UC DAVIS HEALTH

How Community Health Workers Build Trust with Women At-Risk for Maternal Child Health Disparities

BETTY IRENE MOORE SCHOOL OF NURSING

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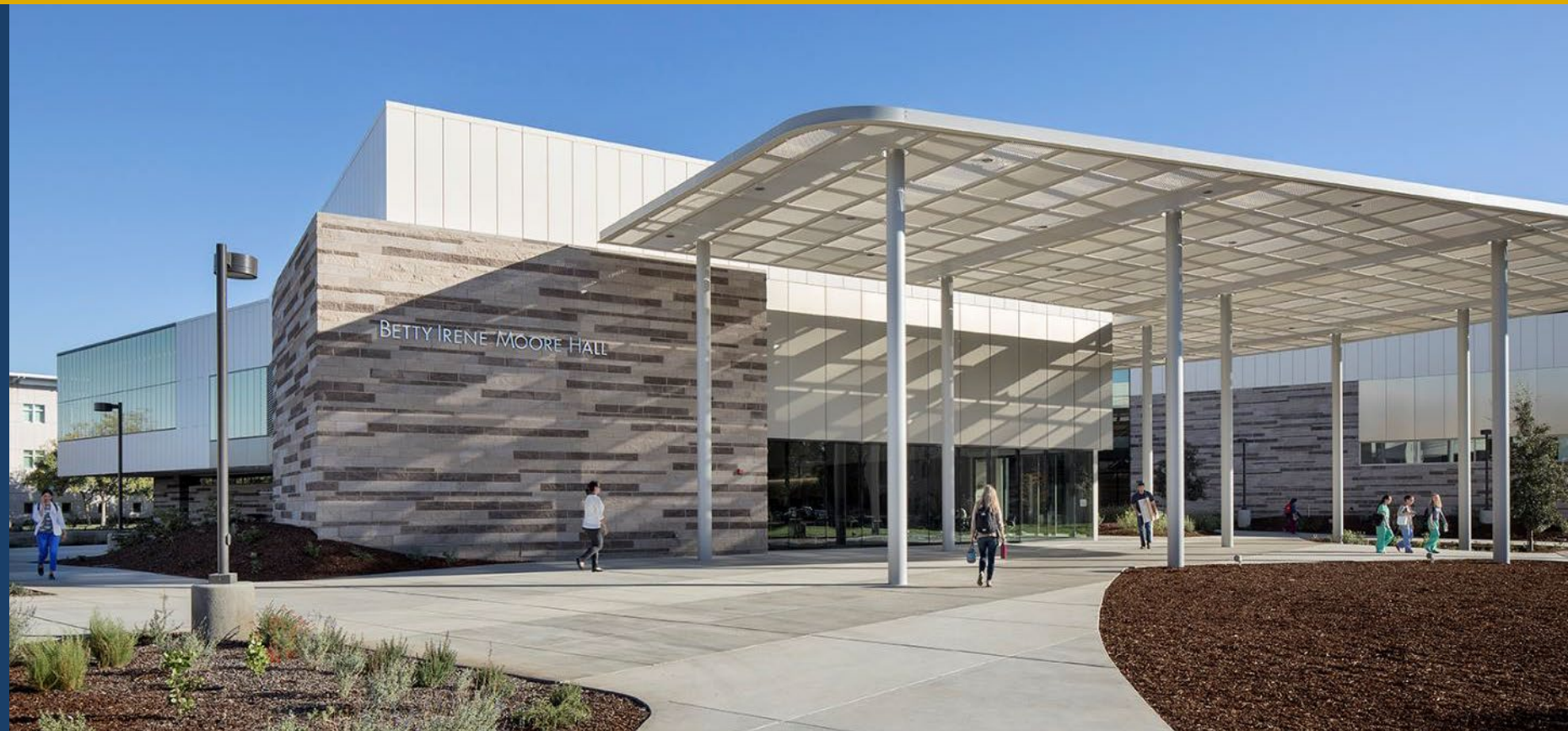


Statement of the Problem

- Institutional racism and experiences of discrimination leads to health care distrust

- Health care distrust
  - affects access to care
  - breaks continuity of care
  - leads to non-adherence or refusal of care

- Together these issues lead to adverse maternal and infant outcomes and health disparities particularly among women of color

