# BARRIERS AND FACILITATORS TO TRUST BETWEEN COMMUNITY HEALTH WORKERS (CHWS) AND THEIR PATIENTS: WHAT WE CAN LEARN FROM CHWS' PERSPECTIVES

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## Dedication

I dedicate this thesis to my parents Leticia and Miguel Guzman who have always provided me with unconditional love and support to pursue my dreams. I also dedicate this thesis to my sister, Cecilia, remember ‘Sí Se Puede’, and to my grandparents Socorro, Jose, and Ines for their encouragement and prayers. I further dedicate this thesis to Natalhy Hinojosa, Alejandra Vega, and Nhu Uong, whose friendship means so much to me. Lastly, to Danny Martinez for always believing I can do anything.

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by

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## Abstract

**Background:** While trust is an essential factor in provider-patient relationships, it is often challenging to establish with vulnerable patient populations. Community Health Workers (CHWs), are typically assumed to have the trust of such populations because of shared backgrounds. We argue that trust is not a given, but something that must be established. It is helpful to identify facilitators and barriers of trust for CHWs in establishing trust with patients. This project was part of a larger evaluation of the Care Connections Program, a CHW-driven care-management program for complex patients empaneled to the Los Angeles County Department of Health Services primary care practices.

**Methods:** This is a secondary data analysis based on qualitative data that was collected using three focus groups consisting of 17 CHWs. Atlas.ti software was used for data analysis. We identified key themes in the data that resonated with the central questions of this project by conducting a literature review, a review of the report generated from the primary analysis conducted by the primary investigators as well as a review of the transcripts.

**Results:** Our analysis of CHWs' perspectives helps illustrate how CHWs characterized the establishment of such trust by overcoming barriers and utilizing facilitators in patient-provider relationships. CHWs invested time to connect with patients on a more personal level, often finding that establishing trust required persistence and multiple attempts at communicating with patients who avoided their help due to distrust. The balancing of their clinical role vs. community identity and trust of their patients was challenging to manage for CHWs as they were advocates for their patients on the one hand, but also bridges to patients for the healthcare system.

**Discussion:** Since trust is not a given and must be established, it was not always easy for CHWs to establish trust in their relationships with patients. The findings of this study suggest that CHWs would benefit from training on how to establish trust with their patients. Addressing the causes for distrust may also benefit patients as they become more likely to adhere to medications, make healthy behavior modifications, and improve their overall quality of life.

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# Chapter 1: Introduction

"'...Patients don't tell the truth to many of their providers, and it takes time for them to tell me the truth. It takes home visits, it takes hanging out, it takes, until, 'Well, you know, I'm going to be honest with you.'" (Excerpt from a focus group interview with a Community Health Worker collected for this study).

This statement is about establishing trust between the community health worker and the patient. Trust is a concept in which individuals have an assumption that other individuals will act in a non-maleficent manner in an interaction, therefore trust is essential for interpersonal connections and for community existence (Hall, Dugan, Zheng, & Mishra, 2001; Mechanic & Meyer, 2000; Thiede, 2005). Trust is known to be a critically important factor in patient- provider relationships because it is associated with patient health outcomes. Community health workers (CHWs) who often come from similar backgrounds as their patients, serve as a bridge between patients and providers, healthcare systems who aim to improve the health of the patients and augment the patient experience in care (Balcazar et al., 2011; Hector Balcazar PhD, 2018). CHWs are increasingly and integrally involved in the provision of health care. In this thesis, I will explore the role of trust in the relationship between CHWs and their patients. While the literature on CHWs assumes that because of shared backgrounds, the trust between a CHW- patient relationship is a given, the CHWs in this study report investing substantial time and effort to develop trust.

## 1.1 What is Trust?

Trust can be thought of as a concept in which an individual assumes the person with whom they are interacting will behave in a "non-harmful or beneficial manner, without having established a contractual relation beforehand" (Thiede, 2005). That is, within interactions an individual can

conclude that the other individual involved will not behave impolitely even if they are not familiar with each other before the interaction. The concept of trust is shared between individuals, individuals and organizations, and individuals and events (Gilson, 2003). This shared notion of trust is what enables everyday interactions between individuals, as well as groups, and promotes communication (Thiede, 2005). Communication is essential within relationships, particularly at the health care level, where the connection between the patient and provider is vital to establish delivery of care (Gilson, 2003).

## 1.2 WHY IS TRUST IMPORTANT IN PATIENT-PROVIDER RELATIONSHIPS?

Trust between patients and providers is a necessary factor in optimal health outcomes because it can affect medication adherence, healthy behavior modification, and empowerment of one's health (Andrews, Felton, Wewers, & Heath, 2004; Gilson, 2003; Sheppard, Zambrana, & O'malley, 2004). The amount of trust within the patient-provider relationship can differ based on the patient's illness, education level, and access to information (Gilson, 2003). In vulnerable populations of patients, the trust may be more significant as trust can arise from the conditions of vulnerability (Gilson, 2003; Hall et al., 2001). Populations or individuals are considered vulnerable due to health disparities in comparison with the rest of the population (Montgomery & Jones Schubart, 2010). Health disparities are defined as "a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage" ("Healthy People 2020 Disparities," 2014). It is therefore important to better understand the levels of trust within vulnerable patient populations and their providers; a decrease in patient trust can lead to a decrease in satisfaction with their providers (Sheppard et al., 2004).

Between providers and their patients, trust is often necessary for a connection that will enable participation in creating health goals and establishing how patients can achieve these goals (Gilson, 2003). The patient will play a more participatory role in the patient-provider relationship once trust is established via respect and acceptance of a patient's life experiences (Lupton, 1997; Sheppard et al., 2004). Increased levels of trust in the provider and health systems may suggest greater implementation of care which in turn can lead to improvements in health (Ozawa & Sripad, 2013). One strategy that has been used to improve trust in health systems is to utilize CHWs with vulnerable or underserved populations with higher proportions of health disparities and lower levels of trust in the health system.

### 1.3 WHO ARE THE COMMUNITY HEALTH WORKERS?

A CHW is recognized by various titles including community health advisors, lay-health workers, lay health advocates, promotor(a)s, maternal child health worker, peer educator and many more ("Community Health Workers Section," ; "Who Are Community Health Workers?," 2002-2019). While CHWs can serve exclusively in community settings, they are increasingly serving in clinical settings as liaisons between patients, the providers and the health care system (E Lee Rosenthal et al., 2010). In this unique role, CHWs can improve health disparities amongst specific patient populations, increase access to health care, and provide patient support (Balcazar et al., 2011; Katigbak, Van Devanter, Islam, & Trinh-Shevrin, 2015; Sheppard et al., 2004). As CHWs are integrated into the clinical setting where they work alongside different members of health care teams, which may include nurses, pharmacists, dieticians, and social workers (Allen, Escoffery, Satsangi, & Brownstein, 2015).

CHWs have various roles within their scope of practice. They may educate patients as well as communities on navigating the health and social service systems, teach about diverse cultural perspectives, and assist in building health literacy in patients (E. L. Rosenthal, 2018). CHWs can also assist in the education of disease prevention or management of chronic diseases (E. L. Rosenthal, 2018). In regard to care coordination, CHWs provide transportation services and assist in reducing barriers to such services for patients (E. L. Rosenthal, 2018). CHWs provide social support for their patient which includes motivating patients to seek health services and support self-management of any chronic diseases (E. L. Rosenthal, 2018). CHWs also advocate for the needs of their patients (E. L. Rosenthal, 2018).

The populations of patients which may be assigned CHWs include underserved populations, elderly patients, pregnant women, or immigrant/minority populations such as Latinos, African-Americans, Filipinos, and Bangladeshis (Albarran, Heilemann, & Koniak-Griffin, 2014; Islam et al., 2013; Katigbak et al., 2015; Litzelman et al., 2017; Sheppard et al., 2004; Spencer et al., 2011). Many of such populations have experienced abuse and mistreatment from health care systems and thus may have high levels of mistrust with health care providers (Boulware, Cooper, Ratner, LaVeist, & Powe, 2003; Clayman, Manganello, Viswanath, Hesse, & Arora, 2010). CHWs are not only seen in the US but are also a part of the health care team globally, to address shortages of health workers in various parts of the world (Oliver, Geniets, Winters, Rega, & Mbae, 2015).

### 1.4 How Does Hall's Dimensions of Trust Assist Understanding Patient-Provider Relationships?

While trust can be conceptualized in different ways in various types of relationships, Dr. Hall and colleagues (2001) proposed a framework which has been most commonly used to

investigate the establishment of trust in patient-provider relationships. They identified five dimensions of trust which include fidelity, competence, honesty, confidentiality, and global trust, which can be thought of as facilitators to trust (Hall et al., 2001). The first dimension of *Fidelity*- which can be thought of as ensuring a patient's best interests and not taking advantage of the patient's vulnerability - can be established by advocacy, empathy, and respect (Hall et al., 2001). *Competence*, the second dimension, is described as avoiding mistakes and providing the best possible care for the patient (Hall et al., 2001). *Honesty* is essential in the patient-provider relationship as it necessary for the patient to receive transparent information from their provider to make health decisions (Hall et al., 2001). *Confidentiality* is the protection of a patient's sensitive information and ensuring that a patient's information is used appropriately (Hall et al., 2001). The last dimension, *Global trust*, is primarily for categorization of characteristics of trust that do not fit exclusively in the other four dimensions; it is a catch-all (Hall et al., 2001). While it is necessary to understand how trust can be developed, it is also necessary to identify what the barriers to trust are to alleviate those issues and maintain a strong patient-provider relationship.

## 1.5 WHAT ARE THE BARRIERS TO TRUST IN THE PATIENT-PROVIDER RELATIONSHIP?

Barriers to trust in the patient-provider relationship were studied by Sheppard and colleagues (2004) in pregnant females which included lack of continuity of care, competence and ineffective communication. Lack of continuity of care with their providers decreased the trust of the patients because they were not able to properly establish a relationship and rapport with their providers (Sheppard et al., 2004). In terms of competence, the patients reported that receiving conflicting information from a nurse and a physician decreased their trust (Sheppard et al., 2004). Ineffective communication included the use of medical jargon by providers that the patient could not comprehend as well as difficulties understanding non-US born physicians. Language barriers

were attributed to decreased patient satisfaction with their physicians because communication is difficult to understand in patients who do not have a full grasp on the English language (Wilson, Chen, Grumbach, Wang, & Fernandez, 2005). The patients also reported that they felt as if health information was being withheld from them and felt as if they were not being listened to by their providers (Sheppard et al., 2004).

In a study conducted by Kravitz et al. (2011), they sought to understand the interpersonal barriers that patients diagnosed with depression face when seeking medical attention in a primary care setting. Some patients expressed feelings of suspicion toward a potential conflict of interest with their primary care physicians and pharmaceutical companies leading to mistrust in their primary care physicians (Kravitz et al., 2011). Other patients felt that their primary care physicians lacked an adequate amount of knowledge to treat or manage patient's depression (Kravitz et al., 2011). Social distance was also brought up as a barrier to trust as low-income patients from this study sensed that their primary care physicians were not fully aware of the daily obstacles stemming from poverty and mental health stigma (Kravitz et al., 2011). The barriers to trust in the patient-provider relationship reveal an issue with health communication that is worth highlighting.

