

FULL-LENGTH ARTICLES

Co-Designing the Role of a Community Health Research Champion: A Grounded Theory Assessment of University and Community Perspectives

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The purpose of this article is to 1) characterize the role of a “community health research champion” (CHRC), 2) outline a hybrid CHRC position which conjoins communities and universities for research, and 3) compare university-based and community-based researchers’ ideated perceptions of this position. Using a participatory co-design process, we contribute to the literature on champions in three ways. First, we examine the qualities, preparation, and supports needed for CHRCs to operate within community contexts and university structures. Second, we share actionable recommendations for how project teams can add CHRCs to advance equal community-university research partnerships. Finally, we distinguish two perceptions of how to complementarily implement the role as a “bridge” or “extender,” reflecting the different values and expectations of community-participatory or community-engaged research.

In community-engaged research (CER), institutional actors, including university, clinical, and public health stakeholders, depend on community assistance and buy-in, with participants contributing to research data and having access to project resources (Schaaf et al., 2020, p. 3). Community champions can help link community members to benefits from CER, filling the gap between project and community. They enable acceptance of a CER project and team (Reid et al., 2019) through supporting participant relationships (Rogers et al., 2018) and facilitating access to community knowledge (Schlechter et al., 2021).

Researchers have documented how a variety of health champions have contributed to implementing and disseminating health interventions and tailoring service delivery for improved health outcomes and health equity. For example, health champions help increase the uptake of interventions (Kokorelias et al., 2023) and foster community ownership of health initiatives (Muscat et al., 2023). Projects with strong champions tend to have better adaptation rates and more effective recruitment strategies (Gruß et al., 2021, p. 56; Lofters et al., 2023). Their involvement often leads to sustained partnerships and higher community participation (Zhang et al., 2022).

Types of Health Champions

Various types of champions have been studied—e.g., clinical champion (Bonawitz et al., 2020), research champion (Hepburn et al., 2022), data champion (Higman et al., 2017), and community champion (Mitchell et al., 2024), to cite several. We distinguish two broad role descriptions in the literature, reflecting health champions' primary work within institutions or communities:

1. Professionals (e.g., clinicians, public health staff, university researchers) champion institutional change and organizational collaboration by, e.g., breaking down silos to coordinate care (George et al., 2022), adapting treatment protocols (Bunce et al., 2020), adopting health literacy strategies (Ayre et al., 2023), or translating research findings into health policies (Towfighi et al., 2020) to serve patient and community needs more holistically and appropriately.
2. Volunteers (e.g., community residents (Reid et al., 2019), immigrants and refugees (Mudyarabikwa et al., 2022), surviving patients or their caregivers (Rafie et al., 2015)) champion community members' knowledge and lived experiences to make outreach, education, and delivery of health care and social services more responsive to local priorities, needs, and assets.

Community Health Research Champions (CHRCs)

We examined how “community health research champions” (CHRC) can enhance university-sponsored CER focused on health, particularly in underserved communities. We understand community engagement as the “active participation of communities, whether connected by geography or interest,” in research priority setting and study design, implementation, and analysis (cf. South et al., 2024, p. 2). The literature has referred to community champions who support research projects as “peer researchers” (Howlett et al., 2024) and “patient research ambassadors” (Hedayioglu et al., 2025). These two examples were from the United Kingdom where community champions are often acknowledged as key partners in community health. Our analysis of how to define and implement the role of a CHRC was derived from a qualitative study that used a participatory co-design process with university- and community-based researchers who have been funded by Indiana Clinical and Translational Sciences Institute (CTSI). We sought guidance from experts based in the domains of universities and communities because different priorities and values tend to govern research in these contexts, reflecting in part the differences between community-engaged research and community-participatory research.