Concept of Trust in Healthcare

- Trust is central in the patient and health professional therapeutic relationship[15]
  - core guidance for conduct behavior for all health professionals.
  - patients' trust promotes healing.
- Distrust is highest among:
  - Low income[11,12] , African American, Hispanic and migrant women[13, 14]

Table 1- Maternal Health Outcomes Compared to non-Hispanic White Women

	African American	Hispanic	Native American
Maternal Mortality			
• Overall[2,3]	2-3X	2-3X	2-3X
• Pregnancy-related-Hypertension[4]	-	3X	
• Hemorrhage due to Eclampsia or Pre-Eclampsia[4]	2-3X	-	2-3X
Preterm Birth[5,8]	↑ 50%	-	-

Table 2. Birth Outcomes

	African American	Native American	Asian
Low-Birthweight (LBW)[6]*	2X		2X
High-Birthweight (HBW)[7] **		9.8%	

*Compared to non-Hispanic White Women

**Compared to National Average 8.2%

Community Health Workers

- Front line health workers that provide basic health care preventive and promotion services.[16]
  - -Trusted members of the community
  - -Bridge the gap between health care and low-income racial-ethnic populations
  - -Evidence of positive health outcomes in MCH populations
  - -improved access to prenatal care and family related community resources

Gap in the literature

CHWs successfully build trust with women from racial/ethnic communities and at-risk for MCH disparities and have historic health care distrust

No studies have examined how CHWs build trust

Inquiry

How do CHWs facilitate trust with low-income racial minority women at risk for maternal child health disparities and who have a historic distrust of the healthcare system?

Method

- Qualitative Interviews and Focus Groups
- Grounded Theory Constant Comparative Analysis
- Inductive Social Constructive

Community Health Worker (CHW): Inclusion Criteria

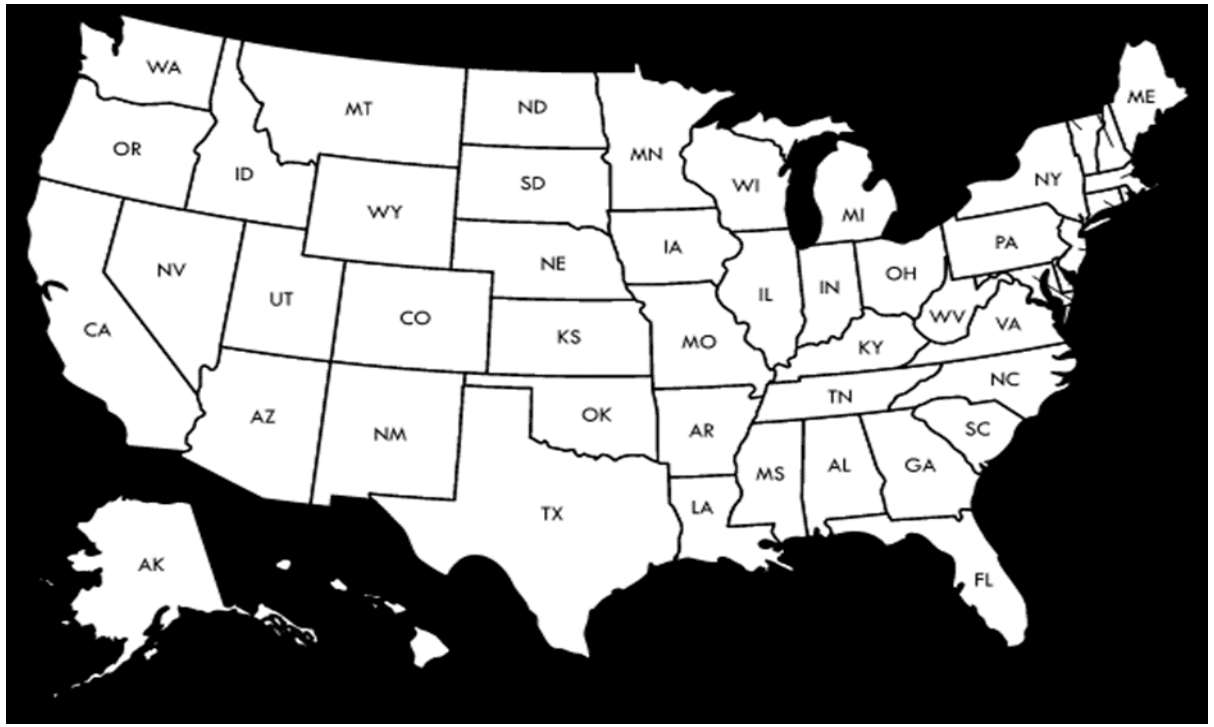
- Identifies as a CHW
- Minimum work experience of 6 months.
- Works with a program that serves low-income diverse minority populations, including MCH populations

