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Scaling Meaningful Impact through Relational, Purpose-Driven Approaches to Community Engagement

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Abstract

One way to address the concern of health systems, academic institutions, and community organizations working in parallel rather than in partnership is to adopt place-based community health models. These models offer an opportunity to align and tailor resources and supports to community residents' needs and culture; however, questions remain about how such context-specific and deeply relational work can be replicated responsibly and effectively across settings or geographic locations. The purpose of this article is to position a current model, designed to bring together multi-sector partners to implement sustainable, trauma-responsive programs shaped by locally identified health priorities, within the broader landscape of community health. The model's first phase, building shared values, creates the foundation for overall integrity, adaptability, and sustainability. Shared values help shape organizational culture, partner alignment, and organization-community relationships, which influence every subsequent phase of replication. Two examples demonstrating how shared values are operationalized within this specific model are presented, demonstrating practical ways to embed foundational beliefs or norms across organizations and disciplines. While the model does not eliminate all challenges to community health or replication, developing shared team or organizational values is an intentionally purposeful, reflective, and grounded process that helps to shape a culture that can be adapted and reinforced across place, time, and setting.

Keywords: community health, place-based models, replication, values, interdisciplinary

Introduction

Community health concerns across the United States have increasingly demanded integrative approaches that are place-based, relationally driven, and responsive to the often complex realities that shape individuals' health and well-being. Despite historically multifaceted efforts to address these concerns, many interventions or models of care often continue to struggle with establishing pathways for demonstrable long-term impact, sustainability, scalability, and connection across diverse communities (National Institutes of Health, 2021). A central challenge is perpetuated by health systems, academic institutions, and community organizations working in parallel rather than in partnership, limiting the collective's response to community-identified health priorities with accuracy and dependability. Recognizing that "The Power of Place" transcends geography is important, as this connection shapes institutional missions, community partnerships, and opportunities for social and economic mobility, and heavily influences community well-being at multiple levels. To effectively address this problem, practice models must aim to strengthen alignment between community organization expertise, cross-sector institutional or organizational capacity, and the lived experiences of the residents who call these communities home (Allen et al., 2020; Towe et al., 2016).

Research highlighting the growing importance of this challenge continues to expand, as inconsistencies in healthcare access, preventative supports, and treatment options continue to illustrate the effects of an oftentimes fragmented and ineffective approach to community or population health (Aguilar-Gaxiola et al., 2022; Michener et al., 2025). In many regions, locally identified health needs remain unmet due to not having structured alignment amongst cross-sector partners that incorporates community context. This reality highlights the need for an adaptable community health model that blends data-driven decision-making with relational practices helping to center empathetic listening, program co-development, and shared accountability.

One emerging solution from which to build from is place-based community health models. By grounding identified health supports in specific community or neighborhood contexts, institutions or organizations are offered opportunity to align and tailor supports to community resident needs and culture. Research has demonstrated that when community engagement practices are aligned with local context and upheld by trusted relationships, these methods are more likely to lead to improvements in a variety of healthy behaviors (Dankwa-Mullan & Pérez-Stable, 2016; McGowan et al., 2021; U.S. Department of Health and Human Services Clinical and Transctional Science Awards Consortium, 2011). Yet, even so, a persistent question remains in how organizations can extend or replicate this type of deeply relational, context-specific model across settings or geographic locations without sacrificing the trust, authenticity, or connection that allows the comprehensive model to be effective.

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Replication, in this sense, should not be merely viewed as the extension of programs into new settings or a "one-size-fits-all" approach, but rather the translation of a model's core components, like values, structures, and community presence, into contexts alongside organization's own history, mission, and strengths. The continued prevalence of chronic disease, unmet behavioral health needs, gaps in access to care, and an overall declining sense of social trust highlight limitations of traditional healthcare models and point toward the need for more person-centered infrastructures that meet people where they are and create a sense of shared ownership or responsibility along the way (Heller et al., 2021; Pro et al., 2025; Webb Hooper et al., 2019). While place-based strategies for community health have emerged, one question remains: how can such models can be responsibly and effectively extended to new sites or geographic locations?

Ultimately, this very question guided the development of the replicable model that informs the present work. The purpose of this article is to position the current model within the broader landscape of community health and to also describe how its first phase, building shared values, creates the necessary foundation for the model's overall integrity, adaptability, and long-term sustainability across settings.

Literature Review

Partnerships between academic institutions and community organizations play a central role in this type of work. Fortunately, higher education institutions have increasingly embraced community engagement as a core tenet, exemplified by the Carnegie Community Engagement Classification's framework that helps to highlight this commitment by explaining why colleges and universities are positioned to play a central role in community-centered health work. The Carnegie Classification of Institutions of higher education defines community engagement as 'collaboration between institutions of higher education and their larger communities - local, regional/state, national, global - for the mutually beneficial exchange of knowledge and resources in a context of partnership and reciprocity' (Carnegie Classification of Institutes of Higher Education, 2025). Smith et al. (2017) describes three paradigms for partnership between universities and communities- community engagement, anchor institution, and collective impact - all of equal importance and with values that can be leveraged across all three. The Community Engagement paradigm emphasizes service-learning, civic engagement and community-engaged research; the Anchor Institution paradigm focuses on economic development of the broader community; and the Collective Impact paradigm emphasizes collaboration across sectors to solve a specific social problem (Smith et al., 2017). By framing community engagement as an evidence-based domain of institutional practice rather than merely a peripheral activity, the Carnegie Community Engagement Classification highlights that relational, community-rooted or place-based work should be viewed as both an academic responsibility and an impactful scholarly undertaking (Carnegie Classification of Institutes of Higher Education, 2025). This is

notable as the Carnegie framework positions higher education institutions as relational anchors within community health environments, while also calling attention to institutional responsibility to support models built on tenets of trust, sustainability, and reciprocal partnership. Together, these paradigms underscore that universities can play multiple roles, as collaborators, economic anchors, and cross-sector conveners, in addressing community health inequities.

Duquesne University of the Holy Spirit is a Catholic university located in Pittsburgh, Pennsylvania, and is the only Spiritan institution in the United States. The Spiritan commitment to serving the disadvantaged led to the university's founding in 1878 as a school for the immigrant poor in Pittsburgh. Over 140 years later, the Spiritan mission continues to be integrated into all aspects of campus life, with an unwavering commitment of service to the Church, the community, the nation, and the world. Given its community engagement efforts and partnerships that address broad community challenges, Duquesne was among 40 institutions nationwide to receive the 2024 Carnegie Classification for Community Engagement by the American Council on Education and the Carnegie Foundation for the Advancement of Teaching (Carnegie Classification of Institutes of Higher Education, 2024). One of the university's five strategic imperatives in its current strategic plan is 'to become the region's flagship institution for community engagement through mutually beneficial partnerships that advance the city, region and world' (Duquesne University, 2024).