The CHRC role does not fit squarely within the professional or volunteer parameters of most champions' research. It is a hybrid role, grounded in community context, knowledge, and relationships and operating across a wider ecosystem of academic research. Tasked with defining this role for Indiana CTSI, our team identified tradeoffs in how to operationalize it given the tensions between university institutions and community settings. The present article analyzes how two sets of university and community experts visualize the CHRC role in terms of the qualities, preparation, and supports needed for CHRCs to operate within community contexts and university structures. We synthesize these visualized features into actionable recommendations for how project teams can collaborate with CHRCs. We also distinguish two perceptions of how to implement the role. Generally speaking, community researchers viewed CHRCs as a "bridge," while university researchers envisioned them as an "extender." These two perceptions parallel, respectively, the values and expectations of community-participatory and community-engaged research. In light of this tension, we offer considerations to project teams on how to partner with CHRCs in advancing equal community-university research partnerships.

METHODS

The present research was undertaken under Indiana University IRB approval (# 23572). Over a 5-month period, we conducted virtual focus groups and interviews with 10 university research leads and 7 community research leads who have been funded by Indiana CTSI's Trailblazer Awards or Trailblazer Planning Grants. Both programs support community-university research partnerships focused on health. Trailblazer recipients are selected through a participatory process, in which community and university reviewers, chairs, and advisory boards have equal voice. Trailblazer teams vary in their methods and degree of community-engagement, but the selection process favors more participatory methods. We engaged these Trailblazer experts to participate in a co-design process of ideating the new role of a "community health research champion" (CHRC).

We selected researchers to invite from over 50 Trailblazer teams funded since 2020. We over-sampled for teams who had completed their study or received new funding to extend their pilot project. We recruited a diverse set of researchers by race, ethnicity, and gender, by research topic, and by geographic location (urban and rural). Our 17 study participants are henceforth called "respondents." The focus group/interview scripts opened with a series of questions prompting respondents to describe and characterize the successes and challenges in their team's community engagement generally. Then we invited them to imagine adding a CHRC to a research team and to envision the elements of a position description, such as qualities, skills, qualifications, activities, responsibilities, training, and compensation. This two-part process aimed to ground respondents' participatory ideation in their experiences with CER. We introduced the idea of a CHRC using generic language. We did not provide a position description prior to the

focus groups/interviews. Near the end of the sessions, we did share a position description drafted by our team in case it prompted further reflections or objections.

Recorded focus groups and interviews were transcribed verbatim and de-identified. We grouped responses by university researchers (UR) and community researchers (CR). Using a grounded theory approach, we coded the respondents' ideated CHRC profiles and the discussion at large using NVivo. We organized the main themes emerging from the discourse of URs and CRs into Needs, Wants, and Problems.¹ "Needs" are defined as non-negotiable traits or characteristics that respondents found necessary to fulfill the duties and responsibilities of the CHRC role. "Wants" are defined as ideal characteristics and traits that are useful to fulfilling these objectives. "Problems" are issues to be aware of when writing a position description or hiring a CHRC. While too extensive to list all respondent thoughts and opinions, prioritizing themes revealed an implicit value scale brought by URs and CRs to specifying the CHRC role.

This thematic coding provided the first set of concepts that framed our analysis. We identified thematic differences between CRs and URs in what they viewed as Needs and Wants for the CHRC role, as well as Problems underlying the conceptualization and definition of the position. Differences included both the respondents' descriptions of their priorities and the frequency with which themes were mentioned. Reviewing all transcripts through the lens of this initial thematic analysis, we identified two more sets of concepts—the values and the rationales underlying the thematic differences between CRs and URs. We then iteratively synthesized the values into recommendations for how to define and implement this role in CER. Finally, we characterized the implicit rationales into two distinct perceptions about CHRCs and their roles in supporting CER. We labeled CRs' view of CHRCs as a "bridge" and URs' view of them as an "extender." Clarifying these two views of the role helped us anticipate obstacles and potential solutions when working with CHRCs in CER.

