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Hospital–Community Partnerships: Facilitating Communication for Population Health on Columbus' South Side

Berkeley Franz[a], Daniel Skinner[a], Anna M. Kerr[b], Robert Penfold[c], and Kelly Kelleher[d]

[a]Department of Social Medicine, Ohio University; [b]Department of Family Medicine, Ohio University; [c]Group Health Research Institute, Seattle; [d]The Research Institute at Nationwide Children's Hospital, Columbus, Ohio

ABSTRACT

Previous studies have focused on the role anchor institutions play in community development. However, less attention has been directed to how hospitals can effectively partner with community-organizations and residents as part of population health efforts. This article examines community views of one initiative developed by a major American children's hospital in partnership with local community organizations. The data for this study come from 35 in-depth interviews with local residents from the neighborhood adjacent to the hospital and two interviews with hospital administrators. Our findings suggest that the contexts in which hospitals and other non-profit corporations operate pose unique challenges to effective communication. In particular, hospitals and community organizations may think differently about the merits and nature of open communication. Especially when acting as anchor institutions working beyond their formal medical expertise, hospitals may struggle to communicate the scope and goals of their non-medical work in the community.

Health scholars are increasingly recognizing that social and economic determinants are key drivers of health outcomes (Franzini et al., 2010; Hilmers, Hilmers, & Dave, 2012; Narine & Shobe, 2014; Phelan, Link, & Tehranifar, 2010). Among these critical supplements to traditional medical services are socioeconomic status, access to food and affordable housing, education, and exposure to violence. Our research study provides an overview of one hospital working to address the social determinants of health in a local neighborhood, and considers how hospitals might act as important "anchor institutions" to improve community health.

'Anchor institution' has recently come to denote a large institution–usually educational institutions and large corporations–that serve as deeply rooted engines of economic development within communities. Not only because of their size, but also relationships with local municipalities, these institutions are unlikely to relocate, in contrast to smaller, less firmly rooted institutions. In addition to educational institutions and businesses, hospitals have recently come to be considered important community anchors (Parrillo & De Socio, 2014; Skinner, Gardner, & Kelleher, 2016). The nascent literature on anchor institutions is not beholden to any particular discipline, but spans numerous scholarly domains, including law, community development, urban studies, higher education, and health care, among others (Cantor, Englot, & Higgins, 2013; Clopton & Finch, 2011; Ehlenz, 2016; King & Redwood, 2016; Patterson & Silverman, 2014; Sibbald & Graham, 2016). Some research suggests that anchor institutions could become strong leaders in promoting economic development and improving community life (Austrian, Alexander, Piazza, & Clouse, 2015; Gertler, 2010).

In his collaborative study of the role of urban academic institutions, Michael Porter popularized the term 'anchor institution' and argued that these institutions are "well positioned to spur economic revitalization of our inner cities, in great part because they are sizable businesses anchored in their current locations" (Initiative for a Competitive Inner City and CEOs for Cities, 2002). These institutions, furthermore, have the potential to improve the health of their communities through resources and programs targeting social determinants of health even as they profit from investing in their surrounding environments (Adams, 2003; Webber & Karlstrom, 2009). There is conflicting evidence, however, suggesting that anchor institutions may harm communities by intensifying gentrification and disrupting valued community dynamics, although these negative impacts do not appear to be universal (Silverman, Lewis, & Patterson, 2014). Few studies have considered how medical institutions, as local anchors, currently work with and within communities and how these relationships might be strengthened. It is this space in the existing literature that the present study seeks to fill.

Most hospitals in the US are non-profit organizations. Since the 1960s, non-profit (tax exempt) hospitals have been required to provide services to their community in exchange

CONTACT Berkeley Franz franzb@ohio.edu Department of Social Medicine, Heritage College of Osteopathic Medicine, Ohio University, Grosvenor 311, Athens, OH 45701, USA

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for this tax break, a process known as community benefit (Folkemer et al., 2011). Traditionally, the majority of hospitals fulfilled this requirement by providing charity care to patients. However, due to concerns that many hospitals were not adequately meeting community benefit requirements, the Affordable Care Act (ACA) greatly expanded hospital responsibilities to their communities and introduced new reporting requirements (James, 2016). Hospitals must now conduct Community Health Needs Assessments (CHNAs) every three years and develop programs in response to documented needs. There is evidence that many nonprofit hospitals have begun to engage their communities through health promotion and other public health activities. Hospitals also have participated in initiatives to reduce crime, provide employment, increase and improve housing stock, and increase food access in an effort to elevate the health of local populations (Burke et al., 2014; George, Rovniak, Kraschnewski, Hanson, & Sciamanna, 2015; Skinner, Donovan-Lyle, & Kelleher, 2014). Therefore, the potential exists for hospitals to become anchor institutions with a defined and active role in community development (Abbott, 2011; Pennel, McLeroy, Burdine, Matarrita-Cascante, & Wang, 2016).

The public demand for hospitals to strengthen their relationships with local communities is at an all-time high (Bosilkovski & Lee, 2013). This demand is consistent with the historical shift in scholarly approaches to public relations —from a functional perspective to a co-creational perspective (Botan & Taylor, 2004). Previously, public relations was approached as a means for achieving organizational goals (Botan & Taylor, 2004) and engagement was considered one-way communication from the organization that demonstrated goodwill toward the community (Taylor & Kent, 2014). More recently, researchers have placed the organization–public relationship at the center of public relations scholarship (e.g. Gruning & Huang, 2000; Kent & Taylor, 2002; Ledingham & Bruning, 1998) and insisted that organizational engagement should be "a two-way relational, give-and-take between organizations and stakeholders/publics" (Taylor & Kent, 2014, p. 391).

