"You're Building Trust, You're Building Rapport": Contributions from Implementers of Health-Focused Community Engagement

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Abstract

Health-focused community engagement (CE) is a common intervention to combat existing healthcare inequity and its disproportionate impact on the health of underserved Black, Indigenous, and People of Color (BIPOC) communities. While health-focused CE may contribute to better health outcomes by establishing feelings of empowerment within the community, strengthening relationships, and increasing a community's resiliency, the perspective of the implementers is often not considered. The current study aims to address this gap by understanding the experiences, beliefs, values, and assessments of health-focused CE staff.

We completed qualitative interviews with individuals conducting health-focused CE and documented their participation in community events to examine the experiences, beliefs, values, and assessments of conducting health-focused CE in underserved communities. Between April and October, 2022, the study team collected data from 26 community events ranging from "very small" (~5 people) to "very large" (~4,000 people), making direct contact with approximately 34 people per event. Qualitative analysis identified three themes regarding the conduct of health-focused CE: 1) mirroring racial/ethnic diversity and language with community members is critical to building trustworthy relationships; 2) while seemingly inconsequential, structural and logistical components are key for building connections that lead to positive health-behavior changes; 3) implementers are driven by and view each meaningful interaction as a piece of the puzzle to create structural change. Evaluating the conduct of health-focused CE through implementor experiences, beliefs, values, and assessments increases the understanding of intervention processes and educates the field on the needs of underserved individuals without disrupting community relationships.

Introduction

Healthcare inequity and its disproportionate impact on the health of underserved Black, Indigenous, and People of Color (BIPOC) communities is well documented and reinforced by existing structural, cultural, and social systems (Berger et al., 2021; Cyril et al., 2015; Haggerty et al., 2020; Renzaho et al., 2016). To counter discrimination and improve health outcomes for underserved populations, collaboration between the healthcare system and BIPOC communities is necessary (Aguilar-Gaxiola et al., 2022; Augsberger et al., 2022). Health-focused community engagement (CE)—or the collaborative effort to alter health-related behaviors through relationship building, education, and advocacy—holds substantial value for increasing health promotion and achieving an equitable healthcare system (Aquilar-Gaxiola et al., 2022, Barker et al., 2020, Cyril et al., 2015, World Health Organization, 2020).

Health-focused CE has been shown to increase adherence to healthy behaviors, improve access to care, and improve health literacy (Cyril et al., 2015; Questa et al., 2020; Sarrami-Foroushani et al., 2014). Furthermore, health-focused CE may contribute to better health outcomes by establishing feelings of empowerment within the community, strengthening relationships, and increasing a community's resiliency (Cyril et al., 2015; Gilmore et al., 2020; Riemann et al., 2021).

Due to the clearly established benefits, health-focused CE efforts are being widely adopted; however, there is a call for increased rigor in the assessment of these practices (Cyril et al., 2015; Sarrami-Foroushani et al., 2014; South & Phillips, 2014) and implementer perspectives have not been considered. An in-depth analysis of staff member experiences, beliefs, values, and assessments opens a unique window into CE intervention. This knowledge has the potential to increase awareness of motivation to be involved in CE work and expands understanding of barriers that have been identified to inhibit CE processes, such as funding

resources, initiating trustworthy relationships with hesitant communities, and inadequate recognition of the value of CE from political and institutional systems (Tembo et al., 2021).

This study developed an approach to monitor and evaluate our CE efforts and aims to provide a guide for the establishment of future CE interventions. We examined the engagement efforts from the perspective of individuals who conduct CE activities to understand the experiences, beliefs, values, and assessments of conducting health-focused community engagement in underserved communities.

Methods

Study Setting

The current project is a component of the Massachusetts Community Engagement Alliance of the NIH (MA-CEAL). This study took place at Boston Medical Center (BMC), the largest safety net hospital in New England (Boston Medical Center, 2023a). BMC primarily provides care for underserved populations in the Greater Boston area with nearly 73% of patients identifying as medically underserved (Boston Medical Center, 2023b). Reflecting the racial and ethnic diversity of Boston, about 32% of BMC patients identify as Black, 15% of patients identify as Latino/a, and approximately 30% of patients do not speak English as a primary language (Boston Medical Center, 2023a; de Onís, 2017). The MA-CEAL project includes a CE team comprised of three full-time employees: the Community Engagement Director and two Community Engagement Specialists. All members of the CE team have considerable experience working in underserved communities in the Greater Boston area and represent a variety of racial/ethnic identities, gender identities, ages, and language abilities. CE team members hold a variety of previous experiences in the healthcare field, including patient advocacy, health education, and health-focused engagement. In conjunction with a network of community partners, the CE team aims to conduct urgent, community-engaged outreach in order to provide the community with awareness, education, and actionable resources. While providing health information, the CE team also addresses broader disparities and inequities as they relate to healthcare and supports access to services within the medical system.