Duquesne University has 10 schools of study, including Schools of Pharmacy, Nursing, Health Sciences and a new College of Osteopathic Medicine. A 2015 systematic review of 24 studies revealed that community engagement models can positively impact health and health behaviors among disadvantaged populations as long as they are well-designed with effective community consultation and participation (Cyril et al., 2015). With strength in the health sciences, along with a mission of service and commitment to community engagement, the university created the Center for Integrative Health (DUCIH) in 2020. Building on decades of community-engaged health programming, DUCIH is dedicated to training and preparing the next generation of practitioners to address data-driven healthcare needs in both rural and urban communities. Priority health areas for the Pittsburgh region identified through the 2017 and 2022 Allegheny County Health Department Community Health Assessment that also align with University strengths are a) access to healthcare; b) chronic disease risk behaviors; c) environmental health; d) maternal and child health; and e) mental health and substance use disorders (Allegheny County Health Department, 2022). Together, these elements create a foundation that facilitates interprofessional education, cross-sector collaboration, and co-creation of data-informed approaches to support community health. More importantly, they bring the university's mission and Spiritan values of service to life by shaping a community engagement approach rooted in relationships. Faculty, staff, and students work alongside communities, shifting the focus away from transactional healthcare delivery toward a more holistic, relationship-centered model that

can be especially impactful for diverse communities and in building sustainable partnerships (Center for Spiritan Studies, 2017).

Alongside the institution's mission and values, the Carnegie Community Engagement Classification serves as a guidepost for positioning community engagement as a scholarly endeavor rather than mere participation. This distinction is important as it strengthens the foundation for community engagement initiatives, helping to reframe engagement from "volunteerism" into a form of institutional scholarship. While this shift may seem subtle, it helps to increase accountability for faculty, staff, and students and encourages sustained, evidence-based, cross-sector partnerships, as compared to isolated or siloed efforts.

DUCIH adapted a collective impact framework and created the Bridges to Health (B2H) Program and Collaborative (Kania & Kramer, 2011). The B2H Program is a place-based community health model that connects multi-sector partners to implement sustainable, trauma-responsive programs shaped by locally identified health priorities. The B2H Collaborative includes multi-sector partners in under-resourced areas of Pittsburgh such as school districts, federally qualified health centers (FQHCs), community-based organizations, and family or senior centers, all with a common goal to improve community health and wellbeing. B2H priorities and programs align with county health priorities (Allegheny County Health Department, 2022), and have resulted in improved access to healthcare (Elliott et al., 2021; Elliott et al., 2015; Elliott et al., 2014; Garmong et al., 2022; Hay et al., 2023) and outcomes related to chronic disease risk behaviors (Elliott et al., 2022; Schoen et al., 2025), substance use disorder (Wright et al., 2020), and environmental health (Gentile et al., 2022; Williams et al., 2024). Through this work, the B2H collaborative seeks to operationalize the five conditions of collective success outlined in Kania & Kramer's (2011) collective impact framework to create alignment and drive lasting impact. This is achieved through cross-sector partnerships, the identification of shared health priorities, and the evaluation of measurable outcomes. Ultimately, these efforts are intended to produce meaningful and sustained impact across the Pittsburgh region.

As the B2H Program has grown since its inception in 2020, DUCIH attended the *2025 Coalition of Urban and Metropolitan Universities (CUMU) Annual Conference: The Power of Place* to determine: (1) whether replicable models of relational, community-centered health exist; (2) how cross-sector organizations conceptualize place-based community health work; and (3) what common challenges professionals and practitioners encounter when attempting to scale deeply relational approaches. The 2025 CUMU Conference also provided a unique opportunity to: (1) situate the current B2H model within the broader landscape of community health innovation; (2) explore and maintain alignment with national health priorities; and (3) begin forming a network of collaborators committed to understanding integrity-centered replication. Through this practice-based work, the 2025 Conference also provided a unique opportunity to explore the guiding question of whether place-based community health strategies have been responsibly and

effectively extended to new sites or geographic locations, and if so, how? DUCIH facilitated a roundtable discussion focused on these themes, inviting registrants to consider not only how relational work takes root in place, but how it grows, adapts, and helps to sustain collective forward momentum.

An important insight that has emerged from both the CUMU Conference and the B2H Program's organizational experience is that model replication is not only a structural exercise, but should also be a relational one as well. DUCIH believes successful models depend on a sense of shared responsibility, as cross-sector teams often face unique pressures while existing in distinct organizational cultures. As such, rooting replication in shared values grounds community health work in shared purpose, while still allowing for adaptation based on the identified community health priorities. Notably, this approach does not prescribe a standardized way of working; but rather, it creates consistency for interdisciplinary teams and organizations to revisit when either facing uncertainty, growth, or cross-sector challenges. By starting with the establishment of shared values, teams and organizations have opportunity to build a foundation for practice that is mission-aligned, coherent, trustworthy, and capable of sustaining both the impactful work and the people around it.

For example, a team comprised of pharmacists, health educators, nurse practitioners, and community health specialists might begin their collaboration by centering shared values around cultural humility, trauma-informed care, resilience, or self-awareness. Even before program implementation begins, this shared foundation acts as a precursor for quality, person-centered care, while also helping to clarify purpose and organizational expectations. At the community level, a health-centered organization exploring a partnership with a local school district may use shared values and principles to shape its early interactions. This may later lead to the organization conducting listening sessions with parents, educators, or school administration to better understand residents' lived experiences, cultural strengths, as well as any physical or social barriers to health. Both examples, albeit at varying levels, communicate respect, trust, and ensure authentic collaboration around identified priorities.

While the DUCIH B2H model includes multiple interconnected phases, including building shared values, identifying data-driven health priorities, as well as building collaborative infrastructure and measuring impact, this article primarily focuses on the development of Phase One: building shared values as the foundation for all subsequent work. Here, this foundation aims to translate abstract values into a structured, facilitated process through which interdisciplinary stakeholders and partners identify, negotiate, and adopt shared values and norms that guide all subsequent activities. Because Phase One shapes organizational culture, partner alignment, and organization-community relationships, its influence stretches to every later phase of replication. For instance, when organizations align work with mission, including why the work matters, how they commit to it, and what principles guide appropriate action, they

create a consistent foundation that can be both generalized and adapted even as community contexts, partnerships, or health priorities transform (Owens et al., 2017; Qin et al., 2023). For that reason, some practice applications and implications later discuss how the values established by organizations at the outset can become positive operational influences across training, interprofessional collaboration, community engagement, and the model's sustainability as a whole.