The notion of relational communication between organizations and publics is central to Kent and Taylor's (2002) dialogic theory of public relations. The theory posits that dialogic communication between organizations and publics is characterized by mutuality, propinquity, empathy, risk, and commitment (Kent & Taylor, 2002). Ultimately, the theory suggests that true organization-public dialogue "values interpersonal interaction, and places an emphasis on meaning making, understanding, cocreation of reality, and sympathetic/empathetic interactions" (Taylor & Kent, 2014, p. 389). Successful dialogic communication in public relations requires establishing a culture of organizational listening (Gregory, 2015; Macnamara, 2016). To foster dialogue with publics, organizations must implement formal policies, technologies, and resources for effective listening, and should demonstrate how feedback from community members influences policy and organizational decisions in order to give value to the voice of the public (Macnamara, 2016). As anchor institutions, hospitals would likely benefit from a dialogic approach to communication to foster long-standing, mutually beneficial relationships with local communities. Therefore, the current study seeks to explore one hospital's communication with the community in which it resides and whether community feedback is perceived by the community to influence organizational action and decision making.

Despite a diverse and growing body of literature on the impact of anchor institutions on communities, scholars have not yet documented the extent to which hospitals are adopting this role. Largely undocumented, as well, are the unique challenges that hospitals, as medically-focused anchor institutions, face in operating as anchor institutions (Birch, Perry, & Taylor, 2013; Ehlenz, 2016). The purpose of the present research, accordingly, was to describe and evaluate a recent initiative in which a major children's hospital, along with various community partners, participated in population health activities in their surrounding community. In this analysis, we specifically explore the strategies hospitals use to communicate with local residents and how the hospital is perceived by these residents when staging interventions outside of the direct delivery of health care, such as those aimed at the upstream social determinants of health (McKinlay, 2005; Phelan et al., 2010).

Method

Framing research questions

Based on the lack of scholarly findings on hospitals as anchor institutions, our interview guide was framed by three broad questions, each of which is informed by a dialogic approach to organizational communication:

(1) How are new hospital-based population health programs interpreted and received by local residents? (RQ1)
(2) According to key resident stakeholders in the community, what is the role of the hospital in the community? (RQ2)
(3) How do residents perceive the strategies hospitals use to inform local residents of future plans? (RQ3)

In accordance with the constructivist variant of grounded theory, these questions are not intended to direct the findings that ultimately emerge from the study, but enable researchers to "explore" a particular set of topics (Charmaz, 2006, p. 29). In the Findings section, we discuss how the themes that emerged from our research relate to our framing questions.

Population and data collection

The data for this study come from a larger program of research on how community members in the South Side neighborhood of Columbus, Ohio interpret neighborhood problems and interventions currently in place, and envision possible solutions. Initial participants were contacted and interviewed with the assistance of a church/community organization. We contacted this church based on their active role in the neighborhood and familiarity with a variety of community members.

After meeting with several church leaders and discussing the aims of our project, they agreed to set aside space after the church service on one Tuesday morning and make an announcement to congregants about our study, inviting them to participate. Specifically, we hoped to include residents who may not have access to email and would otherwise be difficult to recruit. Because the church draws local residents both for church services and a variety of social and community resources, this was an appropriate research site. Of the approximately 75 persons in attendance during the morning service, 22 agreed to participate in an interview at some point in the day. The first two authors stayed after the service for the remainder of the day to conduct interviews.

Because we wanted to increase diversity within our sample, five additional participants were contacted with the help of a local research group affiliated with a nearby university. Once participants consented, we conducted an interview in a local coffee shop. All interviews lasted from 20 minutes to one hour. We utilized snowball sampling to recruit the additional eight participants (Noy, 2008). After completing the initial interviews at the church, we identified patterns and dimensions in which our sample was potentially incomplete. We used purposive recruiting (Bryant & Charmaz, 2007) to identify participants whose perspectives may have been overlooked to flesh out our sample and preliminary categories. This process of seeking out new information continued until no novel findings emerged from interviews, as determined by conversations between the first two authors after each subsequent interview. Theoretical saturation occurred after 32 interviews, but we conducted three additional interviews, which were already scheduled, to confirm that no new information arose. The final sample size of 35 participants is within the standard range for constructivist grounded theory studies (Charmaz, 2006).[1] No demographic data were collected due to concerns about privacy raised in our IRB protocol review. Research participants, however, were broadly representative of the South Side neighborhood, which is composed primarily of non-Hispanic white and black residents who are comparatively poor in comparison to residents from other neighborhoods in Columbus.

To supplement our interviews with community residents, we contacted three employees at the hospital who worked on community development efforts in the neighborhood. Of these three administrators, two agreed to participate in an hour-long interview in order to provide the hospital's perspective on their work in the neighborhood. Since the views of hospital administrators were not the main focus of this study, we regard these interviews as supplementary. These interviews, accordingly, were analyzed separately from those with residents and were meant to provide an alternative perspective on communication between the hospital and local residents. The two hospital employees were interviewed using an adjusted interview guide, with questions framed toward understanding the perspective of the hospital and its employees.

Description of community-hospital collaborations

Over almost a decade, Nationwide Children's Hospital (NCH), along with several community partners, has participated in a series of non-medical interventions and programs in the community proximate to the hospital's campus on the South Side of Columbus, Ohio. This initiative arose in two distinct contexts. First, the hospital was in the midst of a major renovation, which included a new building and vastly expanded campus, thereby creating a need for renewed community relations. Second, the hospital became increasingly committed to engaging the community surrounding its campus, and was approached by various community agencies about supporting local initiatives to improve the neighborhood. Various partners therefore collaborated around shared goals, including the City of Columbus, a local church-run non-profit, United Way, and the hospital. Designed with other successful programs in mind, the goal of this collaborative effort was to "remove barriers to the health and well-being of thousands of families in our neighborhood" (Nationwide Children's Hospital, 2016).

Organized in 2009 under the umbrella of "Healthy Neighborhoods, Healthy Families" (HNHF), the program contained five initiatives: affordable housing, health and wellness, education, safe and accessible neighborhoods, and workforce and economic development (Nationwide Children's Hospital, 2016). The aim of the affordable housing initiative was to decrease the number of cost-burdened households, an initiative that included addressing vacant and abandoned properties, which were often sites for crime, homebuyer assistance/education, and repair grants. Rental support and neighborhood improvement programs were combined with income assistance with the aim of reducing housing payments and—as a corollary—family finances and stress. See Figure 1 for a map of the houses in the neighborhood affected by this program. To promote health and wellness, the program identified increased access to primary care as well as reproductive choice as major commitments. Yet, this focus also extended beyond traditional medical concerns to emphasize access to fresh fruits and vegetables in an effort to prevent obesity, premature aging, and infant mortality.