Rationale for the Approach

We implemented this study design as a response to the challenges of our initial CE monitoring and evaluation design, which took an approach to assessing impact utilizing solely quantitative metrics, such as exact tracking of formal attendee counts and demographics at community events. This early approach created several concerns from the perspective of the individuals charged with doing CE intervention, who believed it led to obstacles to engagement between the CE team, the larger research team, and the community. From their perspective, attempts at data collection created mistrust between CE team members and the community because it disrupted space for cultural sensitivity and time for reflexivity, both of which have been proven necessary for successful community engagement (Cyril et al., 2015; Meade et al., 2007; South & Phillips, 2014; Yan et al., 2022). Additionally, the demand for constant data collection altered the existing dynamic, inhibiting the CE team's ability to build rapport and form relationships. Data collection focused on attendee counts was perceived to add no value to understanding the community engagement process, CE team member experiences, or the intricacies of health-focused community engagement. Learning from these challenges, the current study was developed as described below.

Data Collection and Analysis

Our evaluation approach used two data sources. First, the MA-CEAL CE team members completed a debrief form at the end of each community event that estimated the event purpose, the approximate number of participants, interactions that took place, and general information about the populations participating. Second, CE team members participated in weekly qualitative interviews with the evaluation team to capture the nuances of health-focused CE. The interview guide queried: 1) community engagement strategies; 2) levels of trust; 3) emerging topics of concern; 4) necessary resources; 5) overall community reach; and 6) internal reflections regarding motivation and impact. Monthly, the study team extended the interview to obtain the CE team's broad reflections on progress, overall feelings about the community engagement activities, and general barriers or facilitators to conducting their work (see the appendix for the full interview guide). During interviews, the CE team would also reflect on their process, which could include how they felt about the new methods and the evaluation overall. We continued data collection for six months to pilot our methods,

stopping once saturation was considered reached. We audio-recorded each interview and members of the evaluation team (AT, SB, YN) took detailed notes from the audio recordings. We analyzed data from the debrief forms in Excel using basic descriptive statistics. For the interview data, we took an inductive approach to allow the themes to be generated (Bernard, 2011; Thomas, 2006). To create the initial codebook, four members of the evaluation team (MLD, AT, SB, YN) coded three interviews independently and met to discuss the findings. Thereafter, three members of the evaluation team (AT, SB, YN) consensus-coded each remaining interview and met regularly to update the codebook as necessary. This process continued until all the interviews had been coded. The interviews were coded using NVivo 12.0. When coding was complete, the evaluation team met to identify emergent themes using reflective thematic analysis methods. The Boston Medical Center and Boston University Medical Campus Institutional Review Board approved all study procedures.

Results

Post-Event Debrief Forms

From April to October, 2022, the MA-CEAL CE team participated in 26 community events (discussed in a total of 18 interviews). The CE team completed debrief forms for a total of 18 events to support understanding the reach of the MA-CEAL community engagement efforts. Events the CE team attended ranged from "very small" (~5 people) to "very large" (~4,000 people). On average, the CE team made direct contact with approximately 34 people per event. The majority of events attended included diverse populations. For example, three events were specific to African American populations, three were specific to Latino/a populations, one was specific to Haitian Creole populations, and five were specific to members of community-based organizations (CBOs). The age of attendees varied: children under age 13 were present at 14 events; teenagers aged 13–18 were present at 8 events; adults over the age of 18 were present at 15 events, and elderly populations over the age of 65 were present at 3 events.

Overview of Qualitative Themes

Qualitative analysis identified three themes regarding community engagement efforts from the perspective of the MA-CEAL CE team members. Themes included: 1) mirroring racial/ethnic diversity and language with community members is critical to building trustworthy relationships; 2) while seemingly inconsequential, structural and logistical components are key for building connections that lead to positive health-behavior changes; 3) implementers are driven by and view each meaningful interaction as a piece of the puzzle to create structural change. Each theme is described below and supported by illustrative quotes.