RESULTS

[Table 1](#) and [Table 2](#) present the frequency distributions of coded themes (Needs, Wants, and Problems) for URs and for CRs, respectively. Comparing the tables, there are observable differences between URs and CRs. For URs, having an individual who was *local* to the area or population, good at *communicating*, and had a *research orientation* toward community health were non-negotiable traits (Needs) of the person envisioned as a CHRC. CRs emphasized the Needs for a CHRC who would be a "*bridge*" or "*liaison*," who had *lived experience*, and who would be *integrated into the research team with authority*. At the level of Wants, URs prioritized *research*

¹ We pulled common themes from what the respondents said, using our interpretive creativity to identify and name shared concepts even if respondents used different words.

knowledge of the project, at least at the level of goals, while CRs leaned more toward wanting an individual who can *activate community networks*. There are also shared priorities across these groups' conceptualization of a CHRC. Both groups wanted *sustainability* in the position, and both pointed to the Problems of *financial compensation* and the difficulties of a *single CHRC* representing community perspectives (vs. *a community champions board*).

Table 1. Frequency Distributions of Needs, Wants, and Problems in the Position of a Community Health Research Champion (University Researcher Perspective) N=10

	Coded References ^a	Average Words Coded ^b	Percentage ^c
NEEDS			49.65%
Local	17	616	21.36%
Communicative	19	482.5	19.38%
Research Oriented	8	201.25	8.91%
WANTS			15.98%
Research Project Knowledge	11	314.25	11.78%
Sustainability (of Pay)	5	152.25	4.20%
PROBLEMS			34.37%
Financial Compensation	10	383.5	18.46%
Board vs. Single Champion	10	340.5	15.91%

^aCoded References is the number of times a code was identified, so in the case of Local, it was coded 17 times.

^bAverage Words Coded is the average number of words coded each time respondents referred to a theme. With Communicative, for example, respondents took an average of 482.5 words to explain its value.

^cPercentage (a function in NVivo called "Coverage") weights Average Words Coded for a theme relative to all coded words. Thus, Percentage can be higher for less frequent themes if a theme (e.g., Local) required coding more words due to the indirect or contextual answers of respondents.

Table 2. Frequency Distributions of Needs, Wants, and Problems in the Position of a Community Health Research Champion (Community Researcher Perspective) N=7

	Coded References	Average Words Coded	Percentage
NEEDS			70.84%
"Bridge" or "Liaison"	17	294.5	31.59%
Research Team Integration and Authority	11	212.17	23.20%
Lived Experience	7	110	16.05%
WANTS			11.69%
Activation of Community Networks	4	113.83	9.25%
Sustainability (of Personnel)	1	23.5	2.44%
PROBLEMS			17.47%
Board vs. Single Champion	7	118	12.81%
Financial Compensation	1	26.8	4.66%

We organize our analysis of Results into four main recommendations for how to describe, hire, and operationalize a CHRC position. We draw two recommendations each from URs and CRs (for a total of four), which we develop in separate sections. The four recommendations are not exclusively prioritized by URs (items 1 and 2) or CRs (items 3 to 4), but they are

presented in this way to emphasize in which group each one predominated. The analysis aims to distinguish how the two groups' differing values shaped their recommendations about the position. At the same time, there was substantial overlap in URs' and CRs' commitment to a common objective of strengthening support for community priorities and equal partnerships for more participatory CER.

University Researcher Perceptions

1. CHRCs Must Be Local, Research-Oriented, and Paid

Local (to the Area or Population)

Our UR respondents echoed the literature on community health champions in stressing that a CHRC must be local (Mudyarabikwa et al., 2022; Schaaf et al., 2020; Schlechter et al., 2021) to the area or population in a study. For example, a focus group respondent described the need for "someone who is local, not someone who's driving from a wealthier part of town to represent people, but doesn't have a lived experience, and is fantastic at understanding what communities want and need" (Public Health PhD Candidate, Rural Community Grant). In the same focus group, another respondent reinforced: "The [CHRC] must have really deep connections and good rapport with the communities that we're going to be engaging in, and that way, it would be easier for them to possibly help with recruitment or something of that nature" (Associate Professor of Social Work, Black Men Grant).