## 1.6 Facilitators of Trust: How is Trust Established?

Health communication between provider and patient is often conceptualized as unidirectional and non-participatory, as opposed to an ideal that is multi-directional, embedded in cultural tradition and consensus-based (Thiede, 2005). It is essential to establish a communication system that accepts the cultural backgrounds and freedoms of all participants because once the groundwork of participatory communication is established, this can facilitate trust between providers and patients (Thiede, 2005). Establishing trust between patients and providers is essential because it assists in delivering health information in a capable manner (Thiede, 2005).

Similarly, having patient participation and sharing of power in the relationship dynamic between patient and physician is a key element in establishing patient-centeredness (Krupat, Bell, Kravitz, Thom, & Azari, 2001). Creating a patient-centered dynamic, providers are likely to think of their patients as equals and support them in making the best choices for their health (Krupat et al., 2001).

Being that health communication should aim to be multi-directional, it is essential to also understand the CHW-patient relationship and how it helps develop trust and enhance healthy behavior modifications. As described by Katigbak et al. (2005):

> "CHWs' intimate knowledge of their communities and patient's perceptions that they share a similar culture and values with their CHWs promote trust and rapport which in turn foster therapeutic relationships and lead to plans of care that are acceptable to patients." (p. 872)

CHWs establish trust in their relationships with their patients through shared backgrounds and experiences, communication, access, and social support. CHWs in providing a clear explanation of medically related topics, patients felt that this open communication facilitated trust (Katigbak et al., 2015). Patient access to health care can be improved through the assistance of CHWs. In the study conducted by Islam et al. (2013), the female participants reported trust with their CHWs when they had access to their CHWs through one-on-one visits as this was the time, they felt that they were able to express their concerns. Social support includes informational, instrumental and emotional support (Seeman, 2008). Patients reported trust with their CHWs who took the time to assist them in finding resources or taking the time to drive them to their appointments (Sheppard et al., 2004).

## 1.7 How is Trust Established Within CHW-Patient Relationships?

Overall, the literature on CHWs illustrates how the facilitators to trust shape CHW interactions with patients. In Katigbak et al.'s (2005) study, they aimed to understand how CHWs

improved the overall health outcomes in Filipino Americans with hypertension. In relating with their patients, the researchers determined that sharing a common set of beliefs, language, as well as shared immigrant experiences helped CHWs establish trust with them (Katigbak et al., 2015). In Becker, Kovach, and Gronseth's (2004) study, they sought to understand the relationship formed by CHWs and their patients. They found that CHWs developed trust with their patients because of shared experiences given that CHWs were recruited from the same communities in which the patient's lived (Becker, Kovach, & Gronseth, 2004). Islam et al.'s (2013) study wanted to investigate how CHWs improve the management of Diabetes type 2 amongst the population of Bangladeshi-Americans in New York. The shared backgrounds of the CHWs with their patients was found to help establish and increase the trust of their patients. Communication, especially regarding topics in shared backgrounds, facilitates trust in the CHW-patient relationship but there is an assumption that communication is honest and open at first (Sheppard et al., 2004).

## 1.8 GAPS IN THE LITERATURE

Much of the literature, as illustrated above, assumes that trust is automatically established, by virtue of shared backgrounds, language etc. between CHWs and patients. The five dimensions of trust from Hall et al. (2001) provide insight but are not sufficient in explaining how trust is developed; or in other words, how trust is not a given but rather needs to be established within the CHW-patient relationship. This is the first gap in the literature that this thesis aims to address.

Furthermore, much of the discussion on trust between CHWs and patients is focused on the patient's perspectives. The CHW perspective is often not taken into account but is just as important because communication, an important component of trust, is multi-directional (Thiede, 2005). The CHW perspective on the CHW-patient relationship can provide key insights into how

trust is established. A second gap in the literature that this thesis aims to address is the CHWs perspective on the CHW-patient relationship, especially with regards to trust in this relationship.

While the majority of the studies with a focus on trust within the CHW-patient relationship tend to focus on patient perspectives, there are a few studies which include the CHW perspective on trust. Becker et al. (2004) and Katigbak et al. (2005) have studied trust within the CHW-patient relationship from the patient perspective. Very few articles so far have even included the CHW perspective in the CHW-patient relationship, however the CHW perspectives are limited in scope. In the Becker et al. (2004) study, taking into account the CHW perspective, the CHWs discussed what they looked for in a relationship with their patients. Many of the CHWs discussed that mutual respect was important for the relationship. Mutual respect in relationships are an important interpersonal method of gaining trust with patients (Katigbak et al., 2015). CHWs also stated that having a shared background with their patients as well as having consistency in their relationship established a sense of trust with their patients (Becker et al., 2004). While the positives of the CHW-patient relationship were discussed, the CHWs also mentioned negative aspects which included patients taking advantage of the CHWs and the resources that they could provide for the patients (Becker et al., 2004). In the Katigbak et al. (2005) article, the CHWs perspective is discussed in terms of (Becker et al., 2004) how CHWs needed to communicate with their Filipino patients in a certain manner in order for them to learn to trust the CHWs. The CHWs also mentioned that they spent a lot of time in building relationships with their patients and as a result, the CHW-patient relationship extended past their assigned time together, often having CHWs think of their patients in a familial sense (Katigbak et al., 2015). Shared backgrounds is a crucial dimension of trust in the CHW-patient relationship.

In another study by Snell-Rood, Feltner, and Schoenberg (2019) study, CHWs were assigned to work with Appalachian women with depression in order to improve these women's medical adherence. Here we are given more insight as to how CHWs perceive their relationship with their patients. Many of the CHWs described the slow process it took in order to build trust with their patients often balancing between wanting to help and stepping back so that the patient could learn to confide in them without pushing the patient's boundaries (Snell-Rood, Feltner, & Schoenberg, 2019). In addition, CHWs discussed the importance of providing social support for their patients and providing a non-judgmental environment so that the patients would be willing to talk to them about any topic (Snell-Rood et al., 2019).

When establishing their peer role with the patients, CHWs fostered a trusting environment by wearing clothing that did not indicate status differences as well as communicating with their patients about their current obstacles so that the patients did not feel alone (Snell-Rood et al., 2019). The CHWs mentioned in this regard that when speaking on their own life stories it was important to draw boundaries because at times their stories were not always positive and they did not want to take away from the experience of the patients (Snell-Rood et al., 2019). So far, the literature is pointing towards facilitators of trust, but do not go in depth as much as Snell-Rood et al (2019). The CHW perspective on the CHW-patient relationship can provide more insight to the establishment of patient trust, and with this gained trust how it can be beneficial in understanding the patient-provider relationship.

## 1.9 CONCLUSION

Trust is necessary in relationships, especially in relationships between patients and their providers. Community health workers with their unique role in having a shared background with their patients are able to establish trust and thus facilitate positive health. However, the trust in the

CHW-patient relationship is not developed immediately. This thesis will argue that trust should not be assumed in the CHW-patient relationship but must be established; the CHWs' perspectives help us better understand the barriers and facilitators of trust in the CHW-patient relationship.

# Chapter 2: Methods

## 2.1 SETTING

The Los Angeles County (LAC) Department of Health Services (DHS) created the Care Connections Program (CPP) initiative in order to build a community health worker (CHW) integrated care management program, as this program caters to patients belonging to LAC DHS primary practices ("Community Health and Integrated Programs,"). This initiative integrated CHWs into patient centered medical home teams in primary care practices in five locations in the South and East Los Angeles. These clinics catered to low socioeconomic status patients with a predominance of Latino patients in East LA and African American patients in South Los Angeles.

## 2.2 STUDY DESIGN

The evaluation of the program examined participant health care utilization as well as employed surveys and focus group interviews with patients, focus group interviews with CHWs, and in-depth interviews with administrators to assess the broad impact of the program. The focus of this qualitative data collection was to examine the program aims, which included examining the impact of receiving care from a care team with CHW utilization (CHW care) compared to usual team-based care (usual care) on acute utilization, behavioral health utilization, Patient Activation and Self Efficacy, QOL, satisfaction with care, social support and social outcomes. Examining the broad impact of the program on the lives of CHWs through in-depth interviews and qualitative evaluation was also a key aim and the focus of this thesis.

Focus group interviews were conducted instead of in-depth interviews with CHWs because it was determined that understanding their daily interactions with patients and interactions with hospital staff using focus group interviews in a collective setting would be better, where interaction with coworkers could raise important issues that may not have been voiced by individuals. This approach was also more feasible, given the intricate schedules of many CHWs as well as being more cost effective. Challenges arise using focus groups such as the relatively public nature of focus group interviews, which can leave some individual participants unwilling to divulge key challenges they faced. Nevertheless, focus groups were chosen because of the many benefits of this approach.

## 2.3 SAMPLE

All 22 CHWs in the program were invited to the focus groups but only 17 were able to participate. Of the five who were not able to participate, some had unexpected issues while others were out of the office on maternity leave or vacation. The following CHW characteristics were examined in a demographic survey: age, race/ethnicity, gender, language, highest educational level, prior work experience, whether they live in the neighborhood in which they work, and if they grew up in a similar neighborhood to where they work (Table 1).

Table 1: CHW Demographic Survey Results

| Characteristics | Number (Percentage) N (%) |
|---|---|
| **Age** | |
| 18-30 | 2 (12) |
| 31-40 | 5 (30) |
| 41-50 | 3 (18) |
| 51-60 | 4 (24) |
| 61+ | 1 (6) |
| Blank | 2 (12) |
| **Race/Ethnicity** | |
| African American | 5 (30) |
| Hispanic/Latino | 12 (70) |
| White | 0 (0) |
| Asian | 0 (0) |
| Other | 0 (0) |
| **Gender** | |
| Male | 1 (6) |
| Female | 15 (88) |
| Blank | 1 (6) |
| **Spanish Speaker** | |
| Yes | 10 (59) |
| No | 6 (35) |
| Blank | 1 (6) |
| **Highest Educational Level** | |
| High School | 0 (0) |
| Some College | 11 (65) |
| College Graduate | 3 (18) |
| Some Post-Graduate Training | 0 (0) |
| Graduate Degree | 3 (18) |
| **Prior Work Experience (select all that apply)** | |
| Healthcare | 7 (41) |
| Community Work | 16 (94) |
| Counseling | 7 (41) |
| Education/Teaching | 10 (59) |
| Social Work | 8 (47) |
| Other (Related) Work Experience | 5 (30) |
| **CHW Lives in Neighborhood where they Work** | |
| Yes | 8 (47) |
| No | 8 (47) |
| Blank | 1 (6) |
| **CHW Grew up in Similar Neighborhood to where they work** | |
| Yes | 14 (82) |
| No | 3 (18) |

## 2.4 Data Collection

The qualitative evaluation began by shadowing four CHWs in various locations where they work in order to understand what were the key domains that needed to be further examined in the focus groups that were to be administered with CHWs. Three focus groups were conducted in English with CHWs, some of whom were both English and Spanish speaking. Short, anonymous demographic information forms were collected at each focus group in order to assess basic traits such as age, income, and length of time in program, as well as to assess satisfaction with the program.

Focus group interviews took place in semi-private locations, such as conference rooms in the clinics where CHWs worked. The interviews were 90 minutes to 2 hours in length. Participants provided informed consent after details of the study were shared with them in agreement with ethics requirements. These sessions were audio taped and were transcribed using a transcription service.

## 2.5 Data Analysis

Data was checked for accurate and consistent narrative, analyzed, and de-identified by the primary investigators using Atlas.ti 8.4.0 (ATLAS.ti, 2002), which is a software used for qualitative analysis of data. Focus group transcripts were coded by team members in order to develop analytical categories based on qualitatively informed and modified grounded theory techniques. Team members performed open coding independently from one another on a small sample of the transcripts in order to identify initial themes and to generate codes. Once codes were finalized based on this small sample, all of the transcripts were then re-coded using the finalized set of codes. The two primary investigators further categorized the codes, which allowed constant comparison within and across categories. to identify key themes. Finally, the primary investigators

developed a report based on their analysis, which was the basis of the secondary data analysis that I conducted in this thesis.