HNHF focused its educational initiatives on the creation of mentoring and academic enrichment programs at a local elementary school just south of the hospital, and funded consultant services for child care centers. This included an expansion of afterschool programs and the creation of literacy programs for adults and children. To support neighborhood improvement, HNHF identified as priorities roadway infrastructure improvements (including sidewalk and bike path enhancement, and new green spaces) and transportation. This focus considered crime prevention alongside personal safety programs (from bike helmet and car seat safety checks) as ways to improve residents' personal safety. Finally, HNHF supported economic development efforts to increase the area's workforce. Among the particular components of this focus was a goal of increasing neighborhood employment through job fairs, vendor opportunities at the hospital, and establishing student internship programs for younger residents.

Description of neighborhood

The neighborhood in which HNHF operates includes the three zip codes immediately surrounding NCH in Columbus, Ohio and consists of approximately 4,400 residents. The neighborhood, like

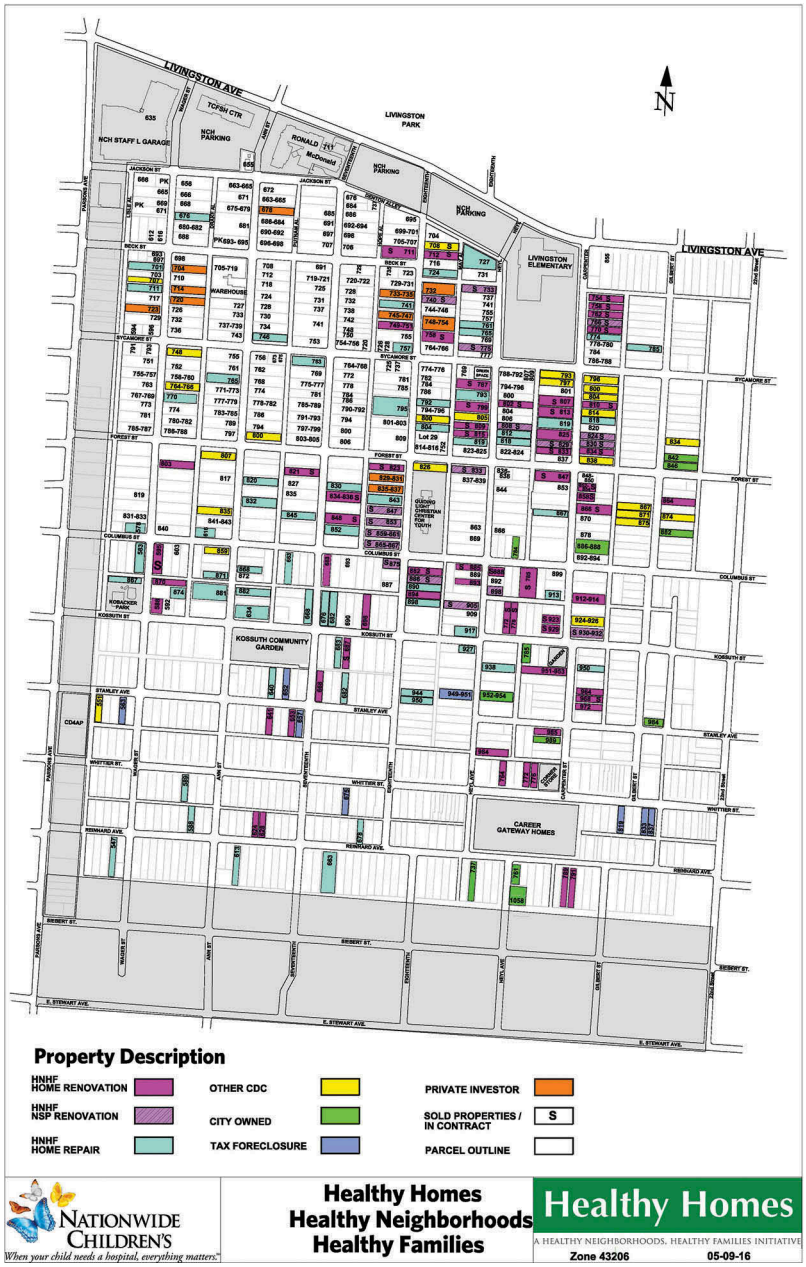

Figure 1. Recent home renovations near the hospital campus.

many urban counterparts, has a history of industrial manufacturing and growth followed by an economic downturn beginning in the 1960s when jobs moved elsewhere (WOSU Public Media, 2017). This historically diverse neighborhood drew workers both from urban areas and Appalachia when manufacturing jobs were widely available. The neighborhood remains diverse with a racial composition that is approximately 48% white, 40% African American, 2% Asian, 2% Hispanic, with remaining residents identifying as two or more races. Approximately 29% of this population are children and among these children, 61% live in poverty. Among adults, 51% are either unemployed or out of the labor force. (U.S. Census Bureau, 2014).

Measures of social determinants such as education, housing stability, violence, and perinatal health provide a more complete picture of the surrounding community. Approximately 19% of residential properties are vacant or abandoned, a finding related to certain types of crime in the literature on neighborhood well-being (Raleigh & Galster, 2014). Violent crimes, robberies, and sexual assaults are three times as common compared to the city of Columbus as a whole, with burglaries twice as likely (U.S. Census Bureau, 2014). Low birth weight, an important factor in infant mortality exceeds both county and state averages at nearly 11% (U.S. Census Bureau, 2014). Finally, educational outcomes are comparatively poor with an approximately 63% 4-year secondary school graduation rate (Ohio Department of Education, 2016).

The collaborative community benefit efforts by the hospital and its partners were motivated by these comparatively poor health indicators. Nonetheless, community members may hold different perspectives on the neighborhood and experience local problems differently. For this reason, our study utilized interviews with local residents to elucidate the nature of communication between various stakeholders and incorporate the values

and needs of local residents when an anchor institution like NCH and its partners at the church, United Way, and Mayor's office are planning and implementing significant changes in a neighborhood.