There is a fine line in URs' responses between needing someone who is "local" to a community, and then wanting someone who shares similar "lived experiences" with individuals within that community. This distinction is nuanced but important because Needs and Wants lie on a values continuum. To clarify the difference, a UR interviewee praised how the community co-lead on their research project, who was not a drug user herself, "was always in the room, reminding those who did the research, who helped to form the policy, who helped to create decisions, and all of the major stakeholders, not to forget about the people who use drugs because they're also the ones with all the knowledge" (Analytical Chemist, Drug Test-Strip Grant).

This observation reinforces two lessons: 1) It demonstrates how URs see a need for people to be from the community and show up for that community versus also wanting individuals who share lived experiences with the community. 2) It also challenges certain ideas of expertise: this community co-lead was not an academic, but she was familiar with the community knowledge base that came through relationships with the people in that community and an understanding of how their patterns of drug use affected the area.

Research Orientation

For URs, another essential quality in a CHRC is a research orientation. This chemist cautioned against hiring a person “who has their own axe to grind. Like if they already know the solution to the problem, right. Then that may not be compatible with the research process.” A CHRC needs to see value in the process of developing novel research questions, collecting and analyzing data, and producing findings grounded in evidence. A second university lead on the Black Men Grant described the staff at their partner organization as “co-researchers.” “They helped to develop the [interview] questions...They were really heavily involved in the research design, in recruitment, in creating a community that we were actively involved in” (Associate Professor of Africana Studies and Religious Studies).

The combination of being local and knowledgeable about a community as well as being invested in the methodological procedures of data-driven research may make finding a qualified CHRC challenging. CHRCs with this combination of skills and qualities also must be compensated, unlike the mostly volunteer positions of community health champions in the literature. A Public Health faculty member on an LGBTQIA+ Health Grant added that an ambidextrous CHRC working in community and research spaces must have “on the ground knowledge of different types of situations that people experience [and] be able to bring that into the academic setting...you can’t buy that type of experience and that type of knowledge and expertise to know how to be able to reach communities.” It is imperative “to compensate people appropriately for their time and their experience.”

Financial Compensation

CER is mostly funded through timeline-specific grants. One reason that community health champions are typically volunteers is that their tenure cannot be solely tied to the timeline of a grant or research project. Rather, they should be permanent fixtures in the community (Gruß et al., 2021; Schaaf et al., 2020), regardless of when the research project takes place. URs rejected, however, volunteer status for CHRCs.

Toward the end of our focus groups and interviews, we shared a draft description of a CHRC position that offered 30-35 hours each month at \$50/hour. A respondent questioned the part-time hours and pay: “For me, I would need more than this number of hours per month, unless I had a lot of people doing it and then it gets a little disjointed, I suppose. I’m not sure who would do this for this little amount unless they were somebody who was trying to go through school” (Professor of Pediatrics, Diabetes Prevention Grant).

Other practical considerations included the short timelines of grants: “if it’s a two year grant, then you have someone working for maybe 12 months, but it’s really uncertain and then they lose their grant funding, and all of

that's really difficult and people don't necessarily want to apply for jobs that are grant funded that are going to end and are only part time" (Public Health PhD Candidate, Rural Community Grant).

UR respondents stressed the necessity for adequate compensation above and beyond the engagement driven by a personal desire or a passion (George et al., 2022). Receiving compensation, grant-funded or not, is a must for CHRCs. Hiring CHRCs into a permanent position, however, is not a need for URs because their work will be complete at the project's end. Yet respondents preferred sustainability in the position because a CHRC's trustworthiness is based in ongoing community relationships.

2. CHRCs Communicate and Support Research at the Level of Goals

Communicative

Communication is central to championing any health intervention or study with multiple stakeholders. CHRCs would need to communicate both local community knowledge and research information. Various UR respondents prioritized the order of the messaging differently, but roughly half put academic researchers in the driver's seat. For example, one UR respondent describes the communication process as follows: "I think the best way is probably working with early researchers like me and then the community partners who need [the] academic expertise [simplified]" (Assistant Professor of Nursing, COVID-19 Community Grant). Another UR saw CHRCs as critical to communication out to community partners and then back to researchers. There must be a "translation between what the academic team's goals are or the language that they use around the work...and [also] that the needs of the community partner are reflected in the work that the academic partner is thinking about" (Professor of Public Health, Special Needs Kids Grant).