In order to be consistent with a stakeholder engaged approach, a draft of the report was shared with the CHWs who participated in the study. Their feedback was asked for, which was going to be included in the report. However, CHWs did not share any comments and feedback. Their time and valuable insights on the evaluation was highly appreciated.

## 2.6 Secondary Analysis

Development for the focus of this thesis included a literature review process to get a general and specific sense of the current information on CHWs, trust development, CHW-patient relationships, and provider-patient relationships. During the literature review process, funneling of the literature was also performed to understand gaps in the literature and how to best address these gaps with the primary data that was collected. Literature that was found relevant for the trust study was analyzed and presented to the team by me for discussion and thematic focus. Analysis of the data occurred simultaneously with the review of the literature. This was to allow engagement with the analyzed data and to find where it resonates best with the literature that was read and reviewed and to develop the focus of the literature review.

The research group which included Dr. Sheba George, Dr. Schetema Nealy, Ahmed, Khalil, Nathan Bautista, and I met once a week for a three-hour period, over 26-weeks to discuss ideas and provide feedback on the literature review, introduction, and methods. On days where the research group did not meet in person, phone meetings were held. Each research group member provided their feedback and worked together to ensure all questions and ideas were addressed.

In the initial data collection period, participant consent was sought and obtained. The data was then de-identified prior to analysis to protect identifying information of the participants.

Investigators, Staff, and Students completed Collaborative Institutional Training Initiative (CITI) courses on Social & Behavioral Research prior to working with the de-identified data. The primary analysis of the data was conducted as an evaluation of the Care Connections Program, and the secondary research question involving the role of trust in the CHW-patient relationship came from the primary data.

## Chapter 3: Results

The results of the study are based on the review of focus group interview data with CHWs. The results examine both facilitators and barriers to trust with patients, from the perspective of CHWs. Barriers to trust are further broken down into medical role-related barriers to trust and general barriers to trust. Facilitators of trust include the dimensions of shared backgrounds, persistence, accessibility, communication, and social support with corresponding evidence via quotes from the CHWs (Figure 1).

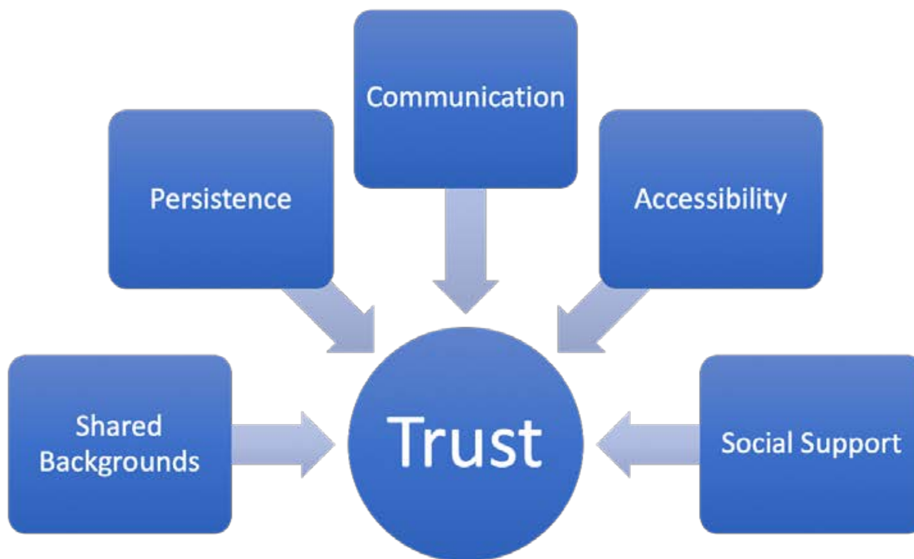


Figure 1: Shared backgrounds, persistence, communication, accessibility and social support are important facilitators used by CHWs for developing and establishing trust with their patients.

## 3.1 FACILITATORS OF TRUST

### 3.1.1 Shared Backgrounds

Shared backgrounds in this case can be thought of as CHWs and patients having similar beliefs, ethnic backgrounds, experiences, or coming from the same neighborhoods or cities. Several CHWs discussed how shared backgrounds allowed for their patients to relate to them and allowed for open dialogue, especially if they grew up in the same neighborhood and was a basis for trust.

> I've had patients that we've gone to the same school, the same junior high. Like, 'Oh, she is from the hood. She knows.' But, I'm an avid skater, so, I've had patients like, 'You used to skate, huh?'... 'Didn't I used to see you at World of Wheels in Gardena?' So, yeah. So, yeah. It makes them feel a little bit more comfortable with you.

In this case, the CHW grew up in the city of Gardena, same as their patient and thus, both the CHW and patient were able to relate to knowing the same places in their city.

Another CHW noted that sharing a similar culture opened the dialogue with patients.

> Once they find out, especially where they ask me if I was born in Mexico or raised here, and then when they say, 'Well, my parents are from Mexico', they want to know a little bit more. And then, once I start telling them, okay, then that's when they make an opinion…

Having a shared background, allowed for the patient to ask questions about their CHW and where they came from in order to relate to each other.

> "And then when you're from somewhere like them, then that's when they start to trust you a little bit more. Like, 'Oh, okay.'"

Another CHW mentioned that their shared culture broke down trust barriers and eased fears about deportation.

> ...One of the family members is the one that said, “Well, my mom doesn’t want to go there because she’s afraid that she’s going to get deported or she’s going to this.” So being that we have the same culture, same understanding, I mean, it usually breaks that barrier and they’ll start going to their appointments because as long as I’m there with them…

### 3.1.2 Persistence

Persistence can be thought of as being determined. In this case, several CHWs were determined to get in contact and continue to keep in touch with their patients.

One CHW affirmed that a lot of the time spent with the patient involves ensuring that the relationship between them is being established. Establishing the relationship involves getting to know the patients on a personal level. “We spend a lot of time nurturing our relationship, getting to know them.”

A CHW noted the challenges they faced when attempting to connect with their patients for the first time but was persistent, wanting to make sure the patient knew she was there for them.

> I had been calling her and calling her, leaving her contact letters and all this stuff, and she never responded...I was about to say forget it, and I sat outside her facility where she lives, but it’s gated. So, I can’t just like, you know, always just walk up to her door or whatever. And I kind of waited to see the activity and I left, and I came back, and I waited, and I happened to see somebody go inside and kind of sneak, you know. And it just so happened I put the letter in her door, because even the mailboxes now are locked mailbox, so I put it in her doorway, between her screen and her door. And by the time I got back here she called me…

This CHW highlights the challenges of establishing trust in a relationship with their patient. Through persistence and patience, the CHW was able to get through to the patient.

It just took me about almost six months in order for her to finally be—when she noticed that I was helping her do certain things. I think her barriers were social barriers first...And I started helping her with her social barriers...Then that's when she's like, 'Okay. Then I can start opening up.'...But, it took me about six months with her. Now, she allows home visits. I can go to her house. I know her daughter and everybody, but it was hard with her at first...

At times, patients do not trust their CHWs and it takes great effort to ensure that there is trust in the relationship. Assisting patients with personal social barriers allowed for trust to be established with this patient.

CHWs reveal that patients are not always honest with their providers and at first may not be honest with the CHWs themselves.

Yeah, they need to know their confidence, you know, patients don't tell the truth to many of their providers, and it takes time for them to tell me the truth. It takes home visits, it takes hanging out, it takes, until, 'Well, you know, I'm going to be honest with you.'

The CHWs explain that gaining the trust of their patience took time and persistence so that the patients could begin being honest with them.

Often times, the CHWs are expected to connect with their patients immediately but they discussed the reality of the time it takes to even locate the patient.

We are asked to, when we're given a patient, within 48 hours to connect with them and 72 hours do this, and whatever. And the reality is that it could take months, at times, to be able to find that person, a), or on the phone, or looking for them on the streets or whatever the case may be.

Forming a relationship with their patients does not happen in two days, rather CHWs must first get in contact with their patients and the process of forming a relationship could take months.

A CHW explained how their patient kept avoiding them and despite this, the CHW kept being persistent until they were able to get in contact with their patient.

> ... I kept trying to find her everywhere...I would go, and I missed her, or she didn't show up... I finally found her after six times... She was avoiding me. But then when it turned out that her medication...was a dose that she needed to change because it was causing a lot and she didn't realize it. We took care of that and she was like, 'Wow, thank you, because had you not found me, I probably would've not wanted to see you.'... 'I'm glad that now you are working with me.

One CHW discussed how her persistence paid off and was able to establish trust once she addressed the concerns her patient had with the concept of a CHW.

> So, it's all about trust and just like breaking down the walls of just the stigma of you're coming from the clinic, or you deal with my doctor. So, once they trust you and believe in you, then it's like, 'Okay...'

Another CHW described that even after 8 months, on occasion, their patient still won't allow house visits but the CHW continues to mention that building trust is important.

> ...Some of them have taken me, you know, eight months to get to say, hey, can I come over to your house, you know. Finally, and it's like, okay, but not all the time. And you know, there's certain restrictions that have to go through there, and you can only come at this time, or whatever. And so, it's hard to get there sometimes with some of the people, at least the ones I'm working with, it's a little bit difficult to get to them at times. But I'd rather build the trust with them as much as I can, to be able to finally get to that point…

### 3.1.3 Communication

Communication is a means through which information can be conveyed and is important as it allows for CHWs and patients to speak honestly and openly. There were different characteristics of communication that were brought up by the CHWs in terms of what was communicated, how information and knowledge were communicated, and why the communication was occurring.

***Communicating What***

Often times, once trust is developed CHWs learn about medications that patients were taking but did not share with them prior to establishing trust.

> "I had one patient that gave me two big bags of medication and I've done the medication review for her weekly because she's constantly in a hospital. So, it's like what happened to this a week ago? 'Okay. I feel like you followed me to this hospital, this hospital. You got me housing. So now, I can trust you.'"

This is important because information that is revealed can help CHWs address any questions or concerns the patient may have or ask the provider.

One CHW recalls when a patient needed to get to know their CHW first before having open and honest communication with them.

> I had this one patient, we have a survey we have to do when we first contact the patient. He answered every question. And then later on, he switched his story and I said, "Why did you tell me all this, that you didn't do drugs, you didn't any of these things in the beginning?" He said, "I didn't know you. So, I had to present myself as—until I get to know you." He said, "No", and he told me everything that he was dealing with because it was important to his healthcare because that barrier that you left out, make sure the doctor knows because when you give blood and you urinate, it's right there. They can read it, but

you have to be honest with the doctor and also be honest with yourself. So, you need the right medications and the right treatment so you can move on with your life. But that was one of the trust issues.

In this case, the patient told the CHW what they wanted to wait until the patient was able to trust their CHW and reveal the right information. Upon learning about this, the CHW explained to the patient why it was important to have honest communication about the patient's medications.

***Communicating How***

In addition, a different CHW noted that part of building trust is being honest and that includes telling patients what they may not want to hear.

You know you diabetic, so why are you in my face eating a double chocolate fudge sundae and stuff, when I know that you got that from Baskin Robbins, you could have went and got some fruit with that. Or, you know what I'm saying? I don't say that, but, not direct…it depends on who it is, because I have been very, very direct with some of my patients, you have to be.

