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Building trust in American hospital-community development projects: a scoping review

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ABSTRACT

Although it has become increasingly common for hospitals to engage in development projects aimed at improving the social determinants of health in surrounding communities, scholarly literature examining the establishment of trust between hospitals and communities is sparse. Because of an extensive and complex history of abuse suffered by marginalized populations at the hands of medical institutions, trust building is critical to the pursuit of equitable health outcomes in these communities. A scoping review was conducted to assess the current base of knowledge for building trust between hospital systems and community members. The review identified only 13 relevant articles addressing this topic, centered on six key themes: with whom to form partnerships; how to form partnerships; conceptualizing and defining trust; questions about investment and hiring; effective communication with communities; and, understanding communities.

1. Introduction

Collaborative development projects involving American hospitals and community partners have become increasingly common over the past two decades [1–3]. As medical institutions begin to fully understand the importance and power of addressing social determinants of health, some are looking outward for ways to improve community health. While their main intent is to improve health outcomes, these projects also stand to improve their position within communities and drive down costs through prevention. These kinds of projects started gaining traction when the Affordable Care Act instituted 'community benefit' requirements requiring non-profit hospitals to conduct Community Health Needs Assessments (CHNA) and develop implementation plans aimed at improving community health [4].

But these logistical and programmatic questions may be secondary to a deeper problem, namely that hospitals and community partners must earn the trust of communities if they are to be well positioned to address risk factors and improve health outcomes. A question therefore arises: what do we know about the cultivation of trust related to planning and implementation of such hospital community development collaborations? This review aims to understand the current state of the small but growing literature that engages the intersection of hospitals and trust within community development contexts.

2. Methods

This scoping review featured a search of EBSCOHost, SCOPUS, and PubMed for 'trust', 'hospital', 'community', and 'partnership' from 2010 to 2020. Due to the specific focus of the research question, narrower search terms proved difficult to isolate. The team excluded articles if they did not include a specific focus on projects in which hospitals or medical institutions were building partnerships with community members or organizations; were primarily biomedical or limited to direct patient care or quality improvement; or were international in scope. Duplicate articles were also excluded. A total of 13 articles were downloaded for analysis.

We followed Arksey and O'Malley in implementing a five stage framework for conducting scoping reviews: 1. identification of the research question; 2. identification of relevant studies; 3. selection of studies to include in the review; 4. charting of information and data within the included studies; and 5. collating, summarizing, and reporting results [5].

Regarding step 4, in which the first and second authors read and coded articles for emerging themes, the iterative process was governed by accepted

methods of thematic coding in constructivist grounded theory [6]. Accordingly, the team's process began with open coding in which key themes were ascertained. In this process, coders approach data (in this case research articles) as though they may be establishing a new discursive space, which Strauss and Corbin have advocated to prevent analysis from being reduced to pre-established categories or concepts [7].

After coding three articles, the two coders met to compare their approaches, both in terms of the themes they saw arising in the data, as well as the specific code applications themselves, though it was understood, as the scholarly literature on thematic coding acknowledges, that the conceptual focus of the codes themselves might differ to varying degrees [7]. The team then proceeded to code the remaining documents, but also returned to prior documents to consider whether a more fine-grained, line-by-line coding process would reveal anything important about the data. In all cases, the first round of themes were deemed appropriate.

One outcome of closely analyzing such a small and emerging scholarly literature was that it limited the amount of disagreement between the first and second authors as they coded. To the contrary, the themes were clear and conceptually broad. The only question concerned nomenclature, namely how to label them. For example, the team decided through an intercoder reliability conference to make a disaggregation within the theme of partnership, determining that it was important to distinguish scholarly contributions regarding the question of choosing appropriate community partners from the act of forming partnerships themselves. As Charmaz notes, this kind of conceptual and categorical discussion is a normal part of the thematic coding process, not only to be expected, but in many ways necessary for conceptual distillation [6].

3. Findings

Six key themes were identified during the coding process: 1. Choosing partners, 2. Forming partnerships, 3. Conceptualizing trust, 4. Investments and hiring, 5. Effective communication and, 6. Understanding communities.

