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Development of tailored feedback reports on organizational capacity for health promotion in African American churches

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ABSTRACT

Standard community-engaged research methods involve reporting research findings back to study participants. Project HEAL is an implementation trial conducted in 14 African American churches. This paper reports on a strengths-based approach to reporting Project HEAL organizational capacity data back to church leadership, through use of individualized church reports. Pastors in each church completed a church organizational capacity assessment. The study team, including community partners representing church leadership, co-created a channel and content to disseminate the capacity data back to Project HEAL church leaders. This consisted of a 4-page lay report that included the church's capacity scores, and recommendations for future evidence-based health promotion programming matched to their capacity. The study team was able to meet with nine of the 14 churches to review the report, which took an average of six and a half weeks to schedule. The individualized church reports were well-received by pastors, who expressed an intention to share the information with others in the church and to sustain health promotion activities in their organizations. Though the individualized reports were embraced by the pastors, it is unknown whether this process will result in sustainable health promotion in these organizations without further follow-up.

1. Introduction

Community-based participatory research (CBPR) posits that action and community stakeholder participation are critical parts of the research process (Minkler & Salvatore, 2012). Community engagement is one approach to facilitate the translation or uptake of evidence-based interventions into practice in community settings (Minkler & Salvatore, 2012). CBPR can increase the relevance and effectiveness of research, support community trust and participation, and facilitate the processes of data collection, analysis, and dissemination of findings (Cargo & Mercer, 2008). It is also recommended that community partners share in ownership of the data and are involved in co-creating data-derived meaning from the results. One of the key CBPR principles is the dissemination of research findings to community partners and stakeholders in order to facilitate sustainable change in promoting health (Israel, 2005; Minkler & Wallerstein, 2008). Community partners are critical in the identification of effective strategies for reaching key decision-makers/leaders/stakeholders in the community and in the selection of appropriate dissemination channels (Minkler & Salvatore, 2012). Disseminating findings to key community stakeholders requires ongoing communication, collaboration, and trust between academic and community partners (Eng, Strazza, Rhodes, & Mebane, 2005; Parker et al., 2005).

While a best practice in community-engaged research, there is little practical guidance on how best to disseminate data back to individual research participants. Discussing research findings through meetings and the importance of dialogue have been previously discussed (Garnett et al., 2015; Piggot-Irvine, 2010). Recommended formats have included briefs, interim reports at project milestones, presentations, and final reports (Shulha, Whitmore, Cousins, Gilbert, & al Hudib, 2016).

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Alternative approaches have been considered for presenting evaluation findings, such as a values-engaged framework and use of poetry. Johnson, Hall, Greene, and Ahn (2013) found that use of poetry helped to engage stakeholders around evaluation findings, add richness to the data, and ease potential tensions that can accompany the communication of evaluation data. Furthermore, dissemination of research findings can contribute to the capacity of organizations once a program/intervention is no longer funded, and might help work towards the long-term institutionalization or sustainability of a program and the health benefits it delivers (Scheirer & Dearing, 2011; Stirman et al., 2012). The step of providing data back to participants also aligns with sustainability planning processes and strategies in the literature (Johnson, Collins, & Wandersman, 2013).

Whereas reporting research data is important at the participant level, for some types of projects it is also appropriate to report back to the participating organizations. The aforementioned strategies might be useful for reporting data back to organizations; however, there are fewer examples of specifically how to do this at an organizational level. As one example, the Chinatown Restaurant Worker Study used CBPR approaches to study the health and working conditions of restaurant workers in San Francisco's Chinatown (Minkler & Salvatore, 2012). Survey data from 433 restaurant workers were collected, as well as observational data using a Restaurant Worker Safety Checklist. Preliminary results were shared with all partners through email and in-person communication at steering committee and project meetings and the restaurant workers were involved in the data interpretation. Study findings were shared through lay/ethnic media, and targeted meetings with restaurant workers and owners, and policymakers. As part of the dissemination plan, approaches were targeted to each stakeholder group.

Another community organization that has been heralded as a successful setting through which to reach medically underserved audiences are churches or faith-based organizations (FBOs). FBOs play a pivotal role in the African American community, providing access to large interpersonal networks, sources of social support, and an infrastructure that can facilitate the establishment and maintenance of health interventions. FBOs have access to volunteers who can support health intervention efforts, often guided by the strong influence of the pastor (Baruth, Wilcox, & Saunders, 2013; Bopp, Baruth, Peterson, & Webb, 2013).