Again, the central question that emerges from this work feels both practical and conceptual in nature: how do organizations extend a deeply, relational, place-based model into new contexts without losing the connection and integrity that make it effective in the first place? To effectively address this question, an understanding of not only the structural details of replication is required, but also the human and cultural factors that truly allow replication to take root. The following sections examine Phase One of DUCIH's B2H model in depth, exploring opportunities for application, discussing its implications for practice, and identifying future directions for developing and studying values-driven approaches to replicating a model of community health.

Application

Application of a values-centered, place-based community health model requires teams and organizations to move beyond theory or concept into structured pathways that translate these shared beliefs or norms into everyday practice and long-term impact. DUCIH's B2H model offers a foundation for those interested in building or adopting a replicable and relational approach to community health by combining place-based care with consistent and sustainable partnership to support community health and wellbeing. How a place-based, relational community health model moves from concept to practice is oftentimes complex and not always easy to trace, particularly when linking specific practices to both short- and long-term goals (Figure 1). However, while Phase One emphasizes building shared values as the foundation, the model's application extends across all subsequent phases, providing a scaffold for teams or organizations across settings or contexts.

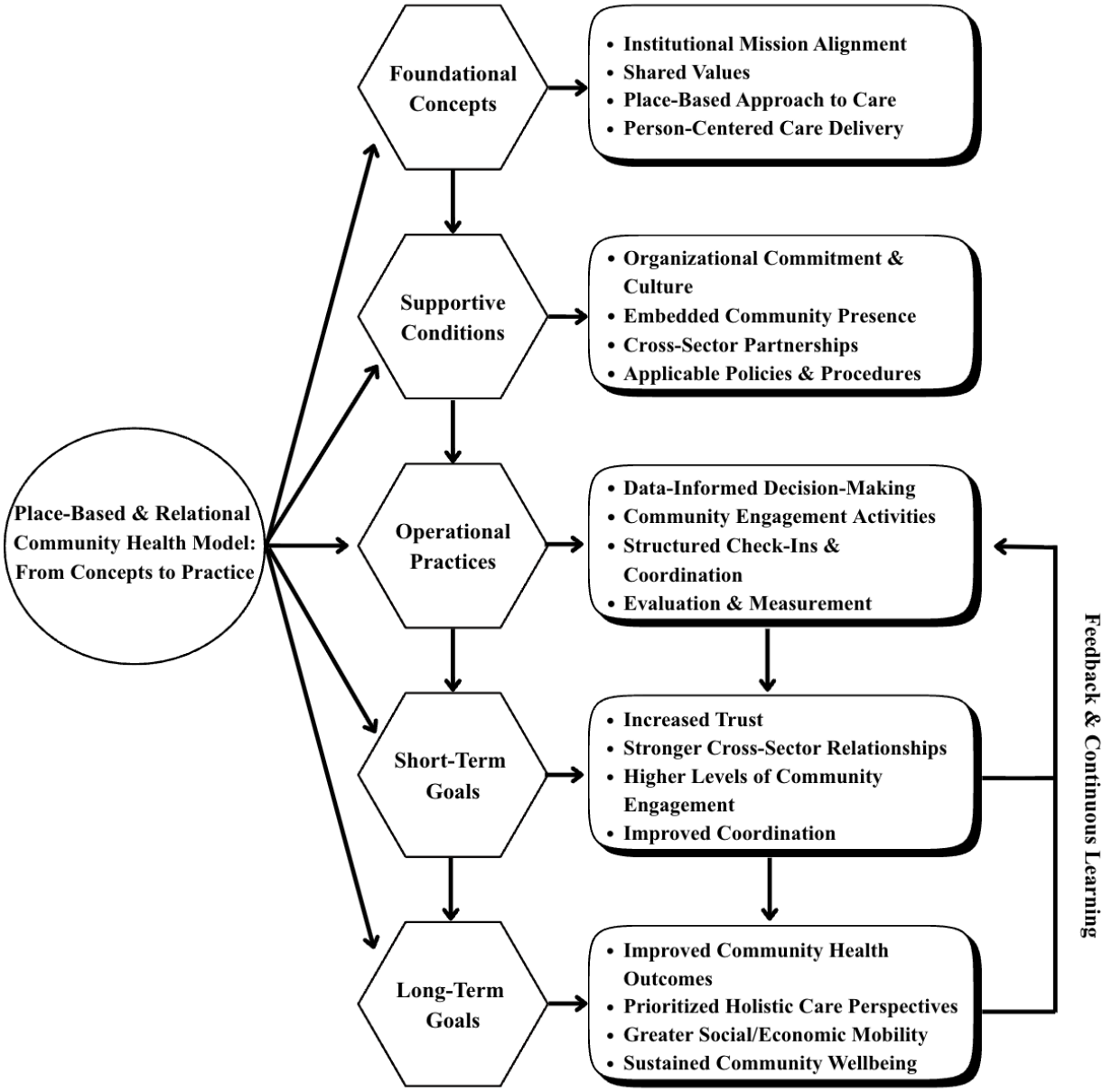

FIGURE 1. Place-based and relational community health model: From concepts to practice.

A tenet of Phase One is that team or organizational values must be made concrete or operational, rather than abstract or nonfunctional. Although often verbalized, shared values or beliefs that help to guide communication or decision making, such as integrity or inclusivity, can be difficult to assimilate into organizational workflows. Use of guided reflective exercises or organizational alignment tools and platforms can help teams transform abstract values into concrete behaviors and goals. When implemented, these activities support teams in developing mission-aligned collaborative routines that can act as a guidepost, especially when working across disciplines or sectors.

For example, a healthcare-focused organization seeking to strengthen community engagement might begin with asking faculty or staff to express what it means to "see people as whole" through the lens of their professional work. Here, it is important to identify an individual to help guide this process. This leadership role may be defined by formal authority or title, but it can also emerge through relational trust built within team dynamics. Who takes on this role may vary across settings, implementation sites, and organizational structures. This flexibility is intentional, as the emphasis is not on credentials alone, but on the ability to facilitate dialogue, navigate differing perspectives, and guide groups through a shared process, as these are all fundamentally relationship-centric rather than purely technical skills. As there is no single standardized approach to identifying shared values, having a trusted facilitator becomes especially valuable, particularly when divergent values emerge that require thoughtful discussion, alignment, and, at times, clear next steps.