3.1. Choosing partners

The question of with whom to form partnerships is the most commonly addressed aspect of trust building in the existing literature. Several articles identified establishing partnerships with trusted community agencies, or at least entities interested in working within them, as a central component to building trust [8–17]. In some cases, organizations already

earned the confidence of the populations that a project aims to serve. In these cases, such communities may already be well-positioned for effective partnership. For example, a 2018 commentary by Wesson and Kitzman details the importance of engagement with underserved populations to understanding and addressing health disparities. They note that because health systems have not traditionally undertaken community outreach or development work, they have historically struggled to develop trust. This shortcoming can only be remedied by working in an intentional and active way with community partners [8].

In 'Vulnerable Immigrant Populations in the New York Metropolitan Area and COVID-19: Lessons Learned in the Epicenter of the Crisis,' Behbahani et al., highlight the importance of partnership in the context of the COVID-19 pandemic, a time when communities may express fear or anxiety related to hospitals as spaces where they may get sick, is likely higher than it has ever been in recent history [9]. Although fear about illness and contagion is qualitatively different than the trust issues we address in this article, the resulting avoidance and downstream effects may be similar. Behbahani et al. find that having a trusted community partner is vital to establishing and maintaining trust between organizations and community members [9]. This sentiment was reinforced by Cutts et al., who note that trusted hospital and community leaders are a necessary component of a robust partnership [10]. These trusted partners bring insight and direction to health efforts within communities, in addition to possessing knowledge about the community culture and what methods may or may not be successful [10,13]. With their guidance, institutions looking to serve as anchors in communities can understand aspects of past efforts that built or broke trust.

Few articles offer best practices for identifying partners, but Wesson and Kitzman [8] argue that anchor institutions can identify trusted agents by first asking employees living in areas of interest to identify faith communities, schools, community-based organizations, local government, and policy makers. They advocate looking to hospital employees with administrative authority, as well as those who tend to be trusted, such as chaplains, when identifying potentially important community connections. While most articles identify organizations as key partners, Wesson and Kitzman include individuals. As with organizations, these individuals are known and trusted leaders who can be invited into partnership. They caution, however, against assuming that certain individuals are trusted, and recommend using community input – such as surveys and focus groups – as guides in identifying trusted entities [8].

Cheon et al. conducted a nationwide qualitative study examining partnering patterns within four hospital system data sets [12]. They find nine main categories of potential community partners: healthcare providers outside the hospital, local public health organizations, local social service agencies, local/state government, non-profit organizations, faith-based organizations, insurance companies, schools, and local businesses. Stempniak offers a helpful addendum to these categories and advises that hospitals pursue partnerships depending on specific health initiatives they aim to address [11]. For example, community health centers are well-positioned to address health care access problems, including those in the area of addiction and mental health, while schools often possess expertise in screening patients and addressing health problems related to obesity. Stempniak highlights a particular trend of hospitals partnering with primary and secondary schools, pointing to Kaiser Permanente's success in this area. In an effort to understand current health care access issues in Los Angeles, a hospital system harnessed long-term partnerships with county health care agencies, community healthcare provider organizations, local community advocacy and service organizations, and the LA Unified School District [13].

3.2. Forming partnerships

Several articles offer methods and frameworks for forming trusting partnerships [10,11,13–18]. A *JAMA* viewpoint by Stout et al. makes the point that before engaging in partnerships, an institution must know itself [14]. Clarity of a health care organization's values, biases, interests, and priorities is crucial to establishing trust in the future due to the need to provide transparency to the community. This awareness lays the groundwork for building trust with the community partner because to identify shared values and goals, both entities should first understand themselves [14].

Representatives from these institutions conducting community outreach should be well versed in the institution's vision and mission statements, as well as their purpose and specific goals for engaging with the community. In 'Leading the Way to Population Health,' Resnick emphasizes the key role that effective and visionary leaders play in this institutional understanding, noting that such leaders can be identified in part by their insistence that hospitals' formal missions include commitment to such work, and that the commitment be reflected in decisions about resources and staffing [15]. Additionally, knowing the community partner is necessary for developing an equitable and trusting collaboration. Efforts must be made in order to understand what matters to both entities and to identify shared values, interests, and assets. Stout

et al. argue that successful collaborations take time because the different entities should understand one another's history and motivations for engaging in shared work [14].