Different patients require a different approach of communication and that may include being direct with the patient's health habits.

I have a patient I've been working with for almost a year and I can tell when she's lying to me. I can tell that she's lying to me and I look at her, and I just give her a look and she kind of goes, 'Well, okay.' 'Did you really take your insulin?' and she's like.... Or she'll tell me, 'I'm eating healthy', and I look in her bag and I'm like, 'Really? Because you have a big old bag of Chips of Ahoy. Really?

CHWs deal with different patient populations but often need to be direct when communicating with them to get their point across.

I...have a patient that is a hardcore, um, gangbanger, so to speak, who's been in some of the roughest prisons...I just look and say, 'You do know I'm not scared of you, right?'...that kind of changed the whole dynamic of how we communicate…

***Communicating Why***

The CHWs often found themselves facilitating the communication between the patient and the provider.

...So, how we can meet in the middle and where can you show some type of empathy towards them like, "Congratulations on this."' I let my patients, or my doctors know, 'They have housing. They have furniture. He didn't smoke for the last two weeks. Just congratulate them on that part. `` And when they notice that, they're like, 'Oh, okay. Thank you,' like make them feel better, not just like, 'Do this, do this, do that.' Like, no. It kind of helps me out a little bit more, less stress on my part and I don't really feel like I'm pulling. Finding some type of balance within my scope of practice.

CHWs who provided information on the patient's progress helped facilitate and smooth the communication between patient and provider.

One CHW mentioned that their patient was going to switch providers due to language barriers. Once the CHW began working with the patient, the patient changed their mind.

...So now that I'm able to be in the room, I'm able to translate for them and now I'm in the room. So, I'm actually listening to everything and body language and everything. And I think I had two patients that were already kind of requesting transfer to a different PCP because of the language barrier. But now that I'm working with them, they like their doctor and they feel that connection because I'm in the room with them…

This is another example of how a CHW can make a difference with communication barriers, as they are able to step in and assist their patients.

Another CHW discussed how they prompted the provider to act during the appointment with their patient.

> The patient is over here and the provider says, Okay. Did you do this?' You know, that physical contact or like face-to-face? And then sometimes, they don't even sit on the little table. So, what I would start doing; I'm like 'Oh, Doctor So-and-So, would you like so-and-so to sit on the table so you can examine her ear or check her ear' and I started doing that. ... So then like, 'Oh, okay...' So then, they go, 'Come sit over here…' Just that physical contact and the doctor actually looking at the patient and everything, that's what they like. Even though it's 15 minutes and the 15 minutes is not enough time, but they don't like when the doctor is like this, looking at the screen and the patient is over here and they're not even—had that face-to-face contact. And sometimes, they get discouraged and sometimes a doctor won't. Like, 'Oh, it's okay. No, no, no. I can check him or her in the chair,' and they leave out there like, "That's it?" Like, "Is that all he's going to do." Like how do you explain that to a patient? So... he's like, 'I've been waiting three months for this appointment and he didn't even check my ear, or he didn't even check my heartbeat, or, you know.' I think it's gotten better, but that's how it was at first. So now, I tend to do that. I'm like, 'Oh, would you like for him or her to sit on the table so you can check,' and... they're like, 'Oh, okay...Go ahead. Sit them on there.' Even if you just check their ear or listen to their heart or just have that face-to-fact contact. They don't like it when the doctor is not engaging with them. They've waited for this appointment for three months

and it’s only 15 minutes. And ten minutes of that is the doctor in the computer doing the notes

Providers have very limited time with their patients and during their visits, patients get frustrated if their concerns are not addressed. CHWs can assist with re-directing the provider to better address the patient’s concerns.

CHWs not only help the provider understand the patient’s point of view but also help the patient understand why the provider may not have enough time during their visits.

I would start to explain to them, ‘Well, she has to document while she’s talking to you. She has 15 minutes. Like, just be a little light on her and have some type of empathy.’ ‘Well, I never looked at it like that.’ And I’m like, ‘She’s seeing more than one person. It’s not just only you.’ So, I start to let them see it from her perspective, not only just coming in and feeling like, ‘Oh, she doesn’t care.’ And after that, she’s just been very nice to me. Yeah, because she was mean at first. She was like the mean girl.

In understanding the perspective of the provider, the patient is less likely to become frustrated with the amount of time allocated for their visit.

CHWs share a bond with their patients and are able to assist them in communicating with their physicians.

Dr. So-and-So didn’t hear me when I said this, so I feel like they didn’t really get it.’ So, then it’s a matter of working with the patient saying, ‘Okay, well, the next visit that we have, how are we going to get that point across? Let’s think of a way to make sure that he hears you when you say that.’

Instead of letting their patients get frustrated, the CHWs are able to find ways to alleviate communication between patients and physicians so that patients have their concerns addressed.

Another CHW recalls how a patient confided in them that they felt ignored by their physician during their appointments.

> His doctors recommended him for the program and as she said, the bridge, barriers and everything, and how to get to your doctor. And that was one thing that he was saying, 'My doctor don't listen to me. All he want to do is what he want to do. He don't listen.' I said, 'Okay. Let's see if we can change that.' And now he comes in—he used to come in frustrated. But now, he comes in a little bit more calmed down and able to communicate with the doctor because I communicated that to the doctor, that, 'He say you don't listen to him. He feel like you don't like to listen to him. He said more or less you're just dictating and see what kind of medications you can give him.' And so, after that they sat down and talked, and things got better.

The CHW advocated for their patient to ensure their concerns were listened to by the physician. The communication gap was eased by the CHW allowing for the patient and physician to communicate in a manner that allowed for both parties to be heard.

### 3.1.4 Accessibility

When a CHW is fully accessible to their patients, it means that they are available to assist them with *whatever* it is the patient needs, *wherever* and *whenever* it is that the patients need them. Several CHWs reported varying degrees to which and a range of ways in which they supported their patients and multiple locations where and different times when they were accessible to their patients.

#### *Accessible for Whatever*

Part of the CHWs job requires securing housing for their patients who need it most. One CHW described the difficulties of navigating the application process.

We're trying to find them and all government programs which is housing, Los Angeles City, Section 8 are closed. A lot of them have a ten-year waiting lists. So, it's not easy to put them in any housing and we're trying to help…. We're going to Los Angeles, L.A. County Housing to see if there's anything available...

Despite the long wait times, the CHWs were determined to provide the resources necessary to assist their patients.

One CHW recalls a patient that needed assistance at the DMV and would meet the patient there to assist them.

...She can drive. But for some reason, somebody said that she was having a moment where she's forgetting and everything. So, she just overcame those challenges as well, but going to the DMV with her, meeting her at the DMV, she was like, "Ah, you really come out here and support, huh?" I said, "Yes, it's what we do," and also going to other hospitals and other clinics and things, meeting the patients there and everything. Like, "You really care, huh? You're here...

The patient was grateful for the support of the CHW in the different types of situations they encountered.

A CHW recalled a patient who would call them during their appointment when they did not understand fully what the provider was saying.

...If he doesn't understand what the medical person is saying or if it's a legal issue, he'll call and open his phone. And he'll have the phone open while he's talking to these people to make sure that I can hear. That's the kind of trust that he has with me...

In this case the patient needed assistance beyond medical issues and would also call their CHW for legal matters. This action indicated to the CHW that the patient trusted them.

***Accessible for Whenever***

Even when many CHWs are not working, they reported constantly thinking about their patients, outside their work hours. For example, one CHW exemplified this as follows:

> My patients call me on the weekend. Sometimes I see my patients out when I'm with my child and it's just like, "I'm taking my meds" or "I had this side effect", or "I went into the hospital." I get text messages over the weekend. "I was in the hospital" or on Saturday. What is being communicated, they're calling "I don't have food. Do you know where I can go to a good bank". So, a lot of times, I can't take my hat off. This job is like 24/7.

There are some downsides for the CHWs who are constantly accessible to their patients. Several CHWs noted that they are not always able to separate their personal life from work life because they are constantly thinking about the wellbeing of their patients.

A CHW recalls an instance when her husband accompanied her on a case that extended beyond her usual work hours.

> The work that I do is very rewarding to the point where even my husband, on a certain case, has stepped out with me because I had to go beyond 5 o'clock. It was 11 o'clock when I got finished with a person, right? Because they needed it, right? Because they had gone out of network and they didn't have the discharge summary as such, but they had the discharge medication and so I had to make sure it got into our system so they could get the medication before they went home so they didn't go without it.

The CHW went above and beyond to ensure that her patient had access to the appropriate medication after being discharged so much so that even her husband was involved. This story exemplifies the blending of both the CHWs personal and work life that occurs.

One CHW mentioned that their patients appreciated having their phone number and having the ability to call their CHW whenever helped build trust in their relationship.

...I think they're all under the impression that they have my actual like cell phone number. So, they like that. They'll call me like after hours and stuff, but or just know that they can easily contact me. If you call the main line here, you have to press a lot of numbers just to get to where you want. Sometimes, they want to talk to the doctor, but you can't actually call your doctor and talk to your doctor on the phone. So, you can call me, give me your concerns and I'll walk right over there, get the answer and come right back, and then the home visits. We get a lot, a lot of stuff done for them. So, I would say that's where the trust comes from.

Another CHW similarly discussed that the ability for their patients to get in touch with them over the phone helps facilitate trust.

...Once you start working with them, they see, like you said, call on the cell phone or call the office. It's easier to get in contact with us than having to call these numbers, or like, "Can you relay this message to the doctor" and I'll tell the doctor. So, it takes a little while just to get there, but eventually we get there.

Physicians do not have the same accessibility as the CHWs. However, the CHWs accessibility allows for the patient's concerns to be addressed.

***Accessible for Wherever***

Forming the CHW-patient relationship by doing home visits allowed the CHW to get to know their patients. This often gave CHWs insight into how the patient lives and what challenges they may be going through.

You try not to think about your patients, but when you go to your patients' house and the conditions that they live, you come home and just like it makes you appreciate more what you actually have... It's hard to take off that hat for me too, and I think about them

> sometimes too. The other time when it was raining, she has a big hole in her ceiling. It's like, oh, my God. It's raining. Did she cover up the hole?" It's like she's going to get sick because it's cold...It's hard to kind of separate that.

Many CHWs went above and beyond their work duties and worried about the well-being of their patients and their families constantly.

Several CHWs discussed the various locations where they will meet their patients including clinics, at home, or at parks.

> ...You might have a mother that's living with dementia or has Alzheimer's, where you're not going to be able to just leave and come to the clinic like that. And you have maybe a husband and a daughter with a grandbaby, you know, and a son that's going through some changes. So, home is probably the best place. And then, yes, on this day I'm available to go walk, right, to deal with my health, to bring down and lower some stuff. So yes, it makes a difference.

One CHW mentioned that they attend yoga classes with their patients. "We go to yoga, or whatever."

Every patient is different and will not be able to meet at the same location for various reasons. The CHWs demonstrate their accessibility to their patients by accommodating to their situation restrictions.

CHWs report that because they are able to spend more time with the patients and go to their homes, they are able to connect with them on a more personal level.

> I think the greatest advantage that we have, to communicate with the patient, We have the opportunity to actually go into their homes and see how they live. See how they eat or what they're not eating or don't have access to, or the way things are, you know? Everybody

> don’t have this cute little cottage with a white picket fence and the Cadillac in the driveway, you know? Some people are literally living in a trailer in the driveway, or whatever.

By seeing and spending time in the homes of their patients, CHWs are able to understand why their patients act or think the way they do.

