Community Health Workers' Critical Role in Trust Building Between the Medical System and Communities of Color

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Community Health Workers' Critical Role in Trust Building Between the Medical System and Communities of Color

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The authors interrogate elements of routine medical practice in New York City to argue for reforms of hospital culture through relational trust-building capabilities of community health workers.

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Takeaway Points

- Trust is not the default for patients of color. Asking many patients of color to "unlearn" their mistrust of hospitals should be reversed to: What can hospitals do to earn the trust of their patients?
- Trust in medical treatments and vaccines cannot be heightened through "more" or "better" information. The relational quality of communication deserves as much attention as the content of the information in interventions.
- Trust cannot be earned overnight; it requires time and attention. Community health workers cultivate relationships with patients, provide them with an essential degree of familiarity with medical expertise and procedures, and can do this consistent, long-term labor.

The COVID-19 pandemic has laid bare discriminatory and inequitable health outcomes in communities of color around the country. In New York City, Black and Latino communities experienced significantly greater hospitalization and mortality rates than the White population, with early (prevaccine) fatality estimates suggesting an approximate 3.5-fold disparity for Hispanic adults and 5.4-fold disparity for non-Hispanic Black adults relative to non-Hispanic White adults.[1] This should surprise no one, given the documented economic and racial inequalities in the United States, and indeed, fine-grained analyses suggest that "structural determinants pervasive in Black and Hispanic communities," primarily associated with poverty, are driving these disparities.[2] The pandemic has also drawn attention to a crisis of mistrust in the relations between communities of color and the medical system. Initially, at least, Black and Latino communities had lower vaccination rates than their White counterparts, and this remains true for the former.[3] How can medical institutions regain the trust of local communities, and who might do this trust-building work on the ground?

To explore these questions, the Trust Project at Columbia University partnered with the Bronx Community Health Network, a nonprofit health center system that provides access to affordable, quality services at school- and community-based health centers, to host a town hall conversation and a follow-up roundtable in fall 2021. Together with local advocates, policy makers, community health workers (CHWs), and the public, we sought to better understand the relationship between Bronx residents and the medical field. The following are the lessons we learned from these

conversations, which we would like to bring to the attention of medical decision makers.

The first point we learned from our participants was that focusing attention on the presumed mistrust of the medical field by communities of color is misguided. Public and academic conversations often begin from the “problem” of mistrust. The unstated premise of beginning in this way is that it is evident that communities of color should trust medical providers and medical institutions. In this reading, the onus is placed on marginalized communities to “unlearn” their distrust toward medical practitioners. Although the academic discussion on mistrust has begun to acknowledge that this premise is wrong,[4] our interlocutors’ daily experiences suggest that these assumptions still guide much of the day-to-day, on-the-ground discourse. Put differently, the national conversation should shift from fixing individuals to fixing the system. It is important to recognize that given the history of medical discrimination and medical racism, trust is not the obvious default for patients of color. Before doctors, hospitals, and health care providers decry mistrust, the task at hand should be to heighten patient engagement and make patients want to come into care, share and disclose important information, and be part of care planning. In other words, the medical field must become more trustworthy.[5]

The second point we learned follows from the first. Attempts to build trust in medical treatments and vaccines often assume that “more” or “better” information is needed to educate mistrustful patients. If, however, the problem is one of trustworthiness, a unidirectional, monologic information campaign is likely to backfire. There is little evidence to suggest that a misunderstanding of the benefits and risks associated with vaccination is the primary driver of vaccine hesitancy.[6] Many interventions based on this “deficit” model have not significantly affected vaccination rates, with some research suggesting that they may even increasethe perceived risks associated with vaccines.[7] Communicating medical advice is not the simple transmission of information. When it comes to eliciting trust, the medium, format, and timing of communication are as crucial—perhaps morecrucial—than its informational content, however scientifically correct. An information blitz from above, coming fast on the heels of a moral panic about “mistrust” and “disinformation,” is likely to elicit the opposite reaction than intended. In other words, the relational quality of

communication deserves as much attention when crafting interventions as the content of the information itself, if not more so.[8,9]

How can such ties be built, where trustworthiness is lacking and will take a long time to rebuild? A third lesson we learned from our conversations is that CHWs already function as essential mediators who perform critical trust-building work (**Figure**). When CHWs are situated at the access points to the medical system, they are uniquely equipped to communicate and negotiate information between both sides (ie, to replace the unidirectional flow of information with a dialogue). Moreover, their training and background, as well as the temporal rhythm of their work, are well suited to remediate some of the aspects of hospital routines that are least conducive to projecting trustworthiness.