Analysis

Both data collection and analysis were rooted in a constructivist grounded theory approach (Mills, Bonner, & Francis, 2006). This approach acknowledges the biases of both participants and researchers and aims to develop a structure for understanding the perspectives of participants that is co-constructed through the data collection and analysis process. The goal of this approach is to discover new constructs and derive new insights from the perspectives of participants rather than test researchers' hypotheses (Charmaz, 2006).

Interview recordings were transcribed by a professional transcriptionist. The same two researchers (BF and DS) who conducted the interviews separately coded the transcripts for themes using NVivo 10. The first phase of open coding involved line-by-line coding of each interview. The second phase involved grouping line by line codes into categories. Finally, theoretical coding involved determining overall themes that emerged and established the relationship between these themes.

Throughout the interview process, the researchers re-phrased participant responses to clarify that their intentions were understood and asked follow up questions where clarification seemed necessary (Sacks, 1984). In addition, after initial coding the researchers met on three separate occasions to discuss recurrent themes and engage in cross-coding. In the case of similar or overlapping codes, separate codes were merged. When discrepancies arose, the researchers discussed these differences until consensus was reached. In addition, the researchers engaged in collaborative memo-writing and questioning of categories to ensure reliability and dependability of results (Birks, Chapman, & Francis, 2008). This project was approved by the Ohio University Institutional Review Board in 2015.

Findings and interpretations

From 35 interviews with local residents and 2 interviews with hospital administrators, we identified 5 related themes that together form the basis for understanding the way hospitals as anchor institutions may relate to the local residents: (1) knowing about NCH as a community partner; (2) knowing about NCH as a medical institution; (3) social determinants of health; (4) hospital and community dialogue; and (5) improving communication to facilitate collaborative efforts. Though they are more expansive than the original questions that framed this project, these themes help us to better understand NCH's role in the community and communication with local community members.

One striking finding that emerged from the study was that many participants were completely unaware that NCH was involved in community development activities. From the perspective of one hospital administrator, there was both a clear mission and a history of action by the hospital to improve the well-being of local residents. Hospital administrator #1 described the hospital's work in the following way:

> I would say at a very high level our goal is to improve the overall quality of life for families in the neighborhood surrounding the hospital. So it's looking at family and child life more comprehensively across all domains, and those include outcomes in housing stability, outcomes in education, success and access outcomes and safety in the neighborhood. Of course health and wellness, our core business, but also employment stability for mom and dad. So we have specific measures around those five domains that we're looking at in terms of success for the neighborhood. But it really is intended to be a place-based approach to improve the overall quality of life.

Despite the strategic planning and history of work in the neighborhood, many participants in our sample were not aware of this work. For example, when asked if the hospital was helping to improve the neighborhood, one resident responded, "I don't really know if Children's Hospital gets around to doing stuff… they're probably busy." A significant number of respondents simply replied with "no" or "I don't know" when asked about the hospital's involvement in the community.

Only a few participants could describe the hospital's work in the neighborhood. When questioned about this involvement, some residents steered the conversation toward the hospital's physical expansion. For example, when asked if the hospital was part of the community, a participant responded, "Man, yes they are. They've taken over Columbus basically." This participant, like a few others was aware of the hospital mostly because of the noticeable expansion and presence in the neighborhood. Another participant, however, provided a comprehensive overview of the hospital's recent community engagement: "Well, they are part of the community and they've been very supportive… they are involved in the businesses… they are involved in housing, they are involved in healthcare issues… " Another interviewee noted: "Actually, you know they have a lot of outreach programs and things, I think it's pretty good and it's healthy. Especially for our children in this area." Although a few residents were knowledgeable about the hospital's involvement in various community initiatives, these perspectives were surprisingly uncommon.

With an awareness of hospital involvement, however, came additional concerns such as a perceived tendency for the hospital to overreach in its efforts or accelerate gentrification. One resident expressed the following concern: "One of the things I see from Children's is like taking over a lot of space. Just like, I worry that's it's just going to grow exponentially and knock out houses and people." That is, although assessments were largely positive, they also highlighted potential problems, especially considering that a number of entities are working in the neighborhood. Residents were not always able to distinguish which projects were the work of the hospital and its partners, and which were part of less community-oriented development projects. Another resident said: "I think that's nothing but a plus for this area and it grows and gets bigger as long as it don't forget what it's there primarily for. And that's for children." Therefore, another potential issue is that the hospital could develop neighborhood initiatives at the expense of their traditional focus, not only on medicine, but children specifically. Despite some knowledge about the hospital's

community involvement, these perspectives were the exception to the rule and related significantly to the challenge of viewing medical institutions as community development partners in addition to their traditional role of providing health services.

Knowing about NCH as a medical institution

When questioned about the hospital's broader impact on the community, conversations often focused—unsurprisingly—on medicine. For example, despite the hospital's work in community development, administrators often tied this work to the hospital's traditional role as a health care institution. As hospital administrator #1 explained:

> It really is about us testing the waters in the neighborhood to see what kind of an impact we can have and how that shapes outcomes on health. I think our school-based health effort is a great example… our role is providing access to health services in a way that supports them being in school. So for example, our school-based asthma therapy program is a great example where we have gone into the school buildings, educated both the school nurse and some of the administrative staff at the school in cooperation with the parents about how to administer the daily medication for asthma at school so that Johnny gets to stay in school and isn't missing long stretches of time away from the classroom because his asthma has flared up. Providing access to services to keep kids in school, you know, our role is our core business, but it does have an impact on success in other areas.

In a similar way, community members emphasized the hospital's traditional medical role when asked about their presence in the community. One participant responded, "A big role… they're convenient, it's open to all the kids, 24 hours," adding "It's part of the community… it's here for everyone." Another interviewee added:

> I seen a lot of change in some areas where [NCH] kind of torn down and built other things but they, I know they help out with my son… I do like the fact that they do help out with children like that and I do feel like they care.

That is, even when some of NCH's non-medical work is mentioned, such as rehabilitating houses, participants often came back to their value to the community as a medical institution.