The history and quality of relationships among participating groups also play a critical role and should be considered. In settings where trust is already established, teams may move more quickly toward alignment and shared understanding. In contrast, where relationships are newer or possibly strained, the process may require more time, intentional trust-building, and open dialogue. In this way, the process is not only shaped by the values being identified, but also by the relational context in which the work is taking place.

Rather than merely discussing abstract or conceptual perspectives, this process invites individuals to define observable behaviors, such as asking culturally appropriate questions, adjusting communication approaches to align with cognitive needs, or building in additional time for community feedback or relationship-building. Here, individuals and teams move through a stepwise process that translates professional values into practice by beginning with identifying a core value and articulating what it looks like in action. It then guides users in translating that value into concrete applications within their practice or profession, which can then be embedded in workflows, daily routines, and micro-practices that, over time, build awareness, may improve outcomes, and reinforce leadership through relationships and connection. This process can be adapted across settings so that teams and organizations can ensure programming reflects both communities' lived experiences and data-driven priorities.

Aside from implementing structural and reflective team activities, DUCIH has begun to operationalize B2H's mission-aligned values through practical tools such as a holistic wellness curriculum and a replication manual. The manual, a playbook for building a replicable model for community health, was drafted to assist teams and organizations adapt implementation steps without losing integrity of the program design. The manual is built to be flexible and provides processes for values identification, partnership building, application of data practices, and a series of templates that offer adaptable structure without standardized rigidity. This tool may be utilized in a variety of formats, including organizational planning meetings, onboarding new

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community site partners, cross-site learning sessions, and efforts by new sites to replicate or develop their own community health model based on local needs and infrastructure.

The wellness curriculum, "The Human Side of Care: A Skills-Based Curriculum for Meaningful, Relational, and Sustainable Practice," is currently being piloted and offers a structured and sequenced method to teach relational competencies, reflection, and values exploration, which are all areas often underemphasized in clinical or higher education training programs. Similar to the replication manual, the curriculum is designed to be adaptable to various needs and contexts. As such, organizations could utilize it in staff trainings, student rotations or curricular activities, as well as targeted professional development within diverse healthcare settings.

In sum, application of shared values should emphasize translation: from values into behaviors, from goals into structures, and from aspirations into team or organizational daily practice. By operationalizing shared values, teams and organizations ground themselves in beliefs and norms that remain constant over time despite growth or change in partnerships, programs, or location. This is one example of how DUCIH has begun to address its central question: how place-based community health strategies can be responsibly and effectively extended to new sites or geographic locations without becoming a one-size-fits-all approach.

Implications for Practice

Building shared values as the foundational stage of a replicable community health model carries important implications for both organizations and practitioners across varied practice settings, training environments, and interdisciplinary professional teams. Phase One of this replicable model serves as both the conceptual and relational infrastructure for all subsequent phases, as data-driven decision-making, asset alignment, and partnership coordination risk fragmentation or inconsistencies without clear, co-constructed values. Research has consistently shown that healthcare teams function more effectively and deliver higher-quality care when they operate from a shared understanding of core beliefs, norms, and guiding principles (Ahmed et al., 2024; Gershon et al., 2004; Mannion & Davies, 2018). For example, care outcomes that may be influenced by the integration of shared values or beliefs include reduced conflict around treatment and care plans, faster consensus on complex cases, more consistent application of patient-centered care principles, and more effective communication with diverse populations, ultimately improving patient satisfaction and overall quality of care. Across practice settings, this means that the alignment of values should not be viewed as a philosophical exercise but rather as a practical requirement for teams responsible for navigating complex patient needs, systems, or cross-sector collaborations.

For future practitioners, Phase One addresses documented gaps across interdisciplinary training programs (Christianson et al., 2007; McCrory, 2025). Health professions education often

emphasizes technical knowledge while providing individuals with limited preparation in relational competencies such as effective communication, empathy, collaborative decision-making, and cultural awareness or humility (Bombeke et al., 2012; Boyte et al., 2025; Rosewilliam et al., 2020). Yet, these competencies directly influence patient adherence, physician job satisfaction, provider burnout, and measurable health outcomes (DiMatteo et al., 1993; Kwame & Petrucka, 2021; Shanafelt, 2009). Shared values offer a structured starting point for building these skills as they give individuals a common language for working across disciplines, navigating uncertainty, and grounding care across dimensions of health. When professionals understand not only what they do, but why they do it, they are likely better equipped to respond to diverse patient populations with clarity, consistency, and authenticity. As such, both Phase One and the wellness curriculum provide opportunities to address these documented gaps by allowing for relational competencies to be further developed through structured dialogue, reflection on applicable case examples, and explicit linking of chosen values (e.g., compassion, trust, respect, etc.) to everyday behaviors.

Shared values also play a critical role in supporting data-driven practice. Many organizations aspire to use data to guide programming or strategy, but data alone cannot generate alignment or collective action. Professional teams that lack shared values may misinterpret findings, implement siloed decision-making, or unknowingly prioritize certain perspectives over others. By contrast, teams grounded in shared values are more likely to engage in inclusive evaluation, ask meaningful questions of the data, and use findings to guide collective and appropriate next steps (Babiker et al., 2014). Psychological safety, or the sense that team members can voice questions, concerns, or interpretations without fear, is also strongly associated with shared values and is proven to enhance team learning and problem-solving in healthcare (Grailey et al., 2021; Silva et al., 2025). As a result, Phase One promotes values that shape norms, such as speaking up when something seems wrong, questioning assumptions and biases, and valuing diverse perspectives. These norms, then, in turn, foster psychological safety, which may enhance how individuals interpret, understand, and learn from data-driven practices.

Another practice implication revolves around how organizations, particularly those in healthcare, structure collaborative practices. Healthcare systems are not only interdisciplinary by nature, but they often act interdependently, despite providers, nurses, specialists, community health workers, administrators, and educators needing to continuously coordinate care (Schot et al., 2020). Shared values give interdisciplinary professionals a common reference point for communication and joint decision-making, especially when settings, populations, or needs differ (Nancarrow et al., 2013). As such, it may be helpful to clarify how values are put into everyday practice. For example, shared values such as empathy and trust may be translated into concrete behaviors and routines and operationalized through structured check-ins, collaborative care planning, and norms that support transparent patient feedback. When a team or organization is able to articulate

its shared commitments in these ways, coordination of care can be easier across programs, partnerships, or referrals.