### 3.1.5 Social Support

Social support is often defined as informational, instrumental, and emotional, as well as referring to the type of assistance a person receives from someone else. The social support aspect of trust is best expressed when the CHW assists their patients with resources they may need in both an instrumental and informational manner. This may include assistance with transportation, help with healthy behavior modification, and teaching their patients self-efficacy. Social support provided by the CHWs for their patients allows for the patient to trust their CHW as they learn that the CHW has their best interest at heart.

#### *Instrumental Social Support*

CHWs provide social support for their patients in various ways to ensure their well-being. One common form of social support that is discussed is in regard to assisting patients with transportation to their health appointments.

> Sometimes, there’s barriers to that because they need transportation, and then sometimes the transportation doesn’t go all the way to their house. One patient lives right across the street from the line, and she can’t just walk across the street and get picked up. They’d have to pick her up at her home. So then, I have to try to get new ways of transportation for her where she has now to get back and forth.

Addressing barriers to accessing health care is an important duty that CHWs performed for their patients to ensure that they were able to attend their appointments as well as improve their health.

A CHW explains that often times, the patient already knows where to go for their resources since they know their communities the best but need assistance in learning to navigate on their own.

> A lot of the clients know where the resources are...They know their communities, but it's more so building a confidence in them to really get...involved with their own community, get more involved with their own health, and their families... because if you're teaching one they're going back home... and expressing that to just not their family, but their neighbors...it's really just providing them with that power, empowering them to utilize the resources and instill confidence in themselves that...their lives matter, their health matters.

Some patients that the CHWs work with may not have a home and they assist in finding the resources for the patients that they may need.

> When we have homeless patients that we have to track down every time we need to make sure they are aware of certain things, and connect with them and try to connect them to the resources, or make sure they meet their appointments and things like that... they become overwhelmed with those things in addition to their medical condition. So, sometimes they just give up, like, 'Why am I living?'...the opportunity that we also have with that patient is to kind of help them see the light. Just help them recognize that they do matter.

In this case, the CHW explains that while part of their job is to help connect the patient with resources, they also help their patients in realizing that their lives matter and to keep optimistic during challenging times.

***Informational Social Support***

Another CHW discussed an alternate way of helping their patient lose weight by teaching her about portion sizes.

> ...I had a patient that she was dealing with this weight loss issue. And so I couldn't tell her how to eat, because she can only buy what she can buy, we've all expressed that. But what I did help her with was portion size. Something that I was able to get certain dishes and pots and pans, and cups and stuff like that donated, and I shared them and took them over to her. And she started using them based on, it only fits here, that's all you eat, you know, just these are the cups, and we kind went through this whole process.

Most healthy options are expensive to buy or are too far from the neighborhoods in which the patients live. CHWs can address these barriers and find other resources for the patient, which is essential for healthy behavior modification.

CHWs take the time to go over the medications and teach their patients about them.

> Like when we've done the med reviews with them, and actually put them in pill boxes, nobody's ever sat down and talked to them about what their medicine is.... but, when you sit down and actually explain everything to them, and they're like thank you so much for helping me and teaching me how to do this because I don't know how to do it before.

Going over a patient's medication allows for better understanding so that the patient can begin to take their medications regularly.

> For my patients, what I have done is made lists in Spanish, put the name of the medication. And I know they can't read it, but I put pictures of what the medications are for, so that they can understand that this is for your heart, this is for your eyes or whatever the case may be, and go over it with them one-on-one so that they can understand...I think some of them are getting it, little by little.

Sometimes patients are not able to read the names of their medications and instead CHWs are able to support the patients by helping them through the process of understanding their medications through picture labels.

***Emotional Support***

One CHW recalled a patient who expressed disinterest in living but by having the support of the CHW, this helped the patient change his outlook on life.

> ... It took a while for me to get him to come in because he basically didn't want to live when I first talked to him. He said, "You call me more than my kids call me." He said, "Why do you keep calling me?" I said I made it a point to myself to call each patient every Thursday until we got a chance to really get in the field and everything...He said, "You call me consistently." And so, he started opening up. He said, "I don't I want to die. I want to live." So now, he's on the road to recovery and everything.

Another CHW recalled the last conversation they had with their patient before they passed away. The patient did not want to go to the hospital and dismissed the advice of their family until the CHW arrived.

> Before they had put the tube in she's like, "Thank you for everything. Just you being here"—because she waited for me to go to the hospital. She wouldn't listen to any of her kids, and the kids were like, "We're telling her, but she like, I don't know." So, I drove behind them. And I never thought it would be last time we'd see her, but yeah, she passed that morning. They called me and they were like, you know, "Just wanted to let you know she passed at 4:30 in the morning and thank you for everything you did for her, but she just passed.

Even in their final moments the presence and support of their CHW meant a lot to the patient and the patient's family.

A CHW mentioned that part of establishing trust in the relationship involves empowering the patients.

> ...You empower them to understand that they have a voice, and this whole process is centered around you. Or supposed to be. So then you allow them to use their own voice to say the things that they need to say. And they feel comforted if you're in the room with them to begin to speak…

Several CHWs agreed that their patients confided in them information that even their families did not know. "Sometimes they say, oh, I've never told anybody this, but I want to share this with you. Their family and friends don't even know half the stuff we probably know." The CHWs became their patient's confidants in some cases, indicating that the patients trusted them with private information.

Mental health services have stigma associated to it. One CHW mentioned that they encouraged their patients to try out these services at least once before deciding it is not for them.

> ...I always assure my patients that I'm not forcing you to go, this is just a suggestion. I encourage it, but if you just go one time and decide you don't like it, you never want to go again, at least you put forth the effort, you gave yourself the opportunity. And in the few cases that I've exposed these people to that idea, they went, it worked for them, they stayed. Take baby steps. If you want me to sit with you, as we've all shared, I'll go to the appointment with you, they feel comfortable with saying certain things. I always let them know, you do not have to disclose anything that you do not want to share…

The CHW continued to mention that they were willing to go to the appointment to ensure that the patient felt comfortable in that environment.

At times, patients were intimidated to go to places because of their education level, however a CHW mentioned that they would let their patients know that they were willing to accompany them or if they could not attend to have the patient give them the information so that they could go over with the patient to make sure they understood.

> ...Because one of my patients say, oh, but I never graduated high school, I don't want to go there, and this and that. And I say, okay, I'll go with you or, you know, make sure you give it to me so that I make sure you understand, so that's another thing...

In summary developing trust involves many facilitators of interaction between patient, provider and CHWs. Examples of these facilitators are listed in Table 2.

Table 2: A Summary of the Dimensions that Facilitate Trust.

| Dimension | Quote |
|---|---|
| **Shared Backgrounds** | *"And then when you're from somewhere like them, then that's when they start to trust you a little bit more. Like, 'Oh, okay.'"* |
| **Persistence** | *"... I kept trying to find her everywhere...I would go and I missed her, or she didn't show up... I finally found her after six times... She was avoiding me. But then when it turned out that her medication...was a dose that she needed to change because it was causing a lot and she didn't realize it. We took care of that and she was like, 'Wow, thank you, because had you not found me I probably would've not wanted to see you.'... 'I'm glad that now you are working with me,'* |
| **Communication** | *"Dr. So-and-So didn't hear me when I said this, so I feel like they didn't really get it.' So, then it's a matter of working with the patient saying, 'Okay, well, the next visit that we have, how are we going to get that point across? Let's think of a way to make sure that he hears you when you say that.'"* |
| **Accessibility** | *"My patients call me on the weekend. Sometimes I see my patients out when I'm with my child and it's just like, "I'm taking my meds" or "I had this side effect", or "I went into the hospital." I get text messages over the weekend. "I was in the hospital" or on Saturday, they're calling "I don't have food. Do you know where I can go to a food bank". So a lot of times, I can't take my hat off. This job is like 24/7."* |
| **Social Support** | *"A lot of the clients know where the resources are...They know their communities, but it's more so building a confidence in them to really get...involved with their own community, get more involved with their own health, and their families... because if you're teaching one they're going back home... and expressing that to just not their family, but their neighbors...it's really just providing them with that power, empowering them to utilize the resources and instill confidence in themselves that...their lives matter, their health matters."* |

### 3.2 BARRIERS TO TRUST

The CHWs also identified three main barriers to establishing trust with their patients as follows: a) They spoke of the challenges of being a liaison or bridge between patients and providers and making sure that each understood the other b) Relatedly, they also spoke of the tension between being both a community member and a representative of the health system when

interacting with patients and c) Finally, they spoke of general barriers to trust which includes age dynamics, distrust in the medical system overall, cultural beliefs, and emotional barriers (Figure 2).

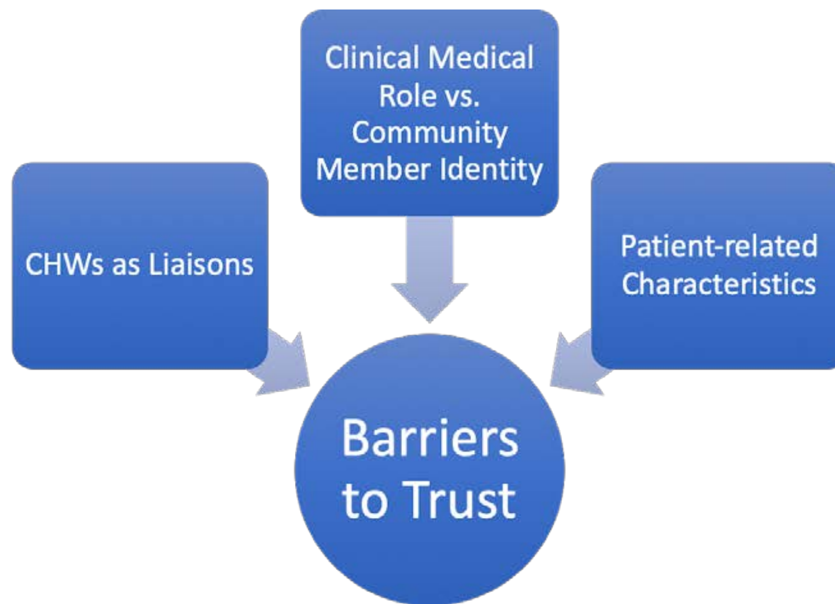


Figure 2: The CHWs and their role as liaisons, the tension between their clinical medical role versus their community member identity, and patient-related characteristics lead to barriers of trust in the CHW-patient relationship.

### 3.2.1 The CHWs and their Role as Liaisons

Many of the CHWs felt they acted as the bridge between their patients and their providers by facilitating communication. At times, being in the middle of these groups led to tension as the CHW had to navigate informing the physician of the patient's health information without losing the built trust of the patient.

The CHWs were in a unique position where they had to balance the delivery of information without losing of trust of either the patient or the provider.

> It's hard to do our job and, you know, kind of have to be DHS employees because it is hard. Because you got to answer to your patient, but then you have your job scope, you know, who's paying, and it becomes difficult. It's ethical because sometimes, you know,

> you know that doctors are pushing a lot of medication on patients and sometimes a patient is kind of like telling me, 'No, I'm not going to take this because this or that,' and you go back to a doctor and they're like, 'Well, they should take it, they should take it, they should take it,' and then you're kind of stuck in the middle. And you go back and you keep pushing on the doctor like, 'You know what, they're not taking this because it's'—I had a medication call from Alta Dena and two of my patients—well, one, this particular, said he was seeing people. Every time he took it he would see people in the background or people coming up to him and he didn't feel comfortable.