Interviewees with children especially emphasized NCH's medical services. One interviewee noted that the hospital "is really helpful for people that has kids and like mine, they have doctor's appointments up there a lot." Another, without children, noted, "I just don't feel the connection to [the children's hospital] because I don't have kids and I know if I had an emergency I'd have to run to Grant or OSU East." As an anchor institution, the hospital's reach is potentially expansive. Yet, many community members assumed that the hospital's population health efforts would be restricted to children. Some community members hesitated to link social problems such as violence to the hospital's role as a medical institution. For example, when asked whether the hospital could help address violence in the community, one interviewee responded, "They just need to help people who have been sick," highlighting the expertise and priority of the hospital.

One resident spoke about more inclusive developments they would like to see happen, specifically:

> Yeah, not just for kids, just get the whole family. Get the momma down there, the daddy down there, once they get finished going the kids ok mom and dad come over here while we checking you out too because you're a part of them.

Another resident noted:

> There have been some more promotions of good health in the area, I don't know if it's the hospital doing that but it just seems like there's been a lot more focus on health in the area. It's unfortunate that they only treat children there, I wish they treated more broad spectrum of people or build offices in the area to help treat a broader spectrum of people instead of just children. But you know they can only do so much as well but at the same token, why would you want to send a child to a hospital if you're not okay with the neighborhood.

Again, it was difficult to imagine NCH improving the neighborhood in ways that were not directly related to their provision of health care.

One interviewee encapsulated the divide between the traditional view of the hospital and the role filled by anchor institutions, noting "I take my grandchild there. We go there for being sick." This statement casts hospitals not as proactive sites of wellness, but places for addressing sickness. The phrase "we go *there*" suggests a division between where residents live and the hospital and distinguishes anchor institutions of proactive population health from reactive spaces of sickness. In some cases, interviewees struggled to characterize the hospital's involvement in the community, not because they were unaware of its presence, but because the model was new and the hospital:

> is part of the community and they've been very supportive but it's because I remember when it was a very small hospital before it became Nationwide Children's Hospital, it's almost they have taken on a corporate side of the, which it's probably good, but I… know they focus a lot of healthcare so I can't take that away…

A persistent disconnect existed therefore between the work that NCH was initiating under the umbrella of population health and the type of activities local residents thought were compatible with the hospital's traditional mission to treat sick children.

Beyond medicine—Social determinants of health

When asked what problems existed in the community, both residents and hospital administrators pointed to challenges posed by non-medical problems such as crime, housing, and unemployment. Hospital administrator #1 described specific non-medical factors that relate to poor health in the neighborhood:

> The underlying piece across all of them is likely poverty, you know, and why is the neighborhood so impoverished? I think there are decades-long explanations for why there is a lack of, you know, employment opportunities at a living wage in the neighborhood. There are public schools that have been consistently failing, so folks are not even getting prepared to succeed in the workforce because they don't have access to high-quality education opportunities. We know that as a result of poverty and lack of employment and lack of educational opportunities, that safety in the neighborhood is a challenge.

As a result of these social determinants, both hospital administrators emphasized the need to expand the hospital's role beyond providing acute medical care to investing in community well-being in order to prevent future illness.

Although many local residents limited the involvement of the hospital to traditional medical problems and especially those affecting children, occasionally interviewees suggested that hospitals might play roles in non-medical areas. This development, however, is likely to cause some confusion within medical institutions, as well as raise questions about expertise as hospitals venture into social sectors beyond their historical medical focus. One interviewee thought of the hospital as a "role model for everybody; even the adults. You know, they always have, you know, papers you can read, pamphlets and stuff like that." Another resident wished the hospital would "open up more programs for our children to maybe train them and put them through some kind of medical training and help them get in school." Others thought that the hospital could capitalize on their children-specific mission to develop non-medical interventions.

A common concern among residents was that there were not enough safe recreation opportunities or spaces during non-school hours. One resident suggested that the hospital could "open up more community centers… where children can come in after school and maybe get an evening meal or educate them on, you know, health issues and what to look for and warning signs, and stuff like that." Others thought that the hospital could provide safe spaces and supervision. One participant explained, "since it's mainly big people out here… they can get some kind of program that they can take their kids and keep them for the day." Other residents thought that the hospital should think more expansively about their role in improving the community.

Because unemployment is a significant concern, several participants suggested that the hospital earmark jobs for community members as they were expanding. One resident described the need for "workforce development kind of training" and noted that this is,

> tied in with the hospital and hopefully I think they're going to add some other employers in there too, but with the idea that someone needs, you know, affordable stable housing and they're willing to be taking this job training to maybe get a job at [NCH], they can live there and the hospital can work with them and you can help get stabilized and it's another way to expand the hospital's reach.

In other words, both hospital administrators and local residents in our sample agree that the hospital's potential impact exceeds its medical contributions to the community. Most important, however, is that many of the activities described by local residents as ways that the hospital might get involved with the community were already being undertaken by the hospital and its partners. For this reason, many participants questioned the communication strategies used by the hospital and why existing development efforts weren't familiar to them.

Hospital and community dialogue

Both hospital administrators and local residents expressed concerns that previous hospital activities had not been clearly communicated with community members. Hospital administrator #2 suggested that "for a long time there was a healthy distrust of the hospitals" because "we hadn't done a really great job of communicating." This administrator went on to specify specific opportunities for communication that had not been capitalized on in the past:

> I think we have to do a better job about—I think we do a great job on communicating when it comes to growth, you know, what we're doing as far as development. I think we could do a better job of communicating around roadway improvement, we get a better sense from the city what's gonna be happening before anybody else does, 'cuz we've worked hard at that relationship with the city and we should maybe do a better job of communicating that with the community, and the community seeing us as kind of an information resource for them with the city… it can't be an email blast. And those folks that attend those community meetings are a small portion.

Echoing sentiments of hospital administrator #2, one resident noted that they "would totally help support the hospital more if I knew that they were building up my neighborhood," adding that the hospital and its partners "should advertise" its non-medical services more. In some situations, the development of a positive view of the hospital by community members suggests opportunities for obtaining community buy in to community development initiatives, as well a potential compatibility between hospital public relations and actual development work. Indeed, many interviewees emphasized name recognition's importance to their understanding of resources. Whereas many residents were not aware of the scope of the hospital's presence in the community, they were disproportionately aware of the presence of another medical provider's role in the neighborhood precisely because it utilized mobile units prominently displaying their name. Though that provider was located on the other side of the city, one interviewee noted, "I see them in the community a lot… I see the church's members there in the community. I feel like we, the help we need, we are getting it."