These two URs position CHRCs as working with the researchers first and then using their familiarity with academic language and concepts to help convey the research project to community organizations and members (cf. Ayre et al., 2023; George et al., 2022). Even when community partners speak back, the input is more consultation than expertise. While appearing bi-directional, the expected communication pattern can often be unilateral.

Research Project Knowledge

In clarifying the value of research project knowledge, both URs and CRs emphasize research "goals." For CHRCs to convey and implement research, understanding the research aims is most important (Ayre et al., 2023). One CR respondent affirms, "I definitely agree that you have to understand the entire project to know what the goals are on the outside or what the driving goals are, and then you've got to be able to provide input that's going to be valuable [and] you have to know what the long term goal is and understand it" (Community Partner, Special Needs Kids Grant).

CHRCs do not have to be experts in various fields of health and medical research or master all the technical terminology and details of the research; they must, however, comprehend the research aims and longer-term outcomes to align the work with community priorities and local context and concerns. While in theory it may be ideal for a CHRC to have some academic background, it should not be a standard for anyone who wishes to be in this role (DeGroff et al., 2018). CHRCs should not be disqualified based on academic credentials. Individuals without a post-secondary education may be appropriate for a CHRC position due to their local community knowledge, experiences, and relationships.

Community Researcher Perceptions

3. CHRCs Should Identify and Bridge “Gaps” in Community-Engaged Research

“Bridge” or “Liaison”

Studies of community health champions often characterize their role as providing a “bridge” between institutional actors and people living in a community (e.g., Muscat et al., 2023; Reid et al., 2019). Schaaf et al.’s review of community health workers (CHW) describes three facets of their “bridge function”: “service extender, cultural broker, social change agent” (Schaaf et al., 2020). CHWs differ from CHRCs in helping connect discharged patients and local residents to appropriate health care and social services, but the terms extender, broker, and change agent are useful in framing CRs’ descriptions of CHRCs’ bridging work in CER.

CRs emphasize the Need for CHRCs to act as a “bridge” or “liaison.” One respondent notes how partnering with organizations and individuals on community health research can reveal unmet needs and lead to requests from the research team for help connecting to resources. A CHRC must be “able to bridge that gap and able to, like if that community group needs assistance, being able to navigate them to where they need to go for that answer or that assistance” (Managed Care Organization Community Partner, Doula Research).

The “gap” here reflects both under-resourced community needs and budgetary constraints of CER. Addressing unmet need may be the ultimate driver of improving community health, yet CER budgets fund personnel, partner and participant costs, and other research expenses focused on specific health topics and relevant education and resources. When research teams pivot to respond to gaps in services, a CHRC’s knowledge of community context and networks of relationships can facilitate both the “extension” of appropriate service supports as well as efficient, feasible reallocations of research funding.

In addition to this resource gap, another CR identifies a relationship gap in CER. In his words, “the engagement of community does not simply mean that I look at the community, it means that I actually form a relationship.

And that's troublesome probably for a lot of academics and researchers. Oh, no, I'm...supposed to be on an inobtrusive pursuit that allows me to remain an objective observer" (Pastor Community Partner, Medicaid Equity Grant). He added that the community and university co-leads on their Trailblazer Award also went "through a cultural template process so that we were able to assess our biases and learn in new relationships."

Perhaps CHRCs' most important bridging work is as a cultural broker. Building trustworthy relationships in CER requires attending to the different types of expertise contributed by academic researchers, community partners, and individual participants. CER recognizes that community participants' lived experiences, cultural intelligence, problem-solving know-how, and local knowledge of assets, needs, and priorities are essential to valid, relevant study findings. As we discuss later, the need for "research team integration and authority" is critical to CHRCs' capacity to address these gaps in community-university expertise and partnerships.