Stout et al. add that partners must clearly establish the anticipated level of collaboration, develop shared agreements and norms, and create mechanisms for accountability and resolving conflicts. They point to the '4 R's' – risks, rewards, responsibilities, and resources – as a framework, and emphasize the development of partnerships that begin with a shared purpose, requiring assembly of a team of individuals united in their basic vision [14]. The assumption is that it is easier to work backwards from a shared vision, working out details along the way, than trying to cultivate a vision where one does not exist. As an interview-based study conducted by Dadwal et al. argues, this vision must be developed collaboratively, and not imposed 'from above' by the more powerful group, such as municipal leaders or anchor institution administrators who seek approval from the community [16].

In a study examining the creation of sustainable and collaborative partnerships, Ainsworth et al. developed a framework they call an 'inclusiveness structure.' [17] This structure draws on many points made above, with emphasis on the humanistic aspects of collaboration:

(1) *Goals & Objectives: The development of clear project objectives*
(2) *Guiding Framework: A rigorous guiding research framework*
(3) *Container: A space or forum in which the group works, including regularly scheduled face-to-face meetings, standardized agendas, and competent facilitation*
(4) *Feedback: Ongoing feedback to the project team on progress toward attaining goals*
(5) *Trust and Bonds: An atmosphere in which trust is developed and social bonds are nurtured* [17]

Power dynamics are a common theme in Dadwal et al's interviews with community stakeholders. This work adds to our understanding of mechanisms for soliciting community input by proposing a variety of methods for measuring the efficacy of partnerships: survey tools, partnership self-assessment questionnaires, qualitative assessments, and the collection of indicators such as attendance rates, participation levels, and project success [16]. The interviewees emphasize that throughout the partnership, power dynamics, understood within their economic, historical, political, and sociocultural contexts, must be acknowledged and mitigated [16]. Van Gelderen et al's [18] article on the implementation of Community-Based Collaborative Action Research (CBCAR) complements this theme, explaining that power dynamics must be clearly addressed and

analyzed so members can ensure that inequity and privilege do not impede the process. This includes recognizing what voices are not being heard from within the community and inviting them to participate [18]. Cutts et al. describe a community mapping workshop that encouraged dialogue about perceived injustices; this session was intended to signal to the community that the health system was motivated to repair and build trust with the community [10].

The level of collaboration expected by partners should be clear from the beginning, and Stout et al. introduce a scale that moves from networking, coordinating, and cooperating, to collaboration, which is regarded as the highest attainment [14]. Once the level of collaboration is agreed upon, accountability mechanisms must be established. Van Gelderen et al. describe one health system and community partner that initially met monthly to develop mission and vision statements, but also to determine how and where to best focus their efforts [18].

Even if these partnership-forming methods are carefully followed and maintained, barriers can break trust if not addressed. Among these barriers are imbalances in power between communities and other entities, such as anchor institutions; a perceived lack of value for community input; arrogance on the part of elite institutions; lack of a shared vision; and lack of time spent cultivating relationships [16]. Failure to take time to connect with the community in a meaningful way may be detrimental to long-term relationships. A partnership requires two parties that both feel heard and understood.

It is critical that time and effort are invested in community engagement to establish rapport early in the process of building partnerships. In an article that described methods for creating long-lasting partnerships, Ainsworth et al. speak to the power of nurturing activities capable of developing social bonds between individuals. These require establishing spaces for interaction, such as sharing a meal [17], though it seems there may also be value in virtual spaces. After investments of time, open communication, and repeated interactions, trust can strengthen [18]. Respect and good communication takes time, transparency, humility, a willingness to listen, shared space, and persistent follow-up [16].

3.3. The meaning of trust in collaborative development relationships

The literature tends to address trust as though a clear definition exists. It is therefore unsurprising that few articles would engage the philosophical question of the meaning of trust or its deeper conceptualization. But the pursuit of such understanding is important considering that hospital-community partnerships sometimes assume understanding of this key point,

only to learn during the course of work that they do not.

For Stout et al., trust in these contexts has two components: structures and situations. Trust in structures means a requirement of honoring agreements, and trust in situations requires shared norms [14]. Ainsworth et al. describes a 'trust-building loop' viewing trust as an 'iterative process' in which the building of confidence allows collaboration to become bolder and less risk averse [16]. It is important to note that trusting relationships often must develop over time.