Some participants suggested that the hospital communicated with neighborhood elites instead of average residents. One resident noted:

> I'm just not in that circle that would know… my criticism of a lot of groups is that they tend to pick people who either they see their names in the paper or who are up front a lot and don't necessarily speak with the people who have the need or live in the neighborhood and know what's going on around them…

Other participants felt that communication only occurred when residents were loud enough to demand a conversation. One resident actively involved in the community described this process of getting the attention of NCH in this way:

> One of the only reasons why they started getting involved with the community is because people got on the news and complained loud enough to say—look you guys are tearing down our houses, you're wrecking up this corner and building all these buildings and you're not getting any input from the community and I think that's why they started… I don't feel the sincerity in it. I just feel the big business coming out.

For some residents, the hospital had not made efforts to make information available to all residents and only did so when prompted by resident action.

Other residents suggested that communication was "intermittent" or inappropriately handled. For example, several participants reported difficulty in receiving updates from the hospital or its partners because not everyone had made it onto mailing lists or the updates come electronically, and are therefore not accessible to some residents. According to one participant, "they invite people to come to different meetings and they'll send out… we're on a mailing list, they would send us stuff… I don't think that that is the answer but I believe that they do that." Another resident pointed out the particular challenge of electronic communication and explained that "if you don't do online… don't know what's happening someplace else and that part I think we've not been effective enough. Social media is wonderful but everybody doesn't use it. The older people, the older residents, sometimes don't have a computer."

Although accessing the internet was a challenge for some residents, others mentioned that online communication could be a beneficial addition to existing communication pathways. The neighborhood, for example, uses the web-based social media platform, NextDoor.com, to share information and coordinate block watch responsibilities. Some residents suggested that the hospital might also join this group. One participant noted, "I think the online thing is making me a bit more aware. I don't see [NCH] posting on there though… " In other words, online communication had the potential to open new spaces for community and hospital discussion, but may exclude residents who don't have access or experience using email or other web-based applications. These residents suggested that there was support for the hospital working in the neighborhood, but a lack of or inappropriate modes of communication made collaboration difficult.

Improving communication to facilitate collaborative efforts

A related finding was whether the hospital would likely partner with local residents even if communication were improved. Although the hospital administrators in our sample acknowledged that there have been many communication failures in the past, they seemed optimistic about future opportunities for collaboration. For example, hospital administrator #2 suggested that:

> I definitely think we did not engage with the community, not at first, in the planning process. I think that what we've seen is that we can't just walk into a community and tell them, 'This is what you need.' You have to have really buy in from the beginning and their opportunity to tell you what they need, which may not always be what the big institution thinks is best.

Hospital administrator #1 expressed a similar optimism that hospital-community relations could improve with more intentional communication. She explained:

> There's a receptivity on some fronts but I would also say we have to work really hard at it. You know, we're this behemoth anchor organization in the neighborhood… People expect and appreciate that Nationwide Children's has resources to bring to bear, but I think we also are kind of constantly battling against the arrogance of our own institution in not wanting to come in and do to, but rather do with.

Both administrators described the complexity involved with figuring out what role the hospital would play in community development and desired additional partners, both from other local businesses and community members to make sure that any changes were the result of a collaborative effort. As hospital administrator #2 suggested, "In regards to really making this sustainable, you need to have more than just one institution kind of anchoring the work or willing to support the work." Hospital administrator #1 echoed this perspective in describing the hospital's ideal role in change:

> But I would say we are a catalyst for change and a partner that has some influence in leveraging resources with other important community organizations. So, you know, our whole premise is we have some resources—and not just financial but, you know, human power that we can bring to the conversation to help connect the dots, to help provide some seed money to support other partners coming to the table. I think we are, you know, a catalyst for change and a facilitator of change.

What was needed to accomplish this vision, according to hospital administrator #1, was not more focus groups or surveys, but "an infrastructure for systematic and regular communication in a way that feels authentic."

When residents were asked about hospital communication efforts, some participants in our sample suggested that the hospital historically employed "planners" who operated independently from community members. In conflict with the goals laid out by administrators, one participant described the hospital as being "in the community, but they're not necessarily with the community." Nonetheless some residents acknowledged that the hospital could become a positive force in the community, but also noted the challenges of getting people organized and active. One interviewee expressed uncertainty about "how to actually loop [residents] in," noting that "short of like door to door," it is hard to reach residents.

Other residents were optimistic, however, and suggested that the hospital and community could realize shared goals. Instead of distinguishing between different types of intentions, these participants thought that future efforts could be improved if the hospital and its partners more fully engaged the community in carrying our projects. One resident suggested:

> If they could partner more with the groups that are trying to do something, which is something that, you know, when they've had meetings and it has had representatives there, what they're usually doing is they're presenting what they're going to do and it might be and it might conflict with what the neighborhood groups want to do. If they could partner more with them and work more with them so that they're both going in the same direction…

In other words, our interviews revealed a great deal of enthusiasm for increasing communication and involving residents earlier in the process. One neighbor suggested, "I think the key is having the neighborhood help decide what the changes are" instead of being consulted once they are in process or already in place. Community dialogue, according to both residents and administrators, represents a more enduring process of communication and seemed to be enthusiastically supported by a variety of participants. According to our findings, there were not only shared goals in seeing the

neighborhood improve, but a clear suggestion that improved communication was necessary in order to realize this shared vision.

Overall, these five emergent themes (knowing about NCH as a community partner; knowing about NCH as a medical institution; social determinants of health; hospital and community dialogue; and improving communication to facilitate collaborative efforts) help answer our initial research questions and reveal additional considerations for anchor institutions. The participants' perceptions of NCH as a community partner addressed how NCH's community initiatives were perceived by local residents (RQ1) and their focus on NCH as a medical institution revealed the primary role of the hospital (RQ2). These findings also suggest that, as anchor institutions, hospitals must acknowledge and address the social determinants of health in addition to providing excellent patient care. Finally, the participants' emphasis on hospital-community dialogue and improving collaborative communication gave us a better understanding of NCH's community-based communication and feedback strategies (RQ3). In the next section, we discuss the theoretical and practical implications of these findings.