Lived Experience

Although some URs saw "lived experience" as a Want, CRs consistently cited it as a Need. A director at a coalition of community action agencies described the value of lived experience to a medical debt research project: "One of the grassroots leaders who came over and worked, continued to work on this project, had her own personal experiences of medical debt. I think it can be challenging work to feel confident enough in a research setting to even know what to say or how to make your voice heard. I think we, that's something we still struggle with" (Institute Director, Medical Debt Research). To make room for this woman's contributions, organization staff reviewed documents in person with grassroots leaders—sometimes one-on-one—instead of sending documents out for review prior to a meeting and then simply opening the floor to comments. They also made time during team meetings for people to process trauma that they or others had experienced. Holding space in these ways creates openings for heartfelt sharing of community expertise. The institute director underscored the experiential difference in understanding "what it's like to navigate social systems from a human level not a numbers level. So you know that the denial rate in SNAP is X, like what does it look like when you are a mom of a kid with cancer and you're driving to [the hospital], which is three hours away and you're getting this letter that says your SNAP benefits are cut off?"

CRs valued lived experience as a required qualification for CHRCs to help steer CER projects by contributing their experiential insights and by serving as cultural broker for community participants. In this capacity, CHRCs read overt and more subtle cultural messages and know what conditions must be in place for truly bi-directional communication to occur.

We note that some URs prioritized bi-directionality as a core CER value, while all CRs did so. In helping move both community health and university research forward, a CHRC cannot lean too far toward community or toward research. By maintaining this gap, CHRCs can identify other gaps that

arise among community participants and academics around resources, relationships, expertise, methods, goals, and so forth. CHRCs may not be “social change agents” like CHWs, but they should be project change agents, who recommend and navigate changes to CER projects with the goals of accruing and validating community expertise and facilitating equal partnerships.

4. CHRC Must Hold Research Accountable to Community’s Diversity

Research Team Integration and Authority

Studies of champions emphasize they must have actionable sway and the capacity to provide direction within an organization (Bonawitz et al., 2020; Bunce et al., 2020). Given the hybrid role of CHRCs, they cannot be unmoored from the community, nor can they be separate from the inner workings of the research project. For CRs, this role must be integrated into the structure of both the community and the research team. For example, one respondent proposed a structure of shared oversight from CRs and URs, where a CHRC is a “mutually shared project manager, right? And it depends on the nature of the specific project, but somebody that is managed by both sides equally...[the] community side and the research side, you know, need to both manage the person that is a liaison” (Pastor). Liaisons may be viewed as diplomatic intermediaries who communicate messages between two parties and seek consensus. For the pastor, however, CHRCs need authority within a given structure to help guide decision-making and use their influence to elicit specified outcomes.

Reid et al. observed how teams with community health champions can struggle to shift from their “advising the work to sharing power and decision making with institutional leaders” (Reid et al., 2019, p. 105S). Another CR respondent echoed this concern: “the community person would need to be somebody who’s pretty comfortable with the research team or with research speak and navigating that space enough to challenge or push back or feel able to direct what the researchers are doing...as researchers we’re trained in methods and considerations that have a place in the conversation, and they need to be there and part of that, but how do you put things on a more equal footing? There has to be a give and take” (Institute Director). A UR respondent reinforced this view, saying a CHRC must have “some agency to be able to move things...They can’t just be a go-between” (Professor of Pediatrics, Diabetes Prevention Grant).

Sustainability (of Personnel)

Sustainability in a CRHC position is a want for both groups of respondents. While URs prioritize sustainability of pay, one CR respondent notes the importance of sustainability in personnel. In her words, “Definitely make sure to have back up plans [for] the people that are on your team....Everybody...moves onto other things, but you want to make sure that

the project doesn't stay stagnant if somebody leaves...You want to make sure that person's task is easily absorbed by someone else or bring in an additional person to make sure" (Community Researcher, Doula Grant).

Continuity in a CHRC position is important to keep research and work flowing so interruptions are minimal. A further concern is the potential loss of authority on the community side if no provision is made for seamless transitions when a new CHRC needs to be hired, especially given the slow timelines of university operations.