The CHWs understand that at times giving medications to patients is not always going to fix the health issue at hand, especially if the patients do not react well to the medications. However, this CHW felt stuck because the provider sometimes has the last say in the situation.

The tension that the CHWs feel from their role caught in the middle of the provider and patient can cause them discomfort.

> Another CHW said that this tension "drives me nuts. I have a couple right now that I'm working with, I know need that counseling, and the provider is not wanting… he wants me to go a different route, and I just I … you're wrong. And now the patient won't go the other route that they wanted them to, you know, they wanted to see…so it's very frustrating.

Patients may often ask their CHWs to not tell their providers certain information placing the CHW in an awkward position because providers may need to know certain patient information in order to treat the patient properly. However, disclosing such information could result in loss of trust of the patient.

> 'I'm going to tell you, but please don't tell the doctor.' And I'm like, 'Well, um, okay.' I explained my role to her once again. Like I work with the doctor. The doctor has chosen

you to be his patient...So, if you don't trust the doctor, can we find another way for you to gain that trust. Is it just completely gone, or do you just want to slowly gain it? So, I kind of see where they're at with it and see if the readiness of just building a relationship with this doctor. If not, if it's just completely out, patient relations is over here and we can change your doctor, I'll help you with that, and from that point, you have to see if the doctor wants to put you into our program. And I can't disclose this information on why you don't want to deal with this doctor, but I will move myself out of the situation because I don't like to be that middle where it's like, 'Well, she told me this and they told me that,' or 'You work this way. So, why are you doing this,' and then that kind of makes me in a sticky situation. So, I'll get a clear, concise cut to what I do and how I do it and if you want to corroborate then we can work it like this. If not, then we can do this. So, it's always an option on the table as far as my part.

One CHW mentioned the challenges of being perceived as part of the system by their patient. Patients are not able to develop trust with their CHW if they are afraid of telling them information. "They're worried about...if the social worker's going to be called on them or something of that sort. That's what they're worried about, and so they won't let you in, because you know you're part of the system"

### 3.2.2 Clinical Medical Role vs. Community Member Role

The CHWs had to maintain a balance in their various roles. One role is that of a bridge between patient and provider and another is to act in a Clinical medical role vs. a community member role. The balance of identity in the latter is difficult for the CHWs to manage as patients begin to see them as a community member. When the CHWs had to perform the clinical aspects of their job such as medication review, this seemed to cause distrust in their patients.

During the early stages of getting to know their patients, performing a medication review may delay the establishment of trust between the CHW and their patient.

> Yeah to be open with me and doing the medication review and one of my first visits is like, oh, they're not going to trust me, or it makes it a little bit difficulty, or it takes them longer to trust me.

When the CHWs perform a medication review, which is part of their role, it can confuse the patient as they may not be used to their CHW acting in a more medical role. "I guess we throw them off with a medication review."

Patients did not trust the CHWs or providers because they have been promised help in terms of their health before but were not given the assistance they were seeking.

> Some of the people I've worked with they go, well, 'so-and-so said they were going to help me, but it never happened." You know, so that's already in their little... library of memories. And so, when you come along, they're like, oh, why should I trust you, you know, kind of thing.

When patients did not trust their CHWs, they would hide their medications until they trusted the CHW to bring all the medication out.

> Sometimes the ones that don't want home visits, it's hard to do a medication review because sometimes they won't bring all the medication with them. I mean I had a patient that it took me the third time to do a medication review until she finally brought everything, and I think it's going back to the trust issue where she probably was like, 'I'm only going to bring what I think I want her to know that I'm taking.' When she ended up bringing all her medication, she had medication from other family members. She had herbs. She had

> all this stuff, but it took me like the third time to actually do a medication review where she actually trusted me and brought everything in.

A barrier to trust described by a CHW is the Latino cultural belief in the use of herbal medications

> The only thing that makes it a little bit difficult is in our culture, some of our patients go to herbs. Now, we don't know whether should we note that, should we not because, you know, we don't know if that's affecting their health or is it? You know, so we're like, what do we do? Do we note it, do we say it?

One CHW mentioned that a barrier to trust was that CHWs are part of the health system. "So, it's all about trust and just like breaking down the walls of just the stigma of you're coming from the clinic, or you deal with my doctor…"

A CHW describes the tension they feel from their roles and how they are perceived by their patients.

> Sometimes I do have a little bit of tension when I do medication review because during medication review, we have to count pills, we have follow instructions and patients look at me like, you're not the doctor. But then at the same time we built that trust during like so many home visits and I guess we're lucky enough to have the ability for patients to trust us and, but, yeah, when I do begin with a patient with a medication review it's a little bit difficult because I don't want them to feel that I'm just watching over them in how to take their medication.

Several CHWs discussed the reactions they received from their patients when they would wear their county badges:

Some of the CHWs experienced unresponsiveness from their patients when they came to perform house visits. “Oh, sometimes the people don’t answer the door.”

One CHWs received pushback from their patient about meeting each other in person even though they had been in contact already.

> They won’t, you know, because like one lady says, “Why should I talk to you?” And I said, “Well, based on the services that I’m trying to provide…oh, no, she said, “Why do I need to meet you? I’ve been talking to you for a while, why do you need to come in my home?” And I said, “Well, don’t you think that it would seem right to at least meet the person that you’re sharing your personal lifestyle with? I mean, wouldn’t that make you feel just a little bit more comfortable?” I said, “I’m cool with it if you cool with it.” But this is the process and I just think that if I’m going to just pour my heart out to someone and share my entire lifestyle with them, I’d at least like to know what they look like.

Another CHW talked about going to the patient’s house after not hearing from them by phone.

> There are sometimes when we have to do what we call drive-bys, meaning that I’ve sent you letters, I’ve made phone calls, nobody’s answered so I have to go find out what’s going on. And people see the badge and they know good and well who you looking for is right inside their house.

One CHW showed up to the patient’s house with the county badge on after not hearing from them. Once the CHW showed up they knew who their patient was by their facial expression. “...They was all looking at us, and it was one that I almost just knew that it was him, because it was the look that he had on his face when I said his name…”

If the patient's neighbors saw the CHW and their badge, they distrusted the CHW and would lie on behalf of the patient and say they were not there noted one CHW. "The neighbors will lie and say they don't know the person, or they say that the person has moved. They're not trusting."

Another CHW mentioned that having the badge sometimes led to their patients avoiding them or confronting the CHW and intimidating them into leaving altogether. "I mean, you know, sometimes they scatter, sometimes they try to stand there intimidating me like that's going to make me go away."

### 3.2.4 Patient Related Characteristics Barriers to Trust

Other barriers to trust include patient related characteristics. This means that the patient's do not trust their CHW because of who they are or what they do but rather because of the patient's own reasons. This could be due to their age, emotional or mental health barriers.

Older patients may not trust their CHWs because older patients have been accustomed to their health habits and felt distrustful of a new person stepping in and suggesting them how to take care of themselves.

> She's an 86-year-old. So, that's another barrier. You know what I mean? She's 86. She's been doing things her own way and it was, 'Here I am.' It's like, 'Who are you?' But, when I started helping her with a lot of her social issues that she had, then she started opening up with her medical issues and we started working with that.

The CHWs describe the emotional challenges that patients face which may be a barrier to forming trust because patients may want to avoid the topic of certain health issues.

> Fear is the other problem. We had talked about fear, also. They don't want to know about certain things that are going on, because if they do then that means they're going to die,

you know? And that’s not necessarily the case. We always talk to them about, if they have diabetes and they think I'm dying, you know, because this is, all these things, maybe they saw somebody lose their feet or whatever. And so, they’re thinking they’re going to go that same route. And then religion is the other one.

One CHW brought up how a patient’s mental health was a barrier to trust.

...I’ve noticed how her patients who are really severe with mental health and those are the ones she has trouble with. They can’t trust. Like the other ones that we have, they’re able to come and talk to us. But, um, mostly I think it’s the ones who just don’t know that they have some type of mental health issue, that’s probably the thing that just holds a barrier for them…

# Chapter 4: Discussion

Trust in healthcare providers is essential to patients' treatment adherence, satisfaction, and health outcomes. Establishing trusting provider-patient relationships may be particularly challenging with vulnerable patients who often have higher illness-related risks, fewer healthcare choices, lower health literacy, and sometimes deportation fears. CHWs are seen as well-positioned to garner trust with such patients because of shared backgrounds. Shared backgrounds include coming from the same neighborhoods or cities or being of the same or similar cultures or ethnicities. The CHWs interviewed provided insight as to how shared backgrounds facilitated trust with patients. Having this shared background with patients was important because it created an opportunity for the CHW and patient to connect. If patients are aware that their CHWs are from their communities or of similar cultures and ethnicities, they feel comfortable in their presence and this may allow more honest dialogue. This was similar to the Katigbak et al. (2015) study where the CHWs who were familiar with the Filipino culture and spoke the same language as their

patients were able to develop trust with their patients (Katigbak et al., 2015). Also, having come from similar neighborhoods allows for CHWs to understand what resources are available for their patients and how to best assist in obtaining them.

Whereas the overwhelming majority of the literature on CHWs assumes that trust is a given, mostly because of the shared backgrounds between CHWs and their patients, our data challenges this assumption. Our analysis of CHWs' perspectives helps illustrate how CHWs must establish such trust by overcoming barriers, such as their role as a liaison, their clinical medical role vs. their community member role, and patient-related characteristics, and utilizing facilitators of trust such as shared backgrounds, persistence, communication, accessibility, and social support, in the patient-provider relationship.

A key revelation from the CHWs' perspectives is how persistence was often needed to establish trust in the relationships with their patients. Often patients who did not trust the CHWs would avoid them and any contact that CHWs attempted to make. The CHWs were expected to make a connection with their patients within 48 hours but reported that forming such relationships can take months. CHWs would often wait outside their patients' homes until the patients finally gave them a chance to speak and work with them. This was a form of persistence, a facilitator of trust mentioned by the CHWs that was needed to gain access to their patients. Persistence is never discussed within the literature and is what CHWs demonstrated when first establishing communication with their patients as it is an essential factor in developing trust.

The CHWs interviewed reported that when the patients learned to trust their CHWs, many of them revealed hidden information such as all the medications they were taking. For instance, the patient who would bring out a few of their medications at each home visit until they trusted their CHW enough to bring out all their medication. This indicates that trust is to be established

and cannot be assumed because of shared backgrounds. It was necessary, CHWs felt, to maintain communication with patients so that the patients could be open and honest with their CHWs in terms of what was being communicated, how the information was communicated, and why the communication was occurring in the first place. Consistent with the literature, our findings from the perspective of CHWs show that when patients felt that they had mutual respect and an equal role in the relationship with their CHW, this fostered an environment where patients felt they could communicate and share their lives openly (Katigbak et al., 2015). Creating this open environment allows for patients to share topics with their CHWs that they would otherwise not feel comfortable revealing to their providers (Islam et al., 2013).

In some cases, the CHWs interviewed reported that patients were not able to express their concerns thoroughly with their providers during visits. The CHWs described being able to accompany their patients to their health care visits and facilitate the communication between patient and provider. They also described patients feeling comfortable with the CHW's presence and being able to express themselves during their visits. Consequently, patients perceived information conveyed by the CHWs as authentic and helpful, which further increased levels of trust as also reported in the literature (Sheppard et al., 2004). Because communication also includes what is conveyed nonverbally, it is likely that CHWs demonstrated qualities such as respectfulness, expertise, and kindness which can be essential to building trust (Sheppard et al., 2004).

