. Fourteen partner representatives from across partnering organizations attended. Of these eleven were community leaders and CHWs who were first-generation immigrants and refugees. This plus/delta discussion supported our commitment to work together and honored partners' perspectives and strengths by illuminating community organization partners' recommendations for more effective processes for deploying the prototype with older adults in the community. This plus/delta time was necessary time for co-constructing a safe and brave space for all to process, listen, and learn from one another about what could work and what could present challenges. The nurtured sense of belonging allowed partners to openly share resulting in their voices being infused into the protocol and a resubmission to IRB where applicable.

Outcomes

Five outcomes emerged from the strengths-based participatory process and plus/delta discussion.

(1) We created separate flyers for each partner with community partners' unique contact information. Two partners presented an anticipatory challenge – that constituents may feel more comfortable speaking with someone they already trust (i.e., persons at the partnering agencies). Adjusting flyers and contact information helped build trust and rapport.

(2) We provided physical sensors to show potential participants during outreach and recruitment. This helped to address the challenge in having to describe the three-dimensional multisensors and door sensor with actual examples.

(3) We adapted the existing prototype design to accommodate multigenerational households. In the context of a discussion about inclusion and belonging, an issue was raised regarding a study inclusion criterion for older adults to live alone. We heard that many older adult community members in both the Asian and Hispanic communities live in multigenerational households yet CHWs thought that those families had elders who would want to participate in the study. Using reflection and responsiveness, the PIs reflected on the prototype's purpose and the study aims, which originally focused on safely extending independence for older adults with chronic conditions living alone. A discussion ensued about

meaningful ambient sensor-based data and how it might be used. We co-created with CHWs a plan for including multigenerational families and their elders that aligned with study aims. This co-created adjustment required using an open, curious mindsets and creative thinking on both sides. The cultural responsiveness exhibited by the PIs further promoted partners' sense of belonging as well as empowerment.

(4) The age inclusion criterion was changed. The representative from the non-profit free faith-based healthcare clinic partner raised a concern about the inclusion age, which was originally set at 60 years+. We heard that their largely Hispanic patient population was experiencing multiple chronic conditions at younger ages and dying younger than their white counterparts. They requested the age inclusion criterion be lowered to age 50 years to accommodate their constituents. This request resulted in requests to IRB and the funding mechanism to make this change. Rationale included the community's request. Permission was granted and the change was made.

(5) Real friendships were formed, and partners continue to get together and grow together. Enduring trust resulted from these initial plus/delta sessions affording many future opportunities to co-learn and co-manage evolving situations throughout the study in culturally safe and effective ways. The sense of belonging continues today – well beyond the end of the study – with all partners continuing in their relations. Relationship activities include attending each other's social and cultural events (Lunar New Year; Cinco de Mayo) as well as fund raising events, and academic scholars joining community group classes and learning sessions as content experts on various topics.

Suggestions for Consideration

We encourage future researchers and partnerships to discuss and identify methods that will promote authentically nurturing a sense of belonging within their partnership and in the work. We posit that this will center learning and working together and honor strengths while addressing community needs towards optimal health and well-being for all. We offer our learnings as suggestions to the broader CBPR research community:

- Recognize that racism (discrimination) can be a daily risk factor. Use a strength-based framework that moves away from a traditional deficit lens.
- Co-develop agreements on how you want to learn and work together as a partnership. This can help provide grounding for a co-constructed safe and brave space.
- Be open and clear when facing challenges in cross-sector CBPR partnerships and do your best to have grit and be responsive, whether achieved or not.

- Stay transparent by staying connected and having ongoing authentic and interactive conversations that are reflective and reflexive. This can encourage exchanges in knowledge and resources among partners.
- Be humble and mindful in your engagement as partners with communities to ensure ongoing *mutual* trust, rapport, respect, and care.

Conclusion

Our cross-sector partnership learned from one another and worked together to prepare for the SHS CBPR initiative to address *techquity* (equity in both health and technology accessibility). Our methodological processes included CBPR principles, adapting the strength concepts of the CCW Framework, and nurturing a sense of belonging within the partnership, reflection, and responsiveness. Multiple challenges in nurturing a sense of belonging were shared by community partners that were addressed by the academic partner as part of co-creating and co-learning in the context of a research study. Suggestions for future partnerships are made that will support sustainable, strengths-based partnerships. We encourage researchers and partnerships to learn from our experience. Enhance future initiatives to authentically nurture a sense of belonging within their partnership and in work done in the rapidly growing area of smart health technology – automated remote monitoring towards optimal health and well-being for all.

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