Recruitment: Criterion Snowball Purposive Sampling

- Northwest Regional Primary Care Association's (NWRPCA) annual conference, Migrant and Community Health
- American Public Health Association Community Health Section
- San Diego Promotores Coalition
- Tiburcio Vasquez Community Clinic (Hayward)
- California Preterm Birth Initiative:
  - West Fresno Community Health Center

Sampling Locations

- Community Based and Hospital Based Programs
- California, Oregon, Chicago, Texas, Maine, Massachusetts, So. Carolina, New York



CHW Demographic (N=32)

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	N=32 (%) or Mean (sd)
Age	40 (11.589)
Gender	
Male	2 (6%)
Female	30 (94%)
Race/Ethnicity	
Hispanic	17 (53%)
Black	11 (34%)
Asian	1 (3%)
Native American	1 (3%)
White	2 (6%)
Marriage Status	
Married	18 (56.2%)
Single	11 (34.4%)
Divorced/Separated	3 (9.4%)
Children	
Y	14 (44%)
N	18 (56%)

CHW Years of Experience and Roles

6mos-5y	14 (44%)
6-10	6 (19%)
11-20	2 (6%)
>20	3 (9%)
CHW Roles **	
Health Educator	14 (44%)
Advocate	13 (41%)
Housing Specialist	3 (9%)
Outreach/Resource Specialist	23 (72%)
Doula	3 (9%)

*All populations are low-income. Some programs have primary target populations Black/Hispanic. Target populations are dependent on location. ** Services overlap. Each service as described by CHW

CHW Programs and Target Communities

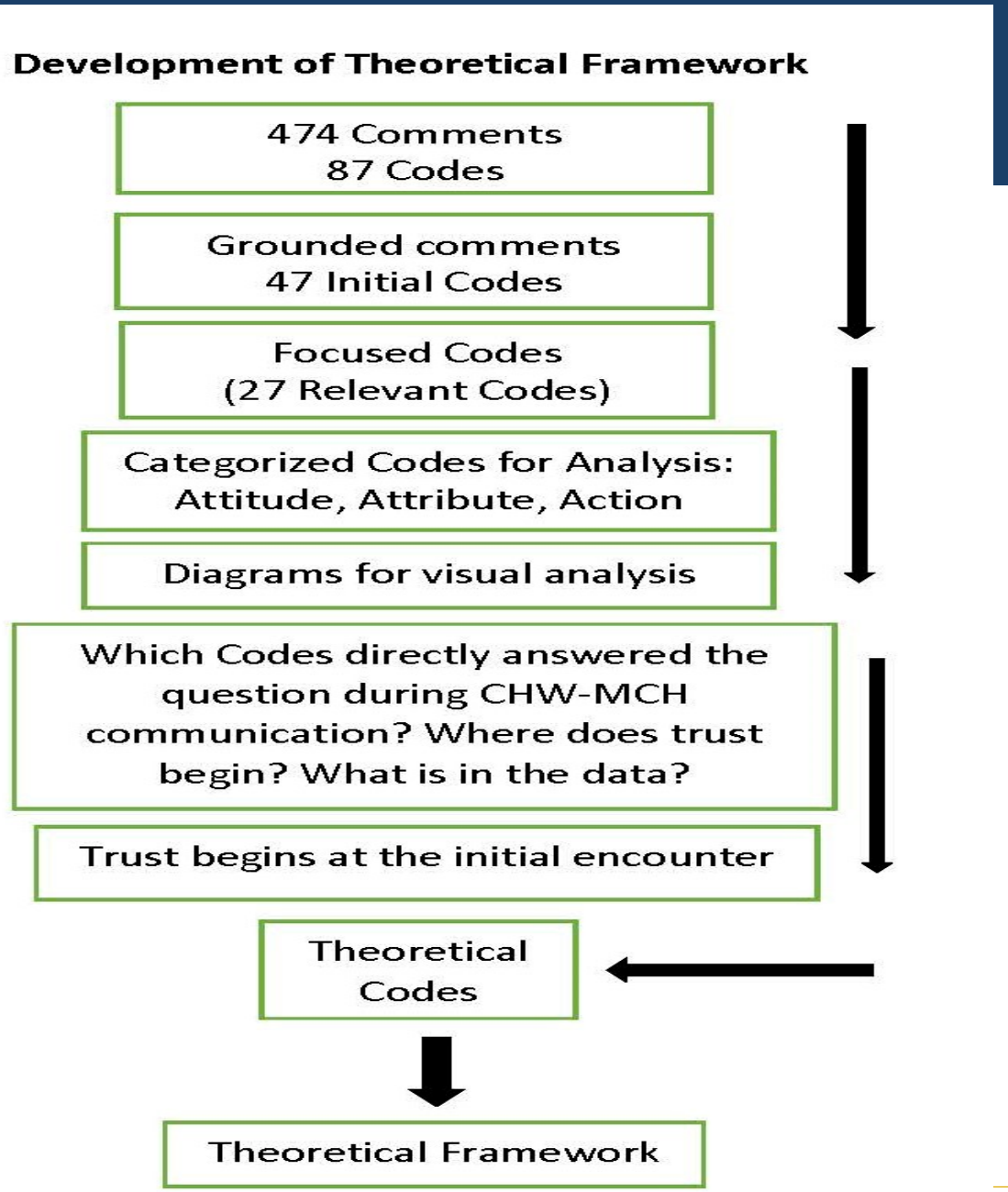
***All populations are low-income. Some programs have primary target populations Black/Hispanic. Target populations are dependent on location. **Migrant Hispanic, Persian, Somalian,**

