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Building Trust and Population Health Management: A Low-Cost, High-Reward Investment

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The Opportunity

According to the American Hospital Association Center for Health Innovation, population health management refers to "the process of improving clinical health outcomes of a defined group of individuals through improved care coordination and patient engagement supported by appropriate financial and care models."[1] The ultimate goal is to optimize the patient experience, lower healthcare costs, and advance the overall health of populations. Common scorecard metrics, which are monitored at the board level, include quality and safety indicators, operational practices, talent management, financial performance, and patient experience.

As boards delve into patient experience indicators, the nuances of fostering trust between the patient and the provider are commonly overlooked. Skepticism of intent or mistrust of a provider hinders the population health agenda and can manifest in an assortment of ways. Patients may be less engaged in their care, delay access to critical preventive services, and/or opt out of disclosing sensitive information that is essential for delivering a more personalized experience.[2] Trust is also a top driver of a patient's willingness to return or recommend a hospital or provider after a care experience. An NRC Health survey showed that patients who answered "Yes, always" when asked if they trust their care team are 65 percent more likely to recommend the hospital to a friend or family member.[3]

1 AHA, "Population Health Management."

2 Johns Hopkins University, "Why Trust in the Healthcare System Matters," September 23, 2024; Susan Dorr Goold, "Trust, Distrust, and Trustworthiness," *Journal of General Internal Medicine*, January 2002.

3 NRC Health, *2025 Experience Perspective*.

While macro socio-political issues and disinformation influence attitudes and perceptions, at the local level there is an opportunity for hospitals and health systems to combat these dynamics. Advancing the population health agenda will require boards and senior leaders to interrogate the status quo to yield a reconceptualized patient experience and a renewed approach to community engagement.

Patient and Community Leader Reflections

In addition to numerous published studies, mistrust of the healthcare sector is supported by interviews my colleagues and I have had with nearly 20,000 patients and community leaders in 15 years of conducting community health needs assessments.[4] The mistrust chasm is especially salient in underrepresented populations.

Understanding root causes is the first step on the journey towards progress. Historical events and status quo practices continue to influence negative perceptions and perpetuate harm. Common themes and observations from patients and community leaders include but are not limited to:

- Individual provider bias, and lack of humility during the patient encounter
- Awareness of a legacy of unethical experimental practices on black and brown communities
- Providers' seeking information without communicating purpose and/or intent
- Environments of care may not reflect the unique lived experiences of the population served
- Questionable motives in a capitalistic society

Healthcare boards should develop a clear picture of the key drivers of mistrust at their own organizations and intentionally build trust into their overall strategic direction and vision framework.[5] Below are both internal and external approaches for building trust and improving population health.

Catalyzing Change: Internal Approaches

As we strive for biopsychosocially postured systems of care over biomedically centered systems of care, trust is a prerequisite. Factors that shape health and well-being are intersectional, complex, and mostly driven by conditions outside of the medical institution, and patients—particularly the most ill—can be socially and emotionally vulnerable and grappling with inconsistent health information from various outlets. In order to effectively connect with patients and understand the totality of forces that may compromise their health and influence their perceptions, trust in the provider and institution is likely to foster an environment where patients are comfortable disclosing sensitive information and fully engaged in realistic goal setting.

Trust is also a top driver of a patient's willingness to return or recommend a hospital or provider after a care experience.

4 Brian Smedley, Adrienne Stith, and Alan Nelson, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare*, National Academies Press: Washington, D.C., 2004; Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present*, Knopf Doubleday Publishing Group, 2008; Christopher King and Yanique Redwood, "The Healthcare Institution, Population Health, and Black Lives," *Journal of the National Medical Association*, May 2016; Christopher King, "The Journey from Medical Care to Healthcare: Lessons from the Field," 2020.