While a promising setting to implement evidence-based interventions, FBOs vary extensively in their governance structure, staffing, physical plant, connections with other community organizations, and in the size and characteristics of congregations. Similarly, a great degree of variability can also be observed in the success that churches have in implementing health promotion interventions. Success in implementing and sustaining such programs is likely associated with the church's organizational capacity (Tagai et al., 2017). There is considerable recent emphasis on "capacity building" in public health research and practice (National Institutes of Health, 2011). Rabin and Brownson (2012) define capacity building as "Any activity…that builds durable resources and enables the recipient setting or community to continue the delivery of an evidence-based intervention…" (p. 27).

The purpose of this paper is to describe a strategy for disseminating organizational capacity data back to African American church leaders whose congregations had participated in an implementation trial, Project HEAL (Health through Early Awareness and Learning). Project HEAL was a cluster randomized implementation trial that included 14 African American churches in Prince George's County, MD. Half of the churches were randomly assigned to receive an in-person ("traditional") training of community health advisors (CHAs) with the other half receiving web-based training ("technology") for CHAs [Holt et al., (2014) for a detailed description of the intervention]. Interventions administered by CHAs promoted guideline-consistent screening for breast, prostate, and colorectal cancers. This manuscript documents the development and dissemination of a report on organizational capacity to the Project HEAL churches, individualized for each church based on their organizational capacity scores. Based on previous research (Chen, Diaz, Lucas, & Rosenthal, 2010; Whitt-Glover, Porter, Yore, Demons, & Goldmon, 2014) and the experiences of the project team, we felt that these data could be helpful for fostering sustainability of health promotion in the churches. This work has implications for those working with organizations, and churches in particular due to their unique organizational characteristics, to encourage the implementation and sustainability of evidence-based interventions and health promotion activities.

2. Methods

2.1. Project HEAL intervention

Project HEAL churches self-identified as predominately African American mid-size (i.e., 150–500 members) Christian churches, that had not hosted a previous similar cancer educational intervention during the previous year. After training and certification, CHAs accessed Project HEAL intervention materials (e.g., recruitment materials, presentation materials) that they used to implement a series of three monthly educational workshops for members of their churches on cancer early detection (cancer overview, breast/prostate, colorectal). Follow-up data on workshop participants were collected at 12- and 24-months (Fig. 1). A detailed description of the CHA training process, including feasibility, is described elsewhere (Santos et al., 2014). Institutional review board approval was obtained prior to data collection.

2.2. Church organizational capacity assessment

After enrollment, each pastor completed a church capacity assessment, which consisted of a one-hour in-person interview with study staff that served to obtain descriptive and organizational capacity data about the churches [described in detail in (Tagai et al., 2017)]. The capacity assessment tool is rooted in previous theory (Greenhalgh, Robert, Macfarlane, Bate, & Kyriakidou, 2004) as well as literature on organizational readiness and capacity (Rabin & Brownson, 2012; Weiner, Amick, & Shoou-Yih, 2008). The capacity assessment contained largely closed-ended questions in three areas including *staffing and space* (e.g., number of paid and volunteer staff, pastor outside employment and education, estimated number of church members, building ownership vs. rental); *health promotion experience* (e.g.,

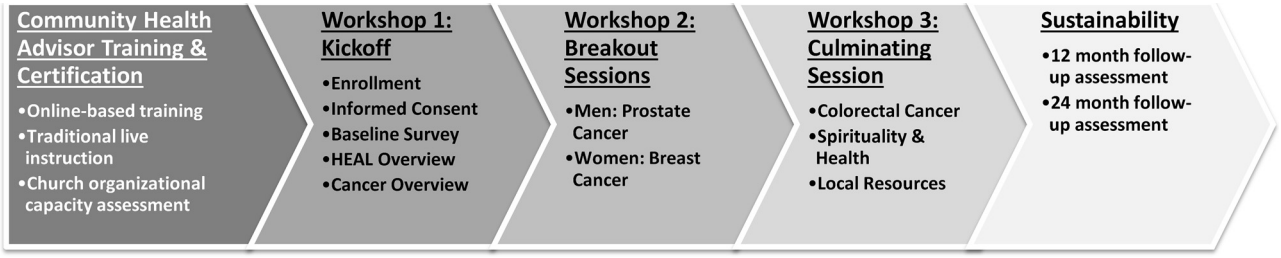

Fig. 1. Project HEAL intervention activities.