	N=32 (%)
Type of Program	
Community Based Program	25 (78%)
Hospital Based Program	7 (22%)
Program Target Population	
Women only	6 (18.7%)
Women and children (families)	9 (28.1%)
Students (14-24yo)	4 (12.5%)
Homeless, women and children	3 (9.4%)
Adults without MCH encounter	10 (31%)
Population Race/Ethnicity*	
African American	9 (28.1%)
Hispanic	21 (65.6%)
Asian	7 (22%)
Refugee/Migrant**	6 (18.7%)
White	2 (6.2%)

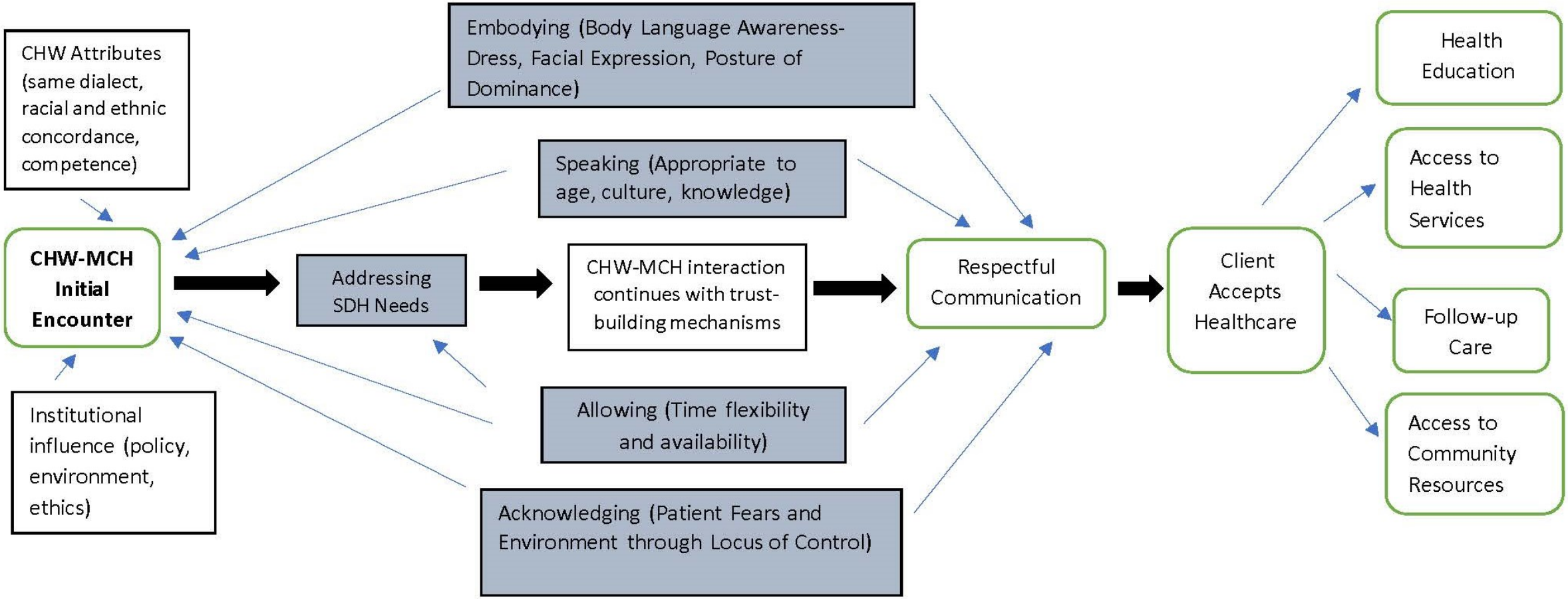
Data Analysis[18]