Another CR respondent expressed frustration over navigating university finance systems when spending grants. Her UR partner wanted to "give us like \$500...right from the beginning, just in order to, like, provide food during a training, right? So that it entices people to come and that they're excited...And we could not make that happen because of bureaucracy. And that was very frustrating. We have worked it out, but it literally took us 2 years. I just spent the first \$4,000 of the grant" (Director of Behavioral Health, Corrections Grant).

The structural power in CER projects resides, by default, on the university side. CHRCs must be aware that most CER is funded, initiated, and implemented out of an academic context following university procedures. At the same time, CER endeavors to glean the richest data by facilitating participants' sharing of community knowledge and by advancing community stakeholders' goals. Ensuring CHRCs have independent authority is essential to adjusting study procedures that thwart community participation and partnership.

Board of Champions (vs. Single CHRC)

One person does not represent an entire community. Describing herself as "not a fan" of hiring a single CHRC for a research team, a CR respondent raised this objection as a Problem: "I just really think a group of people is a better idea. Yeah, I think one person becomes that person. All the things that people said, their concerns, it becomes that university person who's trying to get us to buy in. [A group of people] would just be more of diverse voices in the community and not a voice that's getting paid to represent us" (Community Partner, Drug Test-Strip Grant)

The literature mentions the value of a board of community advisors or advocates (Haw et al., 2025; Muscat et al., 2023; Schlechter et al., 2021). Ideally, community health should not be relegated to the responsibility of a sole individual. This CR respondent prefers a structure where community champions are fully independent of the research team. Support for a community board is shared across CRs and URs, but most respondents saw a sole CHRC working to represent multiple different subgroups as acceptable in principle, even though the notion that "one person can represent all" does not sit well within most communities. A UR respondent defined "a community champion, for better or for worse, [as] trying to elevate the multiplicity of experiences of the community as well as their own. You

want someone who's trusted, who's a truth teller, and that has a history of being embedded in this community" (Associate Professor of Africana Studies and Religious Studies).

Mirroring this observation about community diversity, CRs expressed the Want that CHRCs would "activate community networks" to make communication and the co-production of knowledge not simply bi-directional, but as multifaceted as possible. Research studies have found that engaging widely with community networks garners better research results (Mudyarabikwa et al., 2022).

The Africana and Religious Studies Professor added the value of fostering comradery among CHRCs as well. He favored "a cohort model of [CHRCs] so that obviously, they'd be working with their particular research team or project, but that they would also be meeting somehow to kind of build skills, to kind of deal with questions that they might not feel comfortable talking to their research team about."

Both CRs and URs observed how university sponsorship of CER generates power relations that can impinge on community partners and participants as well as CHRCs. These power relations have myriad sources, including university structures of budgeting, compliance, and Institutional Review Boards along with academic standards of disciplinary expertise and methodological rigor. University support for CER is a gift and a constraint. Both URs and CRs welcomed university sponsorship of CER. They appreciated the difficulties posed by certain university constraints, but there was a tendency for URs to accept these realities more readily in seeing CHRCs as "extenders," while CRs tend to push back more in viewing CHRCs as "bridges."

DISCUSSION

In the present research we analyzed our UR and CR respondents' assessments of successful community engagement and their ideation of a community health research champion (CHRC) position. Implicit in the respondents' visualization of the CHRC role are two distinct rationales for the role. Generally speaking, URs saw CHRCs as an "extender," while CRs envisioned them as a "bridge." CER teams work inside—and outside—the institutional context of universities. We interpret the different leanings of URs and CRs as reflecting their proximity to the structures of academic research. This institutional versus community positioning informs the values tensions and tradeoffs that CHRCs can help navigate. The different yet complementary perceptions of CHRCs as extenders versus bridges also clarify how this role differs from other types of health champions.

The literature tends to define health champions as an "implementation-related role occupied by people who are internal to an institution" (Miech et al., 2018) or as "active community members working to promote health and wellbeing or to improve conditions in their local community" (South et

al., 2024). The hybrid role of a CHRC is not primarily based in either an institution or a community, creating a series of tensions and tradeoffs in how to define, implement, and support this role.