Another characteristic that was revealed about the CHW patient interaction was how CHWs felt the need to be accessible to their patients in order to build trust. To varying extents, the CHWs reported being accessible to their patients in assisting them with whatever they needed, including finding housing, practicing yoga, or going on walks. The CHWs were able to perform home visits and thus see the environment of the patient, but this was only the case after patients

learned to trust the CHWs. In one case, it took six months for the CHW to perform home visits with their patient. In the meantime, the CHW helped this patient with small tasks. Trust had to be developed for the CHW to properly perform their duties. When CHWs make themselves accessible to their patients, whether during home visits or at their offices, this increased trust and commitment to the CHW program (Islam et al., 2013). In this study, the female participants expressed that these one-on-one visits were essential to developing trust with their CHWs because it allowed them to express their concerns to the CHWs (Islam et al., 2013).

Most of the patient populations that the CHWs worked with did not have access to resources. The CHWs reported providing the informational, instrumental, and emotional support that their patients needed. CHWs were there to listen to their patients' stories and connect or help find ways to make things easier for patients to understand, such as translating discharge summaries in the patient's language of comfort or explaining the way that patients' medications function. Thus, CHWs acknowledged the patient's knowledge gaps and were able to teach them (Katigbak et al., 2015).

While there is research on the facilitators of trust, there is little mention of barriers to trust. Barriers to trust need to be addressed for the CHW and patient to form a trusting relationship. Barriers to trust mentioned by the CHWs in this study included issues regarding their role as a liaison, their clinical medical role vs. their community member role, and patient-related characteristics.

CHWs had to balance between being a confidant for their patients and also informing their medical providers of any pertinent medical information without losing the trust of either party. CHWs also had to manage their clinical medical role vs. their community member role, particularly when wearing their county badge to home visits. Wearing the badge at times meant

the patients would not open the door for the CHWs, which meant that the CHWs had to be careful in what they wore to home visits. Similarly, in the Snell-Rood et al. (2019) study CHWs had to wear clothing that did not insinuate any form of a status difference between them and their patients; otherwise, this may result in loss of trust (Snell-Rood et al., 2019). There were also patient-related unique barriers to trust which were due to age, and emotional or mental barriers.

With health care costs on the rise, there is a push for alternatives that allow for the improvement of healthcare access for patients as well as the provision of primary care services in a cost-effective manner (Hartzler, Tuzzio, Hsu, & Wagner, 2018). The CHWs and their roles in clinical care, distribution of resources, and health education can allow for such provision of care. However, despite the contributions the CHWs make in regard to patient health, they remain an underutilized resource (Hartzler et al., 2018). Understanding the importance of the services that the CHWs provide for their patients can help address the health disparities many patients face. Often these disparities, such as poverty and the built environment, lead to hospital readmission for patients with chronic diseases (Singh & Chokshi, 2013). The CHWs thus serve as a notable bridge for under-resourced communities by not only supporting clinical goals such as reducing hospital readmissions but also by going to the cause of the problem and helping to address the underlying social determinants which hinder improved patient health (Singh & Chokshi, 2013).

To reduce health disparities within the communities, this requires an alliance between the communities and health systems. For this alliance to be successful, trust needs to be developed (Wesson, Lucey, & Cooper, 2019). The health systems, in this case, may achieve a level of trust by not only recognizing tensions and the reasoning behind it but by also reaching out to community institutions who have the trust of the community already established (Wesson et al., 2019). An emphasis on the development of trust should, therefore, be a critical component for community

programs, particularly CHW programs. The reason for this emphasis on the development of trust is because there is a presumption that trust is automatically established between the CHWs and their patients due to shared backgrounds (George, 2018). The assumption that trust is automatically established in the CHW-patient relationship is indicated by the relative absence of explicit trust development strategies when it comes to CHW training. The category of skills in which the CHWs are trained include but are not limited to communication skills, interpersonal and relationship-building skills, service coordination and navigation skills, capacity building skills, advocacy skills, education and facilitation skills, individual and community assessment skills, outreach skills, professional skills and conduct, evaluation and research skills, and knowledge base (E. L. Rosenthal, 2018). Within these skills, there is no mention of how to develop trust with patients, which can lead to difficulties in connecting with patients for some of the CHWs because their shared backgrounds are not always enough. A recommendation for CHW training is to include trust development to alleviate this barrier in the future.

## 4.1 LIMITATIONS

Limitations of this study may include the use of secondary analysis. The data and literature were analyzed by me, and as such, I have my own biases. The sample size of three focus groups with 17 CHWs within the Los Angeles County area may be too small to allow for generalizability to a wider population of CHWs. Another limitation is that through the use of secondary analysis, I did not have firsthand experience with the CHW focus groups and was not able to assist in the process of formulating or asking questions.

## 4.2 CONCLUSION

In summary, it was found that CHW perspectives illuminate both the facilitators and barriers of trust in the CHW-patient relationship. Understanding these factors will allow for

enrichment of the facilitators of trust and for improvement of how best to address barriers faced by the CHWs while establishing trust with their patients. This may also improve CHWs' abilities to provide adequate care for the sickest and most vulnerable patient populations of Los Angeles County. A deeper understanding of the barriers and facilitators of trust will help acknowledge CHWs for going above and beyond their job description and for all the labor that they have to do to establish trust. This understanding could also further establish the professional role of the CHW within the healthcare field and pave the way for further expansion of the CHW program in different locations where the patient populations need their services for an improved quality of life.

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# Appendix A

## LITERATURE REVIEW

### Introduction

Community health workers (CHWs) are liaisons between a health care provider and their patient. CHWs also work alongside different members of the health care team of the patient which may include nurses, pharmacists, dieticians, and social workers, who all assist the patient on their medical journey toward improving their health. Typically, CHWs work with patient populations that come from their same community or with whom they share similar backgrounds. They are assigned to various patient populations such as underserved populations and pregnant women, or more specific ethnic populations such as Latinos, African-Americans, and Filipinos. The role that CHWs play is crucial in allowing patients to modify their behaviors and improve their overall health. CHWs can improve the health of their patients by establishing a sense of trust. Trust is significant because it is the basis of the relationship that will assist with the improvement of patient adherence to medical advice (Sheppard et al., 2004). To understand how trust is established within the relationship between the CHW and their patients and how this trust facilitates healthy behavior modifications it is essential first to understand what trust is in relation to healthcare. This literature review will explore the topic of trust, what is known about the basis of trust, as well as discuss the barriers to trust and the gaps in the literature that call for more research.

### Definitions of Trust

Through the literature, there are different variations on how to define trust. However, the definitions of two specific authors are critical to understanding what trust is. Michael Thiede (2005) explored the topic of trust and how it is a psychological phenomenon. Furthermore, Thiede (2005) expresses that trust is a state of mind in which there is an interaction between two persons, and one person expects the other to not behave in a harmful or otherwise beneficial manner,

without a need to establish this beforehand. Similarly, Lucy Gilson (2003) defines trust as a voluntary action that is based on certain expectations of how other people will behave concerning oneself in the future. The takeaway from these two definitions is that trust is perceived during interaction and the behavior during this interaction should not be ill-mannered. This concept is particularly important within the context of a CHW and their patient relationship, as this interaction initially relies on the patient trusting that the CHW will not behave in any form that is harmful to the patient and their well-being.

**Dimensions of Trust**

The authors Hall, Dugan, Zheng, and Mishra were able to review and summarize different sources of literature on trust amongst physicians and medical institutions. With this review of the literature, they were able to identify five dimensions of trust or factors are essential to establishing trust. The dimensions include fidelity, competence, honesty, confidentiality, and global trust (Hall et al., 2001).

The component of fidelity is similar to the definitions of trust provided by both Gilson and Thiede, as it pertains to an interaction where a patient or person expects a specific behavior from the other person with whom they are interacting (Gilson, 2003; Thiede, 2005). Fidelity is described as not taking advantage of the patient in their most vulnerable state and pursuing what is best for the patient (Hall et al., 2001). Similarly, this notion can be tied back to the CHW-patient relationship as well as the physician-patient relationship.

The second dimension is competence, a term that describes a physician who is providing the best care possible for their patient. Competence is a dimension of trust because patients visit their physician with a certain expectation that they will receive the medical attention they need, delivered by a capable physician.

Honesty, the third dimension, is an essential dimension that makes up trust, as a physician should be transparent with their patients and provide them with the relevant information that is needed to move forward with any medical decisions. Honesty is also an essential aspect in the CHW-patient relationship as transparency is also needed from the CHW regarding the patient's health.

Another dimension mentioned is that of confidentiality, or protection of the patient's information and not disclosing it to anyone unless specified by the patient. It is noted that "most patients appear to enter treatment relationships with an assumption of confidentiality,"(Hall et al., 2001).

The last dimension, global trust, is "the soul of trust" (Hall et al., 2001) and this term is used for characteristics of trust that cannot be dissected or categorized into the aforementioned dimensions. Global trust serves as a catchall.

These five dimensions of trust provided by Hall et al. (2001) serve as a basis for other authors who work with measures of trust and how it is established with medical providers, CHWs, and their patients (Becker et al., 2004; Gilson, 2003; Hall et al., 2001; Islam et al., 2013; Katigbak et al., 2015; Krupat et al., 2001; Sheppard et al., 2004; Thiede, 2005)

## How is Trust Established in the CHW-Patient Relationship

Upon further review of the literature, it was found that trust in the CHW-patient relationship is established in five different ways. Trust is established by the sharing of common backgrounds, through communication, medical competence, access, and social support. The development of trust through these five ways within the CHW-patient relationship allows the patient to make health decisions, thus allowing the patients to modify and adopt healthy behaviors. Each of these five ways will be discussed further below.

**Shared Backgrounds**

Perhaps the most predominant way of building trust in the literature was that of having shared backgrounds. CHWs often share a common background with their patients because CHWs often serve in the geographical areas in which they were raised. The sharing of similar experiences or being from a similar area often provides a sense of ease for their patients

The authors Katigbak, Van Devanter, Islam and Trinh-Servin, sought to measure how CHWs can improve the health of the patient population that consisted of Filipino Americans in NYC who have hypertension (Katigbak et al., 2015). The CHWs in this study were part of AsPIRE (Asian American Partnerships in Research and Empowerment) which is a CHW intervention group that helps in improving hypertension outcomes (Katigbak et al., 2015). From this study, it was found that the CHWs used their knowledge of Filipino cultural values to influence health behaviors of their patients (Katigbak et al., 2015). CHWs having a shared background with their patients, such as being from the same places in the Philippines, facilitates the feeling of comfort which then allows the patient to gain a sense of trust with their CHW (Katigbak et al., 2015).

CHWs from the Katigbak (2005) study also speak the same language, Tagalog, as their patients. In an excerpt from an interview, a participant of the program states that "It makes me comfortable that we're [speaking] in the same language and the same accent," (Katigbak et al., 2015). The commonality of language also provides the same sense of comfort and thus facilitates trust in the CHW-patient relationship. Shared immigrant experiences also play a role in establishing trust as one patient said about their CHW during their interview "You were talking with someone who could appreciate, maybe, what you were going through," (Katigbak et al., 2015). Shared backgrounds, similar experiences, and shared language facilitated a sense of trust with the patients and their CHW and thus allowed the patient to make healthier choices in order to improve their health.