Theme 1: Mirroring Racial/Ethnic Diversity and Language with Community Members Is Critical to Building Trustworthy Relationships

To build strong connections with community members, the CE team reflected that two critical ingredients are language concordance with community members and having a CE team that is representative of the community's racial/ethnic diversity:

> I think us being a very monolingual team is a barrier. I think there's a lot of potential to build trust and integration into the community if we can get more multilingual materials and . . . if we can get multilingual speakers at our table. (Mattapan Boys and Girls Club Third Annual Block Party)

In addition, the CE team expressed that sharing their own stories as individuals of color allowed for trust to be built between them and the community, contributing to the strength of the connection:

> . . . [Sharing] a little bit of my experience with the healthcare system, how it could be challenging for, you know, women of color or people of color . . . [allowed me to make] a connection to her. Like, 'Oh, you know, you've been through that too.' (Juneteenth)

By establishing a baseline of trust, the CE team created a space where providing education or resources felt natural and was received more positively by community members.

Theme 2: Structural and Logistical Components Are Key for Building Connections that Result In Positive Health-Behavior Changes

The CE team stressed the important role that logistical and structural aspects of an event can play when conducting CE efforts. While logistical elements of an event may appear inconsequential, they can have a major impact on the ability to

form connections and overall feelings of success. For example, one CE team member stated, "I think the challenge is that—for, like, at least in the Mexican council—it's very small, and so the space is really tight" (Mexican Consulate). In contrast, logistics such as appropriate pace and supportive location can increase the depth of connection with community members:

> . . . When people spoke with us, they were very present with us and there was back and forth, I think, because it was a kind of slower pace . . . so the conversations we did [have] were very back and forth, very high quality. (Roslindale's Farmers Market)

In addition to event pace, event structure and setup can foster engagement: "They set it up so it was a line. So, there's a beginning and you really have to kind of pass all the partners. . . . So everyone had to pass me eventually, which is kind of good" (Home for Little Wanderers). When the structural and logistical elements of an event were in concordance with the needs of the CE team and the attendees, the result was increased feelings of success in community engagement efforts.

Theme 3: Implementers Are Driven By and View Each Meaningful Interaction as a Piece of the Puzzle to Create Structural Change

The CE team reflected on the elements of their community engagement efforts that led to feelings of success, specifically how these feelings of success and making an impact the driving force for continuing their work. The CE team reported that feelings of success were the result of a variety of factors. First, feeling successful was related to believing that community engagement efforts generate a positive impact in the community. "People kept saying very explicitly how thankful they were that we were out there, and that we were providing information and that we're providing tests and all of that" (Recovery Is for Everyone). Another CE team member said:

> Folks who worked at community health centers and clinics at BMC came by and took some of our fliers to post in their clinics. . . . To know that sort of even beyond the interactions that we're directly having . . . these secondary interactions is also really rewarding. (Care in the Square)

Feelings of success were also reported to be a result of both the quality of interactions and the quantity of connections made. In response to being asked what went well about an event, a CE team member reported, "So really that ability to be specific in the information we're providing, to have a meaningful interaction where you feel like you're connecting with someone where you're building trust, you're building rapport . . . again, individualize it to them" (Fall-o-Ween). Similar to the depth of connection, the number of individuals the CE team member reached at an event also contributed to feelings of success. For example, "There were little moments in between people, but for the most part, it was a pretty consistent stream throughout . . . to have consistent people coming throughout the entire time was, I think, a really good sign" (Recovery Month Field Day).

Feelings of success were thought to be a product of providing tangible information and useful materials to the community. When asked what made their work feel successful, one CE team member said:

> I think being able to provide people really concrete information that they could act on . . . when people would come up and ask me about the vaccine recommendations, being able to say, "Yes . . . by CDC guidelines, get the vaccine." . . . There was a concrete actionable [item] that I could give someone. (Hennigan School Open House Night)

Another CE team member said, "People are coming up to us with anxiety, with a concern, with a worry. . . . So it's always nice to see people be reassured when you're giving them information" (Roslindale's Farmers Market).