Shared values such as transparency and respect can also drive patient-centeredness and facilitate cross-sector healthcare coordination by breaking down historical silos, standardizing communication strategies, and aligning various teams or specialties toward a common goal rather than merely individual performance metrics. This can be further operationalized when organizations use their shared values to guide decisions about workload, recognition, and support structures. In doing so, they help foster a culture of trust, reduce burnout, and promote positive engagement across the system. This can be especially applicable to community health settings, where organizations often have cross-sector partnerships. Here, shared values bridge organizational boundaries while helping to uphold trust and sustainability, both internally and externally, helping to again highlight "The Power of Place" and its implications on community health and wellbeing.

For individuals entering health professions, grounding future practice in shared values also supports professional identity formation (Toubassi et al., 2023). The literature increasingly acknowledges that practitioners who feel connected to their organization's values experience greater meaning, lower burnout, and stronger alignment between personal and professional purpose (James, 2023; Norful et al., 2024). Although patient-focused literature often highlights the positive relationship between hope, meaning, and health outcomes, the same relational influences apply to providers (Mardhiyah et al., 2020; Mylod & Lee, 2023). When professionals experience clarity about the values that guide their work, they are more likely to sustain engagement, communicate effectively, and model person-centered care for their patients or consumers (Hannawa et al., 2022). Over time, these provider-level effects may ultimately have positive consequences on system-level health outcomes.

There are also implications for how practitioners are able to support patient storytelling. Helping individuals and broader communities articulate their lived experiences is not only a tenet of quality, person-centered care, it can also be strategic, as surfacing patient voices can help to educate, inform programming, deepen collaborative partnerships, strengthen data interpretation, while also contributing to opportunities for resource allocation (Boyte et al., 2025; Briant et al., 2016; Skelton-Wilson et al., 2022; World Health Organization, 2024). Professionals able to identify and incorporate values, both their own and their patients', are better positioned to support and integrate patient narratives into broader clinical or organizational functions. This aligns with literature illustrating narrative competence as enhancing patient-provider relationships, improving understanding of health-related behaviors, and strengthening patient engagement and empowerment in patients' own care (Chu et al., 2020; Loy & Kowalsky, 2024).

Lastly, beginning with shared values helps organizations to communicate care for their employees. As many professionals want to feel that their employer supports them and is invested in their development, inviting individuals to articulate values and professional purpose in connection to their day-to-day job responsibilities can help show that their perspectives matter and that organizational culture is co-created rather than formed by a top-down approach. This lays the groundwork for long-term retention and stability, both critical components of any organizational model that relies on collaborative community partnerships. When professionals feel supported in aligning their values with organizational mission, they are more likely to extend those same ideals to both patients and communities, only helping to strengthen the relational frameworks inherent to quality person-centered supports (Dunning et al., 2021; Fix et al., 2018).

Together, these practice implications help to demonstrate why Phase One of the B2H community health model is an appropriate starting point for replication, as it establishes the foundational tenets, such as shared values and norms, that allow subsequent phases to occur. By giving interdisciplinary professionals a structured method to align their organizational work with purpose, Phase One offers a replicable foundation that can be adapted to varying contexts without sacrificing integrity when extended to novel sites or geographic locations.

Conclusion

The central question, how to extend a deeply relational, place-based model of community health into new contexts without losing the integrity that makes it effective, remains the challenge for practitioners, educators, and organizations seeking to provide health supports for diverse populations. To support this work, DUCIH has developed both a replication manual and a wellness curriculum to guide the implementation of its community health model across diverse settings and contexts. The manual provides step-by-step guidance on key processes such as identifying shared values, building partnerships, and applying data-informed practices, along with adaptable templates that offer structure without imposing overly rigid standardization. Somewhat similarly, the wellness curriculum offers session-by-session outlines, activities, and case scenarios designed to incorporate foundational values into future practitioners' relational skillsets, ultimately aiming to drive meaningful and sustainable practice across settings and disciplines. Simultaneously, both efforts align DUCIH's purpose with Duquesne University's Spiritan values of service by shaping a community engagement approach rooted in relationships and holistic care.

This article maintains that Phase One of the current community health model, building shared values within and across professional teams, should not be looked at as merely a starting point but a necessary foundation for any meaningful replication effort. Phase One provides a grounding that can ultimately help to guide decision-making, shape collaborative relationships, and ensure interdisciplinary alignment across teams and settings. Research continues to illustrate

that values-based practice strengthens collaboration, supports quality, person-centered care, and can facilitate more consistent and sustainable engagement for cross-sector organizations (Aarons et al., 2014; Engle et al., 2021). This is especially relevant in healthcare and community health settings, where teams routinely navigate cultural differences, resource barriers, and complex interpersonal dynamics. Returning to values as the model's foundation highlights its significance, as without collective principles, the subsequent phases of the model may lack cohesion, and the resulting support systems risk fragmentation or inconsistency over time.

The aforementioned practice implications emphasize that Phase One, as a starting point, is not simply philosophical but rather practical and operational. Skills such as communication, empathic listening, and trust-building, among others, unfortunately, remain underdeveloped in many professional training programs despite their documented connection to improved clinical outcomes, patient satisfaction, and collaborative decision-making. Emphasizing that shared values such as empathy and trust do not depend on large or dramatic actions is important. Instead, these values are often put into practice through small, consistent behaviors, such as structured check-ins, collaborative care planning, and norms that support the delivery of authentic, compassionate patient feedback.

By highlighting the importance of shared values, Phase One directly addresses this training gap and equips professionals to integrate relational competencies into everyday practice. The power of place, when driven by teams grounded in shared values rather than prescribed behaviors, helps individuals navigate the complexity and variation inherent to community health work. While health priorities and programs may differ across contexts, the foundational relational principles remain relatively stable. Together, a strong sense of place and shared values can transform mere physical locations into meaningful spaces grounded in trust, connection, and belonging, ultimately creating environments that serve as centers for community and shared experience.

At a broader level, Phase One should not be examined in isolation. Although shared values become further operationalized in later phases of the model through data-driven decision-making, alignment of assets and infrastructure, and collaborative program design, each of these phases relies on the clarity and connection established at the beginning, and each, in turn, works to then reinforce the values identified early on. Data-driven decision-making becomes more meaningful when partners share a commitment to transparency and accountability; program co-development becomes stronger when partners share mutual respect and recognition of community expertise; and organizational alignment or collaboration becomes more feasible when presence, cultural relevance, and hope guide forward movement. Phase One, therefore, acts as both an anchor and a compass.