Discussion

Our findings reveal multiple communication dilemmas that NCH faces as it moves from a more traditional medical institution concerned mainly with direct patient care and embraces the role of an anchor institution invested in and involved with projects aimed at impacting population health beyond the more traditional medical model. On the whole, the participants in our sample respect the hospital as a provider of high quality health services for children, but have also come to see the hospital as a moral and economic leader in the community. Yet, our findings also reveal that some community members do not consider the hospital part of broader community development efforts. This finding is interesting in light of the fact that NCH is actively engaged with a number of partners in such projects, and dedicates significant staff and resources to addressing determinants of health in the local community. Ultimately, the results of our study offer multiple suggestions for hospitals, community members, and health communication scholars. We discuss these recommendations below.

First, our findings suggest that hospitals must work closely and collaboratively with their local communities to make sure that intended interventions that transcend medical care are known to local residents. These findings highlight specific challenges for anchor institutions working to improve the community in fields distinct from their traditional expertise. Some participants suggested that the hospital's primary responsibility in the community was to provide high-quality medical care to children. As a result, the hospital was meeting many community members' expectations. Although many residents identified significant non-medical problems in the community, such as unemployment and lack of convenient hospital services for adults, they were less likely to suggest that the hospital had a role to play in addressing them. A few participants did share thoughts on how the hospital might help improve the community, but these moments were less common. It is, of course, unsurprising that some residents would primarily think of the children's hospital as a medical institution. However, the finding highlights a disconnect between a hospital that prioritizes work to improve the social determinants of health within its neighborhood and residents who are either unaware of this work or do not see the connection to traditional medical care. Consequently, hospitals must make community members aware of their engagement activities that transcend medical care and demonstrate why efforts to improve social determinants of health are central to the well-being of the local community.

This finding extends existing literature on anchor institutions and organization-public communication by suggesting that hospitals may be unique as anchor institutions and face particular challenges when expanding beyond their traditional and specialized role as acute medical providers. Because hospital interests increasingly span several social sectors, as well as population health initiatives that engage upstream factors, there is likely to be confusion about what role hospitals should play and how best to apply their traditional expertise into novel areas. Community members may not understand why institutions, such as children's hospitals, for example, are seemingly expanding their reach. This is a particularly important finding in light of the fact that hospitals are increasingly being encouraged–and even required–to engage health on the population level and address upstream social determinants of illness (Casalino, Erb, Joshi, & Shortell, 2015; Pennel et al., 2016). Given the ACA's community benefit provisions, nonprofit hospitals need to think carefully about *how* to undertake CHNAs and work with stakeholders to develop formal plans for meeting local needs. Moreover, if community members do not see the need to participate in discussions pertaining to the hospital's non-medical community outreach, effective dialogue will be nearly impossible (Zoller, 2000). Therefore, we recommend that hospital administrators and health communication scholars developing community outreach interventions devote significant efforts to engaging the community in dialogue focused how the hospital can benefit the community in areas beyond traditional medical services.

Next, our results suggest that hospitals must engage community members early and often when developing community benefit projects to ensure the project is unequivocally perceived as beneficial to both the institution and community. Hospitals may face additional negative consequences when working outside of their traditional sphere if community members perceive their work as inappropriate or undertaken without local consent. For example, the hospital and its partners in this study were particularly active in the housing sector. Although this work was clearly done with good intentions, some community members questioned why the hospital was involved in making such significant changes to the neighborhood and specifically expressed concerns about gentrification. This finding confirms that when corporate interests are perceived by community members to be prioritized over community concerns, mutuality, a central facet of ethical dialogue, is constrained. Mutuality refers to the recognition that organizations and communities are interdependent and equal contributors to ongoing conversations about issues pertaining to both (Kent & Taylor, 2002). In the current study,

many of the residents felt that they had not been consulted prior to project implementation. The residents and hospital administrators in our sample both suggest that frequent and in-depth communication will be necessary for anchor institutions to successfully engage communities, especially when working beyond their traditional scope. Our findings provide support for emerging ideas such as community-led health committees (Newman et al., 2011; Franz, Skinner, & Murphy, 2016) to make community perspectives more readily available to hospitals and public health officials, as well as spaces for dialogic interaction. These recommendations demonstrate the need for propinquity in organization-community dialogue, which requires discussion of issues in the present (rather than after decisions are made) and acknowledgement of the past, present, and future of the organization-community relationship (Kent & Taylor, 2002). As a result of this study, we suggest that anchor institutions facilitate frequent opportunities for dialogue about organizational issues (medical and nonmedical), and to encourage conversations about long-term goals rather than immediate results (2002). Moreover, the dialogue should focus not only on what is being done, but why it is beneficial to the insitution and community.

This finding confirms the effort needed to engage in truly dialogic, rather than monologic, community engagement. Though the hospital in the neighborhood we examined appears to value communication efforts with the community and is taking steps to improve communication, many residents in our sample considered those efforts so far to be insufficient or superficial. These perceptions demonstrate that community engagement involves more than gestures of goodwill, but instead requires ongoing interactions that transcend a specific issue and focus on the greater good of the community (Taylor & Kent, 2014). This raises a question concerning the types of communication necessary for anchor institutions to work successfully with communities. The literature on community-based projects shows that effective communication is essential to developing partnerships, but also that communication leads to the sharing of different perspectives and the creation of the kind of interventions that best drive improved community outcomes (Balbale, Schwingel, Chodzko-Zajko, & Huhman, 2014; Garney et al., 2015). Moreover, effective organization-public dialogic communication is associated with increased trust (Yang, Kang, & Cha, 2015). Therefore, we recommend that hospitals foster ongoing dialogue with local community members, rather than communication which occurs after an idea is developed.