5 NRC Health, *2025 Experience Perspective*.

Institutional measures to address these dynamics include systematically monitoring the demographics of the community served and consequently, ensuring workforce planning tactics reflect the input and identity of the community. Interventions are also needed to cultivate institutional cultures to help patients understand the purpose and gravity of questions posed for data collection. In addition, a growing body of research is amplifying the positive correlation between humility and patient satisfaction and health outcomes.[6] Providers who acknowledge their limitations, are open to different perspectives, and prioritize well-being over personal ego or expertise can positively transform patients' perceptions. Intentional efforts to assess the environment of care are needed to ensure the physical environment depicts the culture, identities, and lived experiences of the populations served. Examples include artwork, educational materials, and wayfinding techniques.

Catalyzing Change: External Approaches

The COVID-19 pandemic illuminated deep-seated mistrust and a systemic disconnect between healthcare organizations and their communities. As anchor institutions, hospitals and health systems with a robust comprehensive population health strategy have measures in place to unearth social, economic, political, and environmental conditions that compromise health and well-being. Consequently, they lead, partner, or support the public and private sector to catalyze change. Success requires institutional humility and consistent bidirectional community engagement beyond a program or public health emergency.

Institutional measures to address these imperatives include reorientation of how to interface with the community. The mistrust chasm is likely to persist with a savior mentality or a "build it and they will come" orientation. As a public health best practice, community health improvement can be achieved by shifting power and deploying institutional resources to empower the community itself to formulate the most efficacious interventions.[7] For example, ideation and co-design of interventions with the community are more likely to foster trust, optimize social capital, and yield desired outcomes.[8] Since vulnerable and underrepresented populations reflect diversity and represent different perspectives, boards should reflect on their membership and board recruitment practices. As demonstrated by federally qualified health centers, board compositions that include the voices of the most vulnerable are instrumental for generative dialogue to improve community perception and inspire practices to garner community trust and heighten brand recognition.[9]

In these contemporary times, boards are grappling with unprecedented socio-political dynamics that threaten their population health aspirations. However, intentional efforts

6 Ho Phi Huynh and Amy Dicke-Bohmann, "Humble Doctors, Healthy Patients? Exploring the Relationships between Clinician Humility and Patient Satisfaction, Trust, and Health Status," *Patient Education and Counseling*, January 2020; Peter Ruberton, et al., "The Relationship between Physician Humility, Physician–Patient Communication, and Patient Health," *Patient Education Counseling*, July 2016; Ho P. Huynh and Amy Senger, "A Little Shot of Humility: Intellectual Humility Predicts Vaccination Attitudes and Intention to Vaccinate against COVID-19," *Journal of Applied Social Psychology*, February 2021.

7 Sue Grinnell, Stephani Bultema, and Peter Forberg, "Advancing Equity: Adapting to Local Context and Confronting Power Dynamics—Lessons Learned from ACHs," Public Health Institute, May 28, 2022.

8 Anna Zogas, et al., "Strategies for Engaging Patients in Co-design of an Intervention," *Patient Education Counsel*, June 2024; Carmen Vargas, et al., "Co-creation, Co-design, Co-production for Public Health—a Perspective on Definitions and Distinctions, Public Health Research and Practice, June 2022.

9 Health Resources & Services Administration, "Chapter 20: Board Composition," Bureau of Primary Health Care.

to foster and sustain trust in the healthcare organization is a low-cost, high-reward investment with the potential to serve as one of the most effective population health strategies. Moreover, communities deserve a trusted leader to help them navigate the proliferation of misinformation and disinformation.

The commitment must begin with systematic methods to identify the demographics and socio-cultural characteristics of the community served. Findings can inform strategic cross-functional critical analyses of current and past performance, internally and externally. Lessons learned can inspire new approaches to foster an institutional culture that is valued and trusted by the populations served.

Key Board Takeaways

- What mechanisms exist for the board to learn directly from the lived experiences of vulnerable and under-represented populations?
- Can board members articulate how mistrust is a quality and safety risk?
- Does the board use findings from the hospital's community health needs assessment to inform strategic planning?
- Does the board incentivize senior leaders to serve on boards of community-based organizations that address social drivers of health?

TGI thanks Christopher J. King, Ph.D., FACHE, Associate Professor, Health Management and Policy, Georgetown University, for contributing this article. He can be reached at christopher.king@georgetown.edu.