Application pathways also emerge from this foundation. The accompanying community health replication manual and wellness curriculum both provide practical ways to help operationalize

shared values across organizations and disciplines. Both tools offer activities, reflective prompts, and team processes that help to translate values from abstract statements into more concrete daily practices. These tools are not meant to prescribe standardized implementation practices but rather to support adaptation by allowing organizations to embed appropriate values in their own settings, contexts, and professional work cultures.

Although DUCIH's current B2H model remains early in its replication journey, several future directions have emerged. Specifically, areas for continued study include examining how shared values influence interprofessional and cross-sector communication, levels of community trust in healthcare supports, and team cohesion over time. Another area involves understanding how well Phase One prepares organizations for subsequent replication phases, including community partnership development, program co-development, and sustainability efforts. Additional research may still seek to understand the effectiveness of values-based training curricula, particularly for current or future healthcare practitioners and other professionals whose education emphasizes technical skills over relational competencies. Finally, as additional organizations adopt elements of the B2H model, opportunities may naturally emerge to examine how cross-sector collaborative networks may support model integrity, adaptation, and shared accountability throughout areas of community-based engagement.

Taken together, these future directions highlight the significance of community health work: values are not peripheral but central to creating the structure in which meaningful, sustainable, and patient-centered work takes place. By beginning with Phase One, building shared values, professionals and organizations can commit to a process that is intentionally purposeful, reflective, and grounded. Ultimately, this foundation elevates a process that prioritizes connection, understanding, and presence, which can later lead to coordination, action, and programming. This model does not eliminate the challenges or barriers inherent to community health or to replication; however, it seeks to provide the relational foundation needed to better navigate them. As the B2H replication work further develops and organizations begin to adapt, the model's development will not rely on a standardized formula but on continued investment in shared values that support collaborative growth. Through this foundation, replication avoids duplication and becomes an extension of a values-based culture that can be adapted and reinforced across places, settings, and times.

References

Aarons, G. A., Ehrhart, M. G., Farahnak, L. R., & Sklar, M. (2014). Aligning leadership across systems and organizations to develop a strategic climate for evidence-based practice implementation. *Annual Review of Public Health*, *35*, 255–274. https://doi.org/10.1146/annurev-publhealth-032013-182447

Aguilar-Gaxiola, S., Ahmed, S. M., Anise, A., Azzahir, A., Baker, K. E., Cupito, A., Eder, M., Everette, T. D., Erwin, K., Felzien, M., Freeman, E., Gibbs, D., Greene-Moton, E., Hernández-Cancio, S., Hwang, A., Jones, F., Jones, G., Jones, M., Khodyakov, D.,…Zaldivar, R. (2022). Assessing meaningful community engagement: A conceptual model to advance health equity through transformed systems for health: Organizing committee for assessing meaningful community engagement in health & health care programs & policies. *NAM Perspectives*, *2022*. https://doi.org/10.31478/202202c

Ahmed, Z., Ellahham, S., Soomro, M., Shams, S., & Latif, K. (2024). Exploring the impact of compassion and leadership on patient safety and quality in healthcare systems: a narrative review. *BMJ Open Quality*, *13*(2). https://doi.org/10.1136/bmjoq-2023-002651

Allegheny County Health Department. (2022). *Community health assessment*. Allegheny County Health Department. https://www.alleghenycounty.us/files/assets/county/v/1/government/health/documents/healthier-allegheny/achd-cha-12-01-2022.pdf

Allen, J., Trent, S., & Woods, S. (2020). Building capacity: The case for values-based operations. *Metropolitan Universities*, *31*(1), 78–91. https://doi.org/10.18060/23719

Babiker, A., El Husseini, M., Al Nemri, A., Al Frayh, A., Al Juryyan, N., Faki, M. O., Assiri, A., Al Saadi, M., Shaikh, F., & Al Zamil, F. (2014). Health care professional development: Working as a team to improve patient care. *Sudanese Journal of Paediatrics*, *14*(2), 9–16.

Bombeke, K., Symons, L., Vermeire, E., Debaene, L., Schol, S., De Winter, B., & Van Royen, P. (2012). Patient-centredness from education to practice: the 'lived' impact of communication skills training. *Medical Teacher*, *34*(5), e338–348. https://doi.org/10.3109/0142159x.2012.670320

Boyte, H., Hübler, R., & Ström, M. (2025). "All on an equal plain": Preparing citizen professionals. *Metropolitan Universities*, *36*(1), 4–21. https://doi.org/10.18060/28804

Briant, K. J., Halter, A., Marchello, N., Escareño, M., & Thompson, B. (2016). The power of digital storytelling as a culturally relevant health promotion tool. *Health Promotion Practice*, *17*(6), 793–801. https://doi.org/10.1177/1524839916658023

Carnegie Classification of Institutes of Higher Education. (2024). *Carnegie elective classification for community engagement classified campuses 2024*. Retrieved November 18, 2025, from https://carnegieclassifications.acenet.edu/wp-content/uploads/2024/01/Carnegie_2024ClassifiedInstitutions.pdf

Carnegie Classification of Institutes of Higher Education. (2025). *The elective classification for community engagement*. Retrieved November 11, 2025, from https://carnegieclassifications.acenet.edu/elective-classifications/community-engagement/

Center for Spiritan Studies. (2017). *Spiritan pedagogy: A handbook.* Duquesne University.

Christianson, C. E., McBride, R. B., Vari, R. C., Olson, L., & Wilson, H. D. (2007). From traditional to patient-centered learning: curriculum change as an intervention for changing institutional culture and promoting professionalism in undergraduate medical education. *Academic Medicine*, *82*(11), 1079–1088. https://doi.org/10.1097/ACM.0b013e3181574a62

Chu, S. Y., Wen, C. C., & Lin, C. W. (2020). A qualitative study of clinical narrative competence of medical personnel. *BMC Medical Education*, *20*(1), 415. https://doi.org/10.1186/s12909-020-02336-6

Cyril, S., Smith, B. J., Possamai-Inesedy, A., & Renzaho, A. M. (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. *Global Health Action*, *8*, 29842. https://doi.org/10.3402/gha.v8.29842

Dankwa-Mullan, I., & Pérez-Stable, E. J. (2016). Addressing health disparities is a place-based issue. *American Journal of Public Health*, *106*(4), 637–639. https://doi.org/10.2105/ajph.2016.303077

DiMatteo, M. R., Sherbourne, C. D., Hays, R. D., Ordway, L., Kravitz, R. L., McGlynn, E. A., Kaplan, S., & Rogers, W. H. (1993). Physicians' characteristics influence patients' adherence to medical treatment: results from the Medical Outcomes Study. *Health Psychology*, *12*(2), 93–102. https://doi.org/10.1037/0278-6133.12.2.93