A study that was conducted by Becker, Kovach, and Gronseth looked at the relationship between CHWs and pregnant women as part of the program MOMobile Advocates and how this relationship impacts the intervention methods used by CHWs (Becker et al., 2004). MOMobile Advocates was developed in 1988 as an outreach program in order to provide resources for pregnant women who reside in underserved areas (Becker et al., 2004). The CHWs that participate in this program are also from the same communities as the patients. This participation meant that some of the CHWs themselves had been a part of that same program and thus had a similar experience to share with their patients, which allowed for the development of trust (Becker et al., 2004). These experiences are seen by an interview excerpt of a patient's interview discussing the relationship with her CHW, "We're mothers just like they're mothers. I may be going through something I'm not ready to share cause I'm not ready to give it all out right now. But when I'm ready, I'll let you know when I'm ready…That's why it's built on trust with the Advocate and the client." (Becker et al., 2004).

Islam, Wyatt, Patel, Shapiro, Tandon, Mukherji, Tanner, Rey, and Trinh-Shevrin also sought to measure the impact CHWs had with their patients and their health. The patient population in this study consisted of Bangladeshi-Americans with type 2 diabetes mellitus. A key finding from this study also showed that "The importance of community, including CHWs' community concordance and leadership roles, emerged as key factors that increased the participants' trust in CHWs" (Islam et al., 2013). This shows again that CHWs and their unique ability to provide a shared background for their patients is crucial for the development of trust and their relationship overall.

**Communication**

Sheppard, Zambrana, and O'Malley (2004) specifically researched the health care experiences that enabled trust to develop within prenatal and postpartum women and the influence it had in the delivery of care by the community health worker, in this case known as the lay health worker (LHW). With regard to communication, patients in this study did report a sense of trust with their LHW. Communication was especially crucial when their LHW would share stories about their pregnancies (Sheppard et al., 2004). This example links similar experiences to communication which shows the importance of a shared background again. In this study, the patients also perceived the information given to them by the LHW as accurate and positive (Sheppard et al., 2004).

In the Katigbak et al. (2005) study it was also found that through open communication, the patients felt they trusted their CHW because CHWs explained medically related topics clearly, and this allowed for better patient understanding (Katigbak et al., 2015). A clear explanation of medically related topics was essential as one of the roles of a CHW was to address any barriers a patient may have toward becoming healthier. Often, a physician may not have had the time to explain all medical information, or a patient may not have understood the information given. The mediating role of the CHW allowed the patient to have individual attention and have the CHW answer any questions the patient may have had.

In Becker (2004) study with CHWs and pregnant patients, a component of honesty in communication was necessary for the patients. This can be seen in an interview with a CHW about their relationship with their patients when they state "I just enjoy the relationship and trust…But there's a trust there, and there's a bond that forms, and therefore they'll come to you with anything, and you can help them a lot better because they are telling you things honestly: what the issues are, what their resources are, what they can do." (Becker et al., 2004). Honesty in the relationship

with the CHW and the patient was important because at times the patient may not have wanted to share any medical issues they were having or admit that they have not taken their medications. Honesty played a huge role to help the CHW determine what they could do to help the patient and get them back on track with healthy behaviors.

### Medical Competence

Medical competence in the Sheppard et al. (2004) study conducted with the prenatal and postpartum women was measured regarding whether the patient thought she was receiving good quality of care (Sheppard et al., 2004). Patients trusted their LHWs based on their knowledge of pregnancy and issues related to this, as well as child health issues (Sheppard et al., 2004). Trusting the medical information from their LHW relates to shared experiences because the LHW had also gone through pregnancy and this added another level of trust to the information the patients were receiving.

### Access

Thiede (2005) defined access to healthcare as “freedom to use.” He also discusses that “health policy often focuses on the supply side factors of access to healthcare, but they argue that the demand side requires not only defining access as an opportunity to use healthcare (the physical provision of health care) but also the capacity to use health care”. Access to healthcare is essential to establish for patients, and by improving this access, CHWs can assist their patients with their health. This is seen in the study conducted by Islam et al. (2013) in which female patients mentioned that the development of trust in their CHWs evolves through the one-on-one visits they had with their CHWs. It was during these visits that the patients had access to their CHWs, and it is when they felt that they could voice their concerns with their CHWs (Islam et al., 2013).

Continuity of care was necessary for the patients. It was found that trust was not established when the patients saw different providers because they felt comfortable with providers they saw more often (Sheppard et al., 2004). Continuity has a lot to do with access to health care as some patient populations are not always able to see the same physician. Lack of continuity in this particular study was due to various factors such as not being able to see a provider until late pregnancy, or not receiving care when patients first sought it (Sheppard et al., 2004). The CHW then became a point of continuity for the patient, and by becoming a point of continuity, this then improves the patient's capacity to use health care.

In a study conducted by Kruprat, Bell, Kravitz, Thom, and Azari (2001), which identifies characteristics of physicians and patients that allow for sharing of information, it was found that "Although there are several dimensions to patient-centeredness, one key element involves patient participation and the sharing of power and information between the patient and physician" (Krupat et al., 2001). This finding, though it does not involve CHWs directly, can contribute to understanding their communication with patients. Patients can share with their CHWs information that they do not disclose to their physicians, perhaps because the patient feels an equal element of power with their CHW and thus is able to share information and participate openly and honestly.

**Social Support**

Social support includes informational support or emotional support. Patients reported that during their visits to the clinic a physician or nurse was considered caring if they showed concern not only for the patient's well-being but for the patient's child or children as well (Sheppard et al., 2004). Patients also reported a sense of trust with their LHW or CHW, who took the time to ask how the patient was doing as well as taking the time to drive them to their appointments (Sheppard

et al., 2004). The role of the LHWs or CHWs also consisted of assisting their patients with finding resources that they may need (Sheppard et al., 2004). CHWs were able to assist with their patient's adoption of healthy behaviors by serving as role models and support their patients in becoming more self-sufficient (Katigbak et al., 2015). CHWs are there to assist their patients with their medical needs, but their roles are more profound than this. It is through shared backgrounds, communication, medical competence, access, and social support that CHWs can establish patient trust and assist their patients in adopting healthy behaviors.

**Barriers to Establishing Trust**

While it is important to consider what components establish trust, it is also essential to examine what barriers impede the development of trust. Women reported the use of medical terms as a barrier for communication and thus trusted their providers less (Sheppard et al., 2004). They also expressed that they felt a lack of being listened to by their physicians (Sheppard et al., 2004). Inconsistencies in medical knowledge were also found to be a barrier to trust for patients as seen in the excerpt from Sheppard & et al.'s (2004) study which states "the perception of conflicting information from providers (nurse vs. physician) was viewed as a 'mistake' and a threat to patient trust"(Sheppard et al., 2004). Similarly, if patients were misdiagnosed or given incorrect information, this would also lead to mistrust (Sheppard et al., 2004). Distrust of qualifications of CHWs arose from patients in the Islam et al. (2013) study in which "participants expressed doubt as to the qualifications of CHWs to lead the program because they are not clinicians.". Even though there were doubts, citing credential seemed to resolve this aspect of mistrust from the patients toward their CHWs.

## Addressing the Gaps

According to Thiede (2005), "Health communication, as currently undertaken within health systems is unidirectional, non-participatory and does not create trust relationships. In contrast, communicative action is multi-directional, embedded in cultural tradition and consensus-oriented. There is a two-way relationship between communicative action and trust". CHWs thus provide a way for communication to be multi-directional. This is shown in the study conducted by Islam et al. (2013) where the patients felt that they could share with their CHWs what they were not able to share with their doctors, which suggests that CHWs play a unique role in developing trust not only with regards to the patient, but also with regards to the healthcare system (Islam et al., 2013).

Much of the focus of the literature has been on how patient trust is established from the point of view of the patient. However, as mentioned by Thiede (2005), relationships and trust are multidirectional, so it is also important to understand how trust develops and is perceived from the CHW's perspective. In other words, we may need more research on what CHWs look for in establishing trust in a patient relationship. In review of the literature so far, only the study from Becker et al. (2004) provided information on what aspects a CHW found crucial in their relationship with their patient. One component is respect, respect is vital between the two parties, the CHW and patient, in order for the relationship to continue (Becker et al., 2004). A negative patient characteristic that was stated by the CHWs in this study included clients taking advantage of the CHWs for goods and services (Becker et al., 2004).

## Conclusion

This literature review demonstrates that shared backgrounds and experiences, communication, medical competence, access, and social support are the components which enable trust in a CHW- patient relationship. However, it is essential to not only understand the perspective

of the patient but also that of the CHW and how they establish this trust in the relationship with their patients.

# Appendix B

## FOCUS GROUP INTERVIEW QUESTIONS

### Recruitment and Training

Why do you think people become CHWs?

- What attracted you to apply to this job?
- Are there particular character traits that make someone a better CHW? (e.g. empathy, street smarts)

Which elements of your recruitment/ training have worked well and prepared you to do your work? Which elements of your recruitment/training could be improved?

### Patient Level Barriers and Facilitators

Do you feel that your patients trust their healthcare team? Why/why not?

- Prompts: If not, how do you help establish trust?
- When is it impossible to establish trust and what do you do then?

From your perspective, what are key barriers your patients face to getting healthy that are not easily identified or understood by their primary care providers?

- Prompts: disease management, health literacy, transportation, economics, etc.

What are the challenges involved for you in meeting with your patients at home or in clinics and how do you address them?

- e.g. change in 2-3-hour patient assessment practice, unsafe homes, coordination with families

What tells you that you have achieved your desired patient outcomes?

- o How do you know if a patient is happy with your work as a CHW?
- o How do you know when to graduate a patient?
- o What systems do you use to remember patient encounters and record details while you are on the go?
- How could this be improved?

**Community Level Barriers and Facilitators**

What is your relationship like with the community you serve?

- What defines the communities you work in? Why do you think CHWs are needed in these communities?
- Do you feel that you are part of the communities you work in? If so, how?
- Do you find it difficult to both advocate for communities and represent the clinics for which you work? If so, how do you balance the tension?

**Health System Level Barriers and Facilitators**

How do the CHWs fit into the clinical team (roles)?

  - Prompt: within the PCMH, as patient care champions, with nurses, docs etc.
  - What is the communication like between CHWs and the rest of the care team? Are you able to successfully share your insights?
  - How has the response been to having CHWs as part of the team? What could improve CHW relationships and responses to CHW?

Are your main duties as a CHW clearly defined and do-able in a workday?

- What could improve this?

What issues do you see in the organization of the CHW program's administration or oversight?

- Prompt: What could improve this? (e.g. Orchid training? less paperwork?)

In what ways has this job impacted your life outside of work?

- Has it affected how you think about your own health and your own interactions with the health care system?
- Has it affected your interactions with your families / loved ones as well?
    - Think back to when you started the job and the expectations you had of what it would be like - was there anything that surprised you, that wasn't as you expected?
    - Have we left anything out?

# Vita

Diana Guzman was born and raised in Santa Rosa, California. She graduated from The University of California, Los Angeles (UCLA) in 2015 and earned her Bachelor of Arts in Anthropology and a Minor in Spanish. Diana continued her education by attending and completing the Post-Baccalaureate Program in Pre-Medicine at Charles R. Drew University. Afterwards, she assisted in establishing a new scribe program in Novato, California where she successfully managed the program as the Lead Scribe. Diana then pursued her Master's in Biomedical Sciences at Charles R. Drew University where she has received the Department Award for Outstanding Service and Dedication and earned the distinctions of Dean's List and Summa Cum Laude. During her time as a graduate student, she worked as a teaching assistant for the Undergraduate General Biology Laboratory courses. Diana aspires to become a physician who provides comprehensive care for her patients and instills hope in them to continually move forward, empowered by education and resources.