- Constant Comparative Analysis
- Saturation
- Initial Coding
- Focused Coding
- Theoretical Coding

Theoretical Framework Development



Trust-Building Mechanisms during CHW-MCH Initial Encounter



Rafizadeh, 2021

Mechanism for Trust in MCH Populations:

Addressing Social Determinants of Health Needs

Diapers
Formula
Food
Housing
Transportation
Safety
--Environment
--Physical

"

"So, we can start build this relationship, and we have taken formulas, and pampers, maybe a one and done. We may not have Pampers at the moment; I have a few in the car, then I'm gonna connect you to the services that can help you through the process and help you a little bit further."

Embodying (Body Language Awareness)

- Dress
- Facial Expressions
- Posture (Avoiding posture of dominance)

“Giving them your undivided attention, looking at them and seem interesting and engaged, letting them talk, and depending on the responses that they give, be non-judgement. No matter what they say, I would keep a neutral facial expression, and just to let them keep speaking. I'm not giving them any judgment or looks. I'm not giving any assumptions like that.”

Speaking Appropriate to Age, Culture, Health Literacy

Know that calling an African American by their first name is disrespectful. Know that you need to call Mr. Jones or Ms. Sarah. Know that if you refuse things, like a glass of water, if it's offered to you in a household, even in a black household, how that if you refuse these things, it is offensive. And know how to respect the culture, you know, know the culture, do your research.

Acknowledging Client Fears

Locus of Control

Environment and Emotional Safety

- *I know the providers want the patients to come to where they're are, but maybe some people can't feel too comfortable come into a hospital setting, or come into an office. Sometimes we'll find ourselves out in the community on a bench, or Dunkin Donuts, somewhere public wherever they're comfortable meeting,*
-
- *“If we create a space, meet the person where they are, they're gonna want to open up, they're gonna feel the confidence in what they know. And what they've live, that's meeting the client where they are.”*

Allowing for Time Flexibility

- *“…That's what she needs. It might take a week, but she'll go, 'you know what, L. helped me with this, she can help me." you know what I mean? So you know, doing what you can do to develop that rapport and seeing what's important to them, because it's not our lives, and I've said this before, it's their lives and you kinda have to shape yourself around what they need. You have to respect, them, yeah.”*

Limitations

- **Not transferrable to all CHWs**
  - acute settings
  - other at-risk low-income racial/ethnic populations
- **Does not include perceptions of recipients of CHW care**
  - possible of bias in the findings

Implications

- Implication for Clinical Practice
  - Body and Spoken Language Awareness
- Implication for Health Professional Education and Training
  - Health Policy on Education and Training
    - Respectful Communication and Client Centered Care
    - Diverse Populations with Cultural Norms
- Implication for Future Research
  - Inquiry if all Health Professionals can Adopt Trust-Building Mechanisms

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