Results of Evaluation Process

With the ability to reference and qualitatively compare to the original approach, through conversations our CE team shared their satisfaction with the current research activities and their appreciation for being involved in the study design process. The agency that resulted from being active members of the evaluation design is surmised to have led to increased engagement by the CE team. Furthermore, adherence to study activities, such as timely and accurate completion of post-event debrief forms, indicates that our approach was feasible and acceptable. Lastly, space for reflection held substantial value for the CE team. For

example, one CE team member reflected on their work, "Yeah, it feels really wonderful . . . because we want to connect with the community. I know that's why I do this" (Reggie Lewis Center Student Fair).

Discussion

We employed a qualitative-focused methodology and reflective thematic analysis to achieve an in-depth understanding of the experiences, beliefs, values, and assessments of individuals conducting health-focused CE within underserved communities in the Greater Boston area. Here, we report the findings of that evaluation, as well as the value of assessing the experiences of CE implementers. We found that language concordance with community members and a team representative of the community's diversity were considered crucial ingredients for building a trustworthy presence in the community. Along with trust, we identified logistical and structural aspects of an event as necessary antecedents for providing health-focused community engagement, as they were considered to positively or negatively influence the level of connection with community members. As our CE team indicated that feeling successful in community engagement efforts was directly related to the quality and quantity of interactions, it is critical for community events to be designed in a way that increases a CE team members' ability to engage with the populations present. Another notable finding was that feelings of success and believing they could create positive change in the health of the community were the primary drivers for the CE team. In what can often be challenging work, these feelings motivate and energize the team to continue their efforts, knowing their work is making a difference for the individuals they serve.

Our findings build upon previous work that shows trust, empathy, cultural sensitivity, and time for reflexivity increase the value of CE (Cyril et al., 2015; South & Phillips, 2014; Tembo et al., 2021; Yan et al., 2022). In addition, our findings agree with those of Sarrami-Foroushani et al. (2014) who state that structural factors of events can influence the success of CE intervention. Beyond CE implementers understanding and embracing the importance of these values, it is critical for there to be recognition within the larger healthcare system, including recognition from funders, to move the needle toward equitable change. Previous studies have found that traditional study design, data collection, and assessment methods do not address the needs of the community or community healthcare staff (Aguilar-Gaxiola et al., 2022; South & Phillips, 2014). To evaluate the utility of community engagement as an intervention, researchers must broaden their understanding of community involvement in public health action and how it contributes to the positive influence of community engagement on increasing health equity (South & Phillips, 2014; Tembo et al., 2021). Through pilot-testing an evaluation approach that focused on the perspective of the implementers, we found that our method allowed us to gather valuable data regarding health-focused CE processes and interactions without inhibiting the CE team's ability to build strong connections with community members or disrupting the trust-building process. Rather, our approach facilitated collaboration among researchers, community engagement staff, and community members, while creating a window into health-focused CE from the implementer's perspective. Our experience demonstrates that community engagement workers need to be included and invested in the monitoring and evaluation of their work. Without this investment, adherence to evaluations can suffer and the evaluation can lack quality.

Understanding the motivations behind health-focused CE initiatives provides an important window into increasing this type of community intervention to work toward health equity in our communities. If institutions understand how to provide a positive work atmosphere for CE implementers, they are more likely to be able to recruit and retain these employees, leading to an increased ability to conduct CE interventions. In turn, the community is positively impacted by having greater accessibility to health-focused education, resources, and services through CE practices (Aguilar-Gaxiola et al., 2022; Barker et al., 2020). Additionally, CE intervention provides an opportunity for healthcare systems to be viewed as trustworthy in the eyes of marginalized communities. The current project was born out of a unique funding opportunity that placed emphasis on the value of health-focused CE in underserved communities. Additional funding sources that recognize the positive impacts of CE are necessary to enact larger-scale change.

An additional benefit to our evaluation approach was the opportunity for staff to have a regular space for internal reflections and to debrief the community events they attended. This opportunity was viewed as vital to the success of our CE team and has previously been shown to

deepen connections and increase the depth of CE practices (Goemans et al., 2019). In our experience, the opportunity for reflection increased the extent to which CE team members felt that their work was meaningful and contributed to the well-being of the community. Through conversation, CE team members reported that thoughtful reflection allowed them to feel successful in their work. Future research should further investigate the influence of reflection and the impact it has on motivations to conduct CE intervention.