Consider that the rapid administrative rotation of medical personnel and 15-minute patient consultations—all hallmarks of overwhelmed hospitals that often serve communities of color—are unfit to establish trust in the medical system. Before even meeting with doctors, racial disparities are present in wait times.[10-12] Trust cannot be earned overnight; it requires time and attention, which are both scarce commodities in the notoriously depersonalized hospital system. Hospitals should introduce human-centered routines (more face time and less screen time[13]) that improve the continuity, quality, and patient experience of care. However, they can do this far more effectively if they draw upon CHWs, who cultivate long-term relationships with patients and provide them with an essential degree of familiarity with medical expertise and procedures.

Consider also that most hospitals and the larger health care system do not provide information in easily digestible, linguistically accessible, or culturally resonant ways,[14] leading to apprehension among patients toward the medical establishment when these encounters result in repeated distressing patient experiences—not necessarily outright mistrust. Because CHWs mirror the demographic makeup of the communities they serve, they possess the requisite linguistic and cultural competency to convey public health knowledge to diverse patient groups. This does not excuse doctors, hospital personnel, or medical leadership from attaining basic cultural awareness and humility themselves, nor from hiring and retaining more representative rosters of medical employees. Medical professionals must also

interrogate their own mistrust of patients. Racial prejudice and implicit bias regarding minority groups are widespread in hospitals[15] and can lead hospital employees to dismiss or pathologize patients' reports of their symptoms. Although CHWs can provide critical support for these trust-building efforts, hospitals must cultivate a new culture of patient care.

It should also be noted that the way hospitals communicate medical knowledge often disregards how adults learn. Adults generally do not appreciate receiving lectures for perceived missteps or being told what to do without explanation. This problem is exacerbated by clinical practices that rely on extensive testing in lieu of listening. The deference to tests, taken to furnish "objective" evidence, serves to end conversations while rendering patients' reports of their symptoms conditional upon test results. In such contexts, the reliance on tests makes doctors appear inattentive or even dismissive, thereby undermining their trustworthiness. As familiar members of the community, CHWs can mediate the often conflicting understandings of symptoms between patients and doctors, building trust among all parties.

Finally, we have learned one more lesson from the CHWs who participated in our town hall conversation. We are not the first to suggest the importance of community voices such as CHWs to building trust. Many others—from public health researchers to leaders of the Biden administration's "trusted messengers" program—have argued for the importance of local intermediaries between the medical profession and the public. Although such efforts are laudable for acknowledging the social context of intervention, they are also sociologically naïve. Trusted messengers programs presume that the messengers themselves would naturally trust the message they are asked to convey, or that they have faith in the medical and governmental elites they are asked to represent (ie, they will form a coalition with the elite to influence the patients). In the context of a pandemic, CHWs and other mediators are asked to convey rapidly changing recommendations without having input into their formulation. Loath to risk their own credibility among community members in the process, they are far more likely to align themselves with the patients, against the elites.[13] This is especially true as they are asked to do all this while cognizant of their own experiences of being sidelined and ignored by medical institutions. We do not believe this is a recipe for success.

Despite their hinge position as trusted mediators between the medical field and patient communities, many CHWs remain underresourced and undervalued. If hospitals want to rebuild trust among communities of color, where the pandemic has revealed it to be frayed or absent, they must invest in CHWs by training more of them, paying them commensurate salaries, and including them in decision-making about the messages they are asked to convey. However, CHWs are only one side of the equation. The other side concerns hospitals themselves. They cannot continue to place the burden on communities and CHWs—often the ones most adversely affected by public health crises—to orchestrate the trust-building process. Although community leadership will play an important role in rebuilding trust in the medical system, their efforts must be mirrored by inward-facing efforts to reform the culture of hospital care.

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