Dunning, A., Louch, G., Grange, A., Spilsbury, K., & Johnson, J. (2021). Exploring nurses' experiences of value congruence and the perceived relationship with wellbeing and patient care and safety: a qualitative study. *Journal of Research in Nursing*, *26*(1-2), 135–146. https://doi.org/10.1177/1744987120976172

Duquesne University. (2024). *Vision 150: Continuing the momentum strategic plan 2024-2028*. Retrieved November 18, 2025, from https://www.duq.edu/documents/about/policies-initiatives/strategicplan-2024-28.pdf

Elliott, J. P., Christian, S. N., Doong, K., Hardy, H. E., Mendez, D. D., & Gary-Webb, T. L. (2021). Pharmacist Involvement in Addressing Public Health Priorities and Community Needs: The Allegheny County Racial and Ethnic Approaches to Community Health (REACH) Project. *Prev Chronic Dis*, *18*, E07. https://doi.org/10.5888/pcd18.200490

Elliott, J. P., Harrison, C., Konopka, C., Wood, J., Marcotullio, N., Lunney, P., Skoner, D., & Gentile, D. (2015). Pharmacist-led screening program for an inner-city pediatric population. *Journal of the American Pharmacists Association*, *55*(4), 413–418. https://doi.org/10.1331/JAPhA.2015.14273

Elliott, J. P., Marcotullio, N., Skoner, D. P., Lunney, P., & Gentile, D. A. (2014). An asthma sports camp series to identify children with possible asthma and cardiovascular risk factors. *Journal of Asthma*, *51*(3), 267–274. https://doi.org/10.3109/02770903.2013.867349

Elliott, J. P., Morphew, T., Gentile, D., Williams, P., Barrett, C., & Sossong, N. (2022). Improved asthma outcomes among at-risk children in a pharmacist-led, interdisciplinary school-based health clinic: A pilot study of the CAReS program. *Journal of the American Pharmacists Association*, *62*(2), 519–525.e511.https://doi.org/10.1016/j.japh.2021.11.008

Engle, R. L., Mohr, D. C., Holmes, S. K., Seibert, M. N., Afable, M., Leyson, J., & Meterko, M. (2021). Evidence-based practice and patient-centered care: Doing both well. *Health Care Management Review*, *46*(3), 174–184. https://doi.org/10.1097/hmr.0000000000000254

Fix, G. M., VanDeusen Lukas, C., Bolton, R. E., Hill, J. N., Mueller, N., LaVela, S. L., & Bokhour, B. G. (2018). Patient-centred care is a way of doing things: How healthcare employees conceptualize patient-centred care. *Health Expectations*, *21*(1), 300–307. https://doi.org/10.1111/hex.12615

Garmong, G., Calhoun, B., Colbert, A., Grigsby, V., Mann, J., Nagy, A., Namey, B., Parish, M., & Elliott, J. (2022). Academic Center Partnership with Health Department and Church to Rapidly Deploy COVID-19 Vaccine POD Reaching Underserved Populations. *Metropolitan Universities*, *33*(3), 110–137. https://doi.org/10.18060/25692

Gentile, D. A., Morphew, T., Elliott, J., Presto, A. A., & Skoner, D. P. (2022). Asthma prevalence and control among schoolchildren residing near outdoor air pollution sites. *Journal of Asthma*, *59*(1), 12–22. https://doi.org/10.1080/02770903.2020.1840584

Gershon, R. R., Stone, P. W., Bakken, S., & Larson, E. (2004). Measurement of organizational culture and climate in healthcare. *Journal of Nursing Administration*, *34*(1), 33–40. https://doi.org/10.1097/00005110-200401000-00008

Grailey, K. E., Murray, E., Reader, T., & Brett, S. J. (2021). The presence and potential impact of psychological safety in the healthcare setting: an evidence synthesis. *BMC Health Services Research*, *21*(1), 773. https://doi.org/10.1186/s12913-021-06740-6

Hannawa, A. F., Wu, A. W., Kolyada, A., Potemkina, A., & Donaldson, L. J. (2022). The aspects of healthcare quality that are important to health professionals and patients: A qualitative study. *Patient Education and Counseling*, *105*(6), 1561–1570. https://doi.org/10.1016/j.pec.2021.10.016

Hay, R., Namey, B., Ripper, L., Bunk, E., & Elliott, J. (2023). Analysis of school-based asthma screenings and need for care coordination in underserved urban communities. *Journal of the American Pharmacists Association*, *63*(4s), S48–s51. https://doi.org/10.1016/j.japh.2022.12.010

Heller, C. G., Rehm, C. D., Parsons, A. H., Chambers, E. C., Hollingsworth, N. H., & Fiori, K. P. (2021). The association between social needs and chronic conditions in a large, urban primary care population. *Preventive Medicine*, *153*, 106752. https://doi.org/10.1016/j.ypmed.2021.106752

James, T. (2023). *Putting values at the forefront of health care*. Harvard Medical School. Retrieved November 19, 2025, from https://learn.hms.harvard.edu/insights/all-insights/putting-values-forefront-health-care

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review*, *9*(1), 36–41. https://doi.org/10.48558/5900-KN19

Kwame, A., & Petrucka, P. M. (2021). A literature-based study of patient-centered care and communication in nurse-patient interactions: barriers, facilitators, and the way forward. *BMC Nursing*, *20*(1), 158. https://doi.org/10.1186/s12912-021-00684-2

Loy, M., & Kowalsky, R. (2024). Narrative medicine: The power of shared stories to enhance inclusive clinical care, clinician well-being, and medical education. *The Permanente Journal*, *28*(2), 93–101. https://doi.org/10.7812/tpp/23.116

Mannion, R., & Davies, H. (2018). Understanding organisational culture for healthcare quality improvement. *Bmj*, *363*, k4907. https://doi.org/10.1136/bmj.k4907

Mardhiyah, A., Philip, K., Mediani, H. S., & Yosep, I. (2020). The association between hope and quality of life among adolescents with chronic diseases: A systematic review. *Child Health Nursing Research*, *26*(3), 323–328. https://doi.org/10.4094/chnr.2020.26.3.323

McCrory, K. (2025). *Centering education around learners to develop patient-centered physicians*. Harvard Medical School. https://learn.hms.harvard.edu/insights/all-insights/centering-education-around-learners-develop-patient-centered-physicians