Respondents did not support modeling the position as an institution-based consultant, in which a CHRC is qualified due to professional expertise on a health topic or experience with academic methods of community engagement. Instead, they consistently supported hiring a CHRC who is either local to communities in a study or who has similar lived experiences as study participants (or both). Respondents also insisted on paying CHRCs for contributing to the research team through their local community knowledge and trustworthy relationships. The research team is the primary beneficiary of a CHRC's "community connections." By contrast, community health champions who are volunteers primarily benefit patients and residents with better "service connections."

Hiring CHRCs as "extenders" would add considerable value to a research team. CHRCs can communicate research goals and procedures for recruitment and data collection to potential study participants—a critical function of research for all stakeholders. Additionally, CHRCs can educate community members on services related to health and break down complicated research projects and concepts. Similarly, CHRCs can purposefully educate researchers about the culture of a community as well as its members' priorities, assets, needs, and challenges. This educational process should ideally result in an improved research framework, timely and uneventful study implementation, and data gathering more likely to be representative of the community.

Hiring CHRCs as "bridges" would help respond to the ways that university standards and systems create a de facto power imbalance. Respondents identified many "gaps" for CHRCs to bridge, which partly reflect the limitations of university researchers and grant-funded projects in responding to the range of community health needs and having time for relationship- and trust-building. Respondents also emphasized that CHRCs must be supported in exercising authority on a research team to counterbalance the institutional pressures of university research standards and requirements. Working as bridges, they would be an "activist facilitator," in the words of one UR respondent, to help represent and channel community pushback for equal university-community partnerships and meaningful participation by community members.

The different perceptions of CHRCs as extenders versus bridges turn on two sets of values in CER. On the one hand, university researchers are rightly concerned with the academic values of methodological rigor in study design, disciplinary impact of research results, and compliance with financial and ethical requirements. On the other hand, community researchers legitimately prioritize the community values of representative validity in data collection and analysis, local relevance of research topic, and action-oriented outcomes that improve people's health. Both community-engaged research and

community-participatory research seek to navigate these value tensions. A key difference is how far they shift power and decision-making from university researchers to community participants.

Whether acting as extenders or bridges, a CHRC can help research teams bring these two sets of values into creative tension. The extender perception continues to center universities as the primary agent of CER, however, while the bridge perception unsettles this presumption. Despite the different leanings of UR and CR respondents, a partial consensus emerged in favor of the bridge perception being more desirable. While UR respondents may have felt more acutely the force of academia's professional and evaluative standards and requirements, URs were also ready to disrupt their hold on the research process to conduct CER addressing the motivators of UR and CR partners alike.

LIMITATIONS

Although the present study has offered new perspectives around CHRC roles and functions, adding to extant knowledge, it is not without methodological limitations. The first one is that, as a qualitative study, it may shed light on the features of a phenomenon but cannot quantify the trends at large, thus remaining limited in its generalizability. Additionally, we conducted a detailed examination of the recollection of experiences by respondents who had been involved in prior research; those recollections may be open to biases such as recall bias and prosocial bias. Finally, our highly targeted population groups allowed us to attain a rather large overview of what works and what does not work when it comes to optimizing a CHRC among diverse, vulnerable, and challenging population groups; but it is not a complete overview.

FUTURE DIRECTIONS

We plan to propose pilot study components in future CTSI-funded projects, where different CHRC profiles would be debated, co-created, and co-implemented by URs and CRs. Those partnerships will allow us to quantify and refine our understanding of how to operationalize the CHRC position in a variety of projects; such contrasts will help focus and refine the CHRC figures that work across specified community contexts and university structures.

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Data Availability

The data are not publicly available due to privacy or ethical restrictions.

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Conflicts of Interest

The authors have no conflicts to disclose.

Ethics

This project was approved by Indiana University IRB #23572

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Supplementary Materials

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Table 1

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Table 2

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