The data from our study suggest that engaging in this ongoing dialogue is a beneficial mode of collaboration where anchor institutions prioritize significant community involvement and avoid working behind the scenes. According to the hospital administrators in our sample, anchor institutions may be wary about seeming too eager to improve the community through outreach or fearful of dominating programs. Others will prefer to partner with social service agencies and local businesses that are already supporting or carrying out various types of work. Some institutions may simply prefer to operate quietly and not disturb existing momentum in the neighborhood. Others, depending on their institutional context, may wish to promote their efforts directly. Clear, however, is that given the difficult histories that many of America's most vulnerable neighborhoods —including Columbus's South Side—have experienced, when community members hear about the involvement of anchor institutions, but are not communicated with directly, even good projects can raise questions about what else may be occurring without their involvement. Anchor institutions must demonstrate empathy to communities by supporting and confirming their goals and interest and demonstrate a true commitment to genuine, truthful dialogue that is mutually beneficial (Kent & Taylor, 2002).

Finally, we recommend that hospitals, community members, and communication scholars recognize the need for multiple modes of dialogue that ensure all community members are invited to contribute to the dialogue. Communication between anchor institutions, their partner organizations, and community members can take on many forms that transcend merely knowing about an intervention. In some cases, many goals for community development may be shared, but this agreement is unclear because regular communication has not been facilitated. For example, many residents shared examples of the hospital communicating selectively with local professionals or community leaders, or informing residents of programs through mailings or electronic communication. Neither of these strategies truly integrates residents' perspectives into programs or respects the value of having authentic participation from a variety of stakeholders. Effective, dialogically-based communication with communities requires organizations to consider all opinions worthy of consideration and a commitment to seek out opposing or marginalized viewpoints that can help foster creative solutions (Kent & Taylor, 2002). Hospitals must be sure that appropriate communication mechanisms are in place to foster dialogue with diverse community members. Additionally, there is a profound difference between soliciting buy-in for existing plans and working collaboratively with community members to plan, carry out, and evaluate any changes to the neighborhood (Minkler & Wallerstein, 2008). Our results confirm that organizations must remain aware that community members may view some forms of dialogue as empty gestures that only impede tangible benefits such as creating jobs or improving community health (Zoller, 2000).

Despite our findings that communication is an important consideration for anchor institutions concerned with positively impacting communities, there has so far been a gap in the literature detailing best practices for communication in these contexts. Perhaps this is partly because anchor institutions inhabit unique neighborhoods, making universal recommendations for successful communication difficult. Another option may be that hospitals, especially after the ACA, are exploring what it means to be an anchor institution focusing on public health in addition to health care. Our findings support the establishment of regular and substantive dialogue between hospitals and communities that allows for mutuality in determining what role a hospital will play as a neighborhood anchor institution.

Our findings also point to the advantages of using Kent and Taylor (2002) dialogic theory of public relations to inform future studies exploring the application of these best practices. Despite NCH's current engagement efforts, few community members

perceive that the hospital is truly engaged—suggesting the hospital's communication efforts are, for the most part, unidirectional. This is not surprising considering that, historically, hospital public relations practitioners were primarily responsible for disseminating information; only recently have they become more involved in building and nurturing community relationships (Bosilkovski & Lee, 2013; Ledingham & Bruning, 2000). The previous discussion suggests that Kent and Taylor (2002) five dimensions of dialogue may prove beneficial for anchor institutions. If hospitals like NCH ensure their communication with local communities is characterized by mutuality, propinquity, empathy, risk, and commitment (Kent & Taylor, 2002), they can establish an ongoing collaboration-oriented dialogue that involves conversation, relationship building, and mutual trust (Ganesh & Zoller, 2012). Hospitals taking on a community development role should consider how they might engage local residents to find practical and sustainable communication strategies, especially those that could potentially aid in cultivating successful dialogue around community development.

Our study suggests that hospitals face unique challenges when their community engagement efforts transcend traditional medical care, especially if the benefit of those efforts are not well understood by the local community. These findings reveal the complex task hospitals face establishing their role as trusted health care providers, but also in defining their role as anchor institutions that can benefit community development in a variety of nonmedical ways. Therefore, communication scholars should acknowledge the multiple goals that must be accomplished through organization-public dialogue. Additionally, our findings suggest that community members are well-aware of the health-related services of local hospitals, so hospitals and communication scholars must identify particular communication strategies that foster dialogue about the broader mission of the organization.

Conclusion

Successful communication between hospitals and communities ultimately requires that a dialogical theoretical orientation drive and come to characterize hospital–community interactions. Given the different concerns and cultures that historically take root in hospitals and communities, however, the development of such an approach will not come naturally and will require proactive steps. This will require trainings within hospitals to ensure that employees–from administration to staff–increasingly come to think of themselves as dialogically bound to communities. Attentiveness to preconceptions and biases, brought to light through structured dialogue, will underscore the important role that mutuality must play to move past the loggerheads at which hospitals and communities often find themselves. This means, as well, that those tasked specifically with communicating with community members and leaders must undergo a shift in consciousness that thinks dialogically and collaboratively rather than merely informing the community about plans. The radical shift that our findings point to requires a nontrivial change in hospital culture itself, which has tended toward cloistering and nontransparent planning. The crucial move toward dialogic relations will have to internalize the extent to which hospital missions are not only compatible with such a turn, but require it. Researchers will need to develop more nuanced models and training modules for helping hospital administrators and staff to wrestle with their own preconceptions about community involvement in developing visions for hospitals to more completely involve community members, as well as for community leaders and members to better understand how to work with hospitals.

What does it mean for anchor institutions and their ability to strengthen communities if local residents are unaware of their involvement? At a minimum, poor communication puts interventions at risk if residents do not accept changes being made to their neighborhood and may foreclose opportunities for future collaboration between hospitals, community partners, and residents. We argue that this challenge requires rethinking how these organizations conceptualize their role in the community and communicate with residents. Understanding how both local residents and hospital administrators interpret the involvement of anchor institutions in their neighborhoods may be important for the sustainability of interventions. Although many anchor institutions express a desire to improve their surrounding environment, and often dedicate significant staff and resources to this end, these efforts can fall short, and even be counterproductive if communication with community members is not handled correctly. By embracing a dialogic approach to communication, anchor institutions can foster ongoing, mutually beneficial conversations with community members about issues affecting both parties. Ultimately, understanding the perspectives of local residents in perceiving the work of anchor institutions may hold some value for community institutions interested in establishing community development initiatives and encourage reflection on the type of communication necessary to facilitate collaboration and improved well-being.

Note

1. A copy of the interview guides used for residents and hospital administrators is available from the corresponding author.

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