There are several limitations to the current study. First, having data collection completed by colleagues of the CE team members may have affected their ability to speak openly about their experiences. Second, the MA-CEAL CE team experienced turnover during the study that may have impacted consistency during the period of data collection. Third, we acknowledge that providing full details regarding the demographics of our participants would increase transparency, yet we are unable to reveal precise demographics due to the potential risk of this information allowing our participants to be identified. Additionally, the CE team captured debrief form data for only 18 out of 26 events. Nonetheless, having the majority of events represented in the quantitative data provides a window into the reach of our intervention. While this type of evaluation is crucial for elevating the voices of those charged with CE, we recognize the limitation of not directly measuring community member voices. While a complete evaluation of the effectiveness of our engagement efforts would require community member perspectives, our approach is intended to be an internal monitoring and evaluation effort, rather than an evaluation of intervention effectiveness. Despite these limitations, we feel the perspectives provided by CE team members hold significant value to inform institutions as they build CE intervention teams in the future and allow the voices of individuals conducting CE work to have space in the literature.

Conclusion

We employed a qualitative-focused methodology to identify the experiences, beliefs, values, and assessments of individuals conducting public health CE. We found: 1) mirroring racial/ethnic diversity and language concordance with community members is critical to building trustworthy relationships; 2) while seemingly inconsequential, structural and logistical components are key for building connections that result in health-behavior changes; 3) implementers are driven by and view each meaningful interaction as a piece of the puzzle to create structural change. Our study design allows CE team members to reflect on their engagement in a way that provides insight into implementor contributions to public-health efforts and provides a guide for future health-focused CE processes. Understanding motivations and processes behind CE intervention has the potential to increase intervention initiatives in the future, working toward greater health equity. To expand on this novel work, future studies should focus on how to continue to provide space in the literature for implementor perspectives while also identifying mechanisms to assess impact in a way that is acceptable to community members and community engagement teams.

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Data Availability Statement

The data that support the findings of this study are available upon request from the Institutional Review Board at Boston University Medical Campus and Boston Medical Center at medirb@bu.edu.

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Competing Interests

The authors have no competing interests to declare.

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Appendix

Interview Guide

CE Core – Post Event Interview Guide for event X:

1. In a few words, can you tell me the general purpose of this event?
    a. Can you give me your general impressions of how this event went?
    b. What went well? What could have used improvement? How?
    c. What was the motivation behind being at this specific event?
        i. Was there a specific population you were interested in accessing? Theme? Etc.?
2. How do you feel conversations with community members went at this event? Please elaborate.
    a. Can you share an example of a conversation that felt challenging?
    b. Can you share an example of a conversation that felt successful? What made this feel successful?
    c. Do you feel like you were able to access the people you were looking to engage with at this event?
    d. Tell me how you felt about the conversations.
    e. Do you feel like you were able to engage with community members in a way that felt meaningful to them?
3. Did any emerging topics of concern arise at this event?
    a. Probe about: healthcare concerns, COVID-19 info (long COVID, vaccine, etc.).
    b. Were there any instances/conversations where the topic of trust was brought up by a community member? If so, please elaborate (COVID19, information, healthcare, etc.).
    c. What's the most commonly discussed topic?
    d. What is your impression of the emerging topics? How do these impact you?
        i. Why may there not be emerging topics? Related back to trust and how we can work for CEAL to be trustworthy.
        ii. How do you think these emerging topics impact next steps for CEAL?
4. Do you feel like the way in which we are presenting ourselves and public health information is accessible to the specific community we are engaging with?
5. If this event was hosted by MA-CEAL, were there any facilitators/barriers for the CE team?
    a. Probe about: event organization, set up, partnerships, etc.
    b. If there were barriers, how were they overcome?

Questions to add once monthly:

6. In general, what has been the level of engagement from community members at events?
    a. Probe about: swag use, prize wheel, conversations, etc.
    b. Can you provide an example of engagement that felt successful to you?
7. Is there anything CEAL admin/staff can be doing to further support the success of our CE events?
    a. Probe about: support for new ideas?
    b. Are there gaps we can address? Does this new topic/concern indicate the need for new materials/strategies/approaches?
8. Can you talk about your experience, etc. (How does it feel to be doing this work in the community?)