McGowan, V. J., Buckner, S., Mead, R., McGill, E., Ronzi, S., Beyer, F., & Bambra, C. (2021). Examining the effectiveness of place-based interventions to improve public health and reduce health inequalities: an umbrella review. *BMC Public Health*, *21*(1), 1888. https://doi.org/10.1186/s12889-021-11852-z

Michener, J. L., Williams, A., Oto-Kent, D., & Aguilar-Gaxiola, S. A. (2025). Community engagement: A foundation for health equity and resilience. *American Journal of Public Health*, *115*(S2), S104–s109. https://doi.org/10.2105/ajph.2025.308029

Mylod, D., & Lee, T. H. (2023). Giving hope as a high reliability function of health care. *Journal of Patient Experience*, *10*, 23743735221147765. https://doi.org/10.1177/23743735221147765

Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten principles of good interdisciplinary team work. *Human Resources for Health*, *11*, 19. https://doi.org/10.1186/1478-4491-11-19

National Institutes of Health. (2021). *Minority health and health disparities strategic plan 2021-2025*. U.S. Department of Health and Human Services, National Institutes of Health Retrieved from https://www.nimhd.nih.gov/sites/default/files/NIH-Wide_MHHD_Strategic_Plan_2021-2025_508.pdf

Norful, A. A., Brewer, K. C., Cahir, K. M., & Dierkes, A. M. (2024). Individual and organizational factors influencing well-being and burnout amongst healthcare assistants: A systematic review. *International Journal of Nursing Studies Advances*, *6*, 100187. https://doi.org/10.1016/j.ijnsa.2024.100187

Owens, K., Eggers, J., Keller, S., & McDonald, A. (2017). The imperative of culture: a quantitative analysis of the impact of culture on workforce engagement, patient experience, physician engagement, value-based purchasing, and turnover. *Journal of Healthcare Leadership*, *9*, 25–31. https://doi.org/10.2147/jhl.S126381

Pro, G., Neighbors, H. W., Wilkerson, B., & Haynes, T. (2025). Place-based access to integrated mental health services within substance use disorder treatment facilities in the US. *Social Science & Medicine*, *369*, 117843. https://doi.org/10.1016/j.socscimed.2025.117843

Qin, X., Wang, B. L., Zhao, J., Wu, P., & Liu, T. (2023). Learn from the best hospitals: a comparison of the mission, vision and values. *BMC Health Services Research*, *23*(1), 792. https://doi.org/10.1186/s12913-023-09699-8

Rosewilliam, S., Indramohan, V., Breakwell, R., & Skelton, J. (2020). Learning to be patient-centred healthcare professionals: how does it happen at university and on clinical placements? A multiple focus group study. *MedEdPublish*, *9*, 53. https://doi.org/10.15694/mep.2020.000053.1

Schoen, R. R., Hatcher, T., Ripper, L., Morphew, T., Breitbarth, M., Barton, E. B., & Elliott, J. P. (2025). Rx for Change: An Integrative Approach to Community-Clinical Linkages and Impact on Health Outcomes. *Journal of the American Pharmacists Association*, 102480. https://doi.org/https://doi.org/10.1016/j.japh.2025.102480

Schot, E., Tummers, L., & Noordegraaf, M. (2020). Working on working together. A systematic review on how healthcare professionals contribute to interprofessional collaboration. *Journal of Interprofessional Care*, *34*(3), 332–342. https://doi.org/10.1080/13561820.2019.1636007

Shanafelt, T. D. (2009). Enhancing meaning in work: a prescription for preventing physician burnout and promoting patient-centered care. *Journal of the American Medical Association*, *302*(12), 1338–1340. https://doi.org/10.1001/jama.2009.1385

Silva, B., Henricksen, J., Larsen, G., Talbot, K., & Stewart, C. (2025). "Just" speaking up requires increasing psychological safety. *Pediatric Quality & Safety*, *10*(S1), e834. https://doi.org/10.1097/pq9.0000000000000834

Skelton-Wilson, S., Sandoval-Lunn, M., Zhang, X., Stern, F., & Kendall, J. (2022). *Methods and emerging strategies to engage people with lived experience*. Washington, D.C.: U.S. Department of Health and Human Services. Retrieved from https://aspe.hhs.gov/reports/lived-experience-brief

Smith, J., Pelco, L., & Rooke, A. (2017). The emerging role of universities in collective impact initiatives for community benefit. *Metropolitan Universities*, *28*(4), 9–31. https://doi.org/10.18060/21743

Toubassi, D., Schenker, C., Roberts, M., & Forte, M. (2023). Professional identity formation: linking meaning to well-being. *Advances in Health Sciences Education: Theory and Practice*, *28*(1), 305–318. https://doi.org/10.1007/s10459-022-10146-2

Towe, V. L., Leviton, L., Chandra, A., Sloan, J. C., Tait, M., & Orleans, T. (2016). Cross-sector collaborations and partnerships: Essential ingredients to help shape health and well-being. *Health Affairs*, *35*(11), 1964–1969. https://doi.org/10.1377/hlthaff.2016.0604

U.S. Department of Health and Human Services Clinical and Transctional Science Awards Consortium. (2011). *Principles of community engagement*. (No. 11-7782). National Institutes of Health. Retrieved from https://ictr.johnshopkins.edu/wp-content/uploads/2015/10/CTSAPrinciplesofCommunityEngagement.pdf

Webb Hooper, M., Mitchell, C., Marshall, V. J., Cheatham, C., Austin, K., Sanders, K., Krishnamurthi, S., & Grafton, L. L. (2019). Understanding multilevel factors related to urban community trust in healthcare and research. *International Journal of Environmental Research and Public Health*, *16*(18). https://doi.org/10.3390/ijerph16183280

Williams, P., Zuberi, A., Hyatt-Burkhart, D., & Elliott, J. P. (2024). "People should not have to live under these conditions": Using focus groups to inform the development of a

community-led intervention addressing air quality and health equity. *Environmental Justice*, *17*(5), 316–323. https://doi.org/10.1089/env.2022.0066

World Health Organization. (2024). *The power of storytelling for health impact*. Retrieved November 19, 2025, from https://www.who.int/westernpacific/newsroom/feature-stories/item/the-power-of-storytelling-for-health-impact

Wright, Q. E., Higginbotham, S., Bunk, E., & Covvey, J. R. (2020). The impact of a pharmacist-led naloxone education and community distribution project on local use of naloxone. *Journal of the American Pharmacists Association*, *60*(3, Supplement), S56–S60. https://doi.org/https://doi.org/10.1016/j.japh.2019.11.027