Frerichs et al. describes the results of a survey employed to rank and evaluate the most important factors of trust within three stakeholders of community projects: academics, healthcare professionals, and community members [19]. They found that community members placed higher value on communication, credibility, and the anticipation and resolution of problems than did health professionals and academics. All groups, however, valued authentic, effective, and transparent communication, in addition to mutually respectful and reciprocal relationships. Committed partnerships and sustainability were also favorably rated [19].

3.4. Community investments

Strategies for community investment arise as an important theme for anchor institutions to consider in building trust. Weston, Pham, and Zuckerman find that institutions must develop a multifaceted approach addressing the needs of socioeconomically disadvantaged neighborhoods, including strategies for 'attracting' and 'orienting' local residents to the proposed work [20]. These different aspects are important for generating and maintaining trust with populations with a history of poor treatment by the medical community. Beyond hiring community members, they also discuss supporting existing companies within the area. Some spending can be directed to local vendors, including those offering facility and janitorial services, but also construction, food service, advertising/marketing, and information technology support [20].

Several articles acknowledge that some communities distrust the organizations that seek to do positive work within them [8–11,13,14,19]. However well intended organizations may be, historical tensions or past disappointments can engender skepticism about the potential for positive change. This is especially true with investments – including 'hire local' and similar programs aimed at improving unemployment rates – which may be received skeptically by communities that have experienced decades of under- and even disinvestment.

Hospitals' cash and cash equivalents can be shifted to local community banks and credit unions. Community-based financial services may be able to offer low-risk, fixed income investment products that can in turn provide resources to the community, potentially increasing the local stock of affordable housing, food, childcare, and access to direct health care services. Stempniak emphasizes the importance of commitment to community development investment, stimulating the local economy, creating affordable housing, building assets to rejuvenate neighborhoods, addressing food deserts, bolstering workforce capacity, and hiring locally [11].

3.5. Communicating with communities

The literature suggests that anchor institutions must adapt their communication strategies in order to build trust with communities. Frerichs et al. seeks to uncover what partnership qualities were most important to building trust between community members, health care providers, and academic researchers [19]. They find that stakeholder groups view communication and the quality of relationships to be the most important [19]. There is an understanding of the need for such communication, but lacking in-depth case studies, existing research has yet to advance best practices for such work. Strategies include providing culturally-responsive and sensitive materials, as well as announcements and developing strategies to update communities on community health initiatives led by hospitals.

One example of such an approach is to provide promotional and educational materials, as well as social media posts, in Spanish and English. Behbahani et al. add that because some undocumented immigrants are uncertain of how medical institutions handle immigration status, it is important to clarify that this information will remain confidential [9].

Stempniak highlights the importance of involving residents in the evaluation of ongoing community health projects, and notes that community members should be involved in a meaningful way in the design of surveys [11]. In addition, this consistent evaluation led by community members can benefit hospitals by 1) assessing the efficacy of their initiatives and 2) communicating initiative successes to the community via the residents conducting the surveys.

3.6. Understanding the community

Existing scholarship suggests that organizations attempting to work in areas in which they are unfamiliar may lead to a misunderstanding in community needs and perspectives. Partnerships with community entities are not only effective vehicles for trust building but can also increase understanding of the community [14,20]. Iyer et al. describe an intervention designed to understand current health care access issues faced by uninsured patients in Los Angeles [13]. Because the hospital system had established 'effective and trusted partnerships' with community organizations, these organizations were able to reach out to the system for assistance in convening focus groups with community members, including uninsured residents who were not generally considered leaders in the community [21].

Effective community engagement requires understanding available resources. An analysis of social determinants of health provides a snapshot of community functions and is critical to devising effective strategies to address community-level needs beyond clinical care [20]. Fully grasping barriers such as inadequate linguistic competency, food insecurity, or a lack of transportation must be part of the preceding groundwork and help shape collaborative programming. Outreach is required to identify present strengths, understand social determinants, and prioritize health concerns. This information can be acquired by several means including windshield and foot questionnaires, observations, interviews, focus groups, secondary data, field notes, narrative reflections, or polling [14,18]. Cutts et al. argues that mapping is critical to 'align, leverage, and mobilize community assets,' which further expands the scope of outreach if the aim is to truly understand a community [8].

Data should be presented and agreed upon by all invested parties. This may be achieved through an open forum where the importance of collaboration is demonstrated, and the community can certify that their voices were heard [18]. Follow up engagement could also take the form of post-initiative surveys gathering residential feedback [14]. Ainsworth, Diaz, and Schmidtlein warn of the futility of needs assessments that are done with little community input, warning against final reports that do not inform actual change in communities [17]. Worse than being merely ineffective, such reports can erode trust, creating perceptions of future efforts as pointless even if driven by a renewed commitment to community collaboration and improvement. Final plans should include ongoing reflection to identify assets and gaps within the community, making it possible to establish priorities [18].

4. Discussion

The specialized focus of this scoping review limits us to a small dataset of key articles, unsurprising in an area of emerging scholarly interest. However, there is a fast-growing body of literature on the individual concepts that comprise our focus. Scholars have

engaged a range of issues at the intersections of medicine and trust, including some that address trust in medical institutions [21–26]. There is also a rich, growing literature–including journals dedicated to the subject–on community development and health [27,28]. A key motivation for this review was our sense that hospital administrators and community collaborators would benefit from understanding what is known about the specific challenges and considerations that bear on community development initiatives in various stages of planning, implementation, or assessment around the USA.

Tracking what we know about trust building in hospital-community collaborations is important. Not only are hospitals increasingly engaging in these projects, but they often lack expertise to carry them out [11,17]. In addition, many medical institutions have long struggled to build trust with local communities, especially communities of color, despite often providing critical services to these communities in the form of direct patient care [13,29]. With changes in American health care, including changes to hospitals' financial underpinnings and missions, trust developed in the area of direct and traditional health care services may not translate to population health-oriented work being done for 'community benefit.' [30] To the contrary, some hospitals may be frustrated by the fact that good will earned in one area may not lead to good will on the other.

It is unsurprising that the most persistent theme in the articles reviewed concerned the 'how' and the 'whom' of building partnerships. That these themes arose specifically in relation to trust building reminds us that while partnerships may be key, developing the correct partnerships may be even more important. This young literature makes clear that many institutions may not know where to begin to do the community-facing work increasingly required of them. Even more important than 'how' and 'whom' may be how to cultivate and care for these relationships once they have begun, and how to directly confront some of the imbalances in power and equity that are likely to exist in these relationships. Reframing the discussion in terms of the assets that exist within communities, not only to address inequities, but also to ensure that development is building on and drawing from existing assets, will be central to this work [31].

Beyond the large-scale questions associated with the 'how' and 'with whom' of partnerships is the need for best practices that anchor institutions and other stakeholders can consider in preparation to engage communities. These must include humility manifest in an institution's awareness that it lacks the requisite information to undertake this work. A core strategy for correcting this partial knowledge is leaning on trusted community members and organizations in such a way that authentic partnerships can be formed, drawing on anchor institution expertise and capital so that knowledge about the community, its history, and its needs, flows upward instead of issuing from administrators and planners who may not fully understand those communities. For example, while hospital chaplains may be more likely than other employees to be trusted by the community, this is unlikely to be universally true. Hospitals must be careful not to assume that certain hospital employees are trusted community entities [8].

It is noteworthy that none of the articles reviewed offered best practices for identifying effective community partners. Instead, the literature tends to assume that certain entities – such as faith-based organizations – will be trusted by community partners. While this may sometimes be the case, we lack a theoretical framework for distinguishing trusted from untrusted partners, aside from advice that community members themselves are best positioned to report on this information. There is clearly a space for better understanding what makes a community partner a 'good fit', and what challenges certain partnerships may encounter.

While many studies offer best practices for clinicians to develop trusting relationships with patients, the hospital-community development literature provides no guidance for building trust with individual community members. Medical institutions can better train clinicians to provide non-discriminatory, culturally humble, and anti-racist care to patients, but these efforts do not necessarily translate to work beyond hospital walls. Future studies should consider how to establish trust between hospitals, hospital systems, and communities, and the need to advance a systematic framework for undertaking collaborative work between hospitals and communities. The existing literature provides a starting point, but work remains to be done.

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