Community Trust Must Be Earned: Building Authentic Relationships Is the Key

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ABSTRACT:

BACKGROUND: After Mercy Hospital closed, PHMC Public Health Campus on Cedar (Cedar) opened on its site. According to our survey three years later, only 17.6% of households in the catchment area used Cedar's services. A history of hospital closures and the former hospital's reputation contributed to deep community mistrust in local health care institutions.

OBJECTIVES: This study examined community awareness of, trust in, and willingness to try Cedar.

METHODS: Using a community-based participatory research (CBPR) approach, the evaluation team, a Community Advisory Board, and an Evaluation Committee developed a representative household survey. Analysts used chi-squared tests and logistic regression to identify factors related to awareness, trust, and willingness to use services.

RESULTS: Almost (60%) of respondents were unaware that Cedar is now operating on the former hospital site and 58.8% reported willingness to use its services. Respondents who selected Health Provider skills (63%; p=.004) as the trust variable most likely to increase willingness are most likely to use Cedar. The regression model, including all predictors, showed the odds of being aware were highest among residents living in the neighborhood >2 years (AOR=2.89 CI = 0.89-2.73), the odds of being willing to use Cedar were highest among residents with asthma (AOR=3.0 CI = 1.65-6.09]) and lowest among residents diagnosed with a heart condition (AOR= 0.002 CI = 0.07-0.51)].

CONCLUSION: Community mistrust continues to limit Cedar's reach. Trust-building efforts that center transparency, provider quality, and community voices can increase utilization and ensure health equity.

KEYWORDS: Community-Based Participatory Research, Community health partnerships, Community health research, Health disparities, Health outcomes, Health Facilities, Needs Assessment, Quality of Health Care

Introduction

Philadelphia is the second poorest large city in the United States, with 19.7% of residents living in poverty.1,2 In recent years, Philadelphia experienced the closure of multiple safety net hospitals, including St. Joseph's Hospital in 2016, Hahnemann Hospital in 2019, and Mercy Hospital in 2020. Mercy Hospital served African Americans in West and Southwest Philadelphia who experienced some of the City's worst health outcomes while experiencing higher poverty and shorter life expectancies. Additionally, more than half of residents in these areas have at least one chronic disease, a rate significantly higher than the citywide average.3

African Americans have historically expressed distrust toward medical, public health, and government systems.4,5,6 Schwei et al. (2014) found identifying as African American is significantly associated with lower levels of trust in medical institutions.6 Distrust, in this context, refers to the belief that healthcare system actors may act with harmful or self-serving motives and therefore should be questioned.5 This distrust reflects a rational response to a long history of systemic injustices and harmful experiences. African Americans have faced. Historical abuses (i.e., Tuskegee study; Flint, Michigan water crisis; and problems with the COVID vaccine roll-out) reinforce African American distrust towards healthcare systems in general.5 Distrust is often rooted in personal experiences, such as losing loved ones to what is considered substandard care, further deepening mistrust.5 For example, in the current study, some Philadelphia residents refer to a former hospital once operating on the site as "Killercordia," which reflects the deep sense of betrayal and lingering negative experiences associated with the institution.

Trust in healthcare institutions is a critical determinant of patient attitudes, health behaviors, service utilization and overall health outcomes.4,5,6 Low levels of trust can lead to

health disparities, reduced access to health care and poorer outcomes while high levels are associated with better health outcomes and a greater willingness to seek care.4,5,6 When community members perceive a healthcare institution or provider as untrustworthy, they are less likely to use related services.6,7 Given the history of harm experienced by African Americans in healthcare settings, intentionally rebuilding trust is essential. Fortunately, trust can improve through positive patient experiences.6 Creating positive healthcare experiences with patients is key to rebuilding trust and improving health outcomes. 5,6

The PHMC Public Health Campus on Cedar (Cedar) was established to ensure continued access to essential services at a site where a safety-net hospital closed. Cedar represents a partnership between the not-for-profit Public Health Management Corporation (PHMC), Penn Medicine (Penn), and Children's Hospital of Philadelphia (CHOP). Cedar functions as a comprehensive public health hub: PHMC offers primary care, dental services, and medical respite. Penn provides emergency department (ED) and adult crisis response center (CRC) care, two inpatient acute medical units, an inpatient detox unit, two inpatient acute psychiatry units, and an outpatient cardiology clinic. CHOP delivers pediatric CRC services and inpatient psychiatry units at Cedar.

Despite a range of services at Cedar, lack of awareness remains a barrier to service utilization.8 9 Cedar's model—with Research suggests raising awareness can increase engagement with health services. Its co-location of services, care coordination and community-centered approach—offers a unique opportunity to both raise awareness of locally available care and increase trust. Together, these elements can strengthen community relationships, increase utilization of services, and contribute to improved health outcomes in surrounding communities.

To better understand the impact of this new model, evaluators from PHMC and Drexel University conducted a community-engaged evaluation incorporating a place-based initiative framework to assess baseline outcomes related to the co-location of services at Cedar. A Cedar Evaluation Committee (CEC) was assembled by initiating an open call for members from a diverse pool of community residents, community advisory board (CAB) members, academic partners, small business owners, and faith-based organizations. CEC recruitment flyers were posted in corner stores, community centers, daycares, faith- based organizations, small businesses, and on Cedar's campus. Residents could nominate themselves or anyone who lived, worked, or worshipped in the surrounding neighborhoods. CEC captured diverse community perspectives to ensure community collaboration could shape the evaluation process with community-based participatory research (CBPR) objectives in mind. This process not only ensured a diversity of faiths, education/income levels, genders, races, and occupations represented, but that diverse voices would be included in the decision-making process.

CEC was composed of 21 members - eight community members and thirteen researchers and Cedar partners (residents, faith-based leaders, academic partners). CEC participated in design workshops, reviewing study protocols, guiding messaging strategies, and co-interpreting results and dissemination. The CEC provided feedback, make recommendations, and decisions by consensus. This group was independent but complementary to the preexisting CAB, with some CEC members also serving on Cedar's CAB. Information was shared between both committees and CEC members presented information to the CAB on 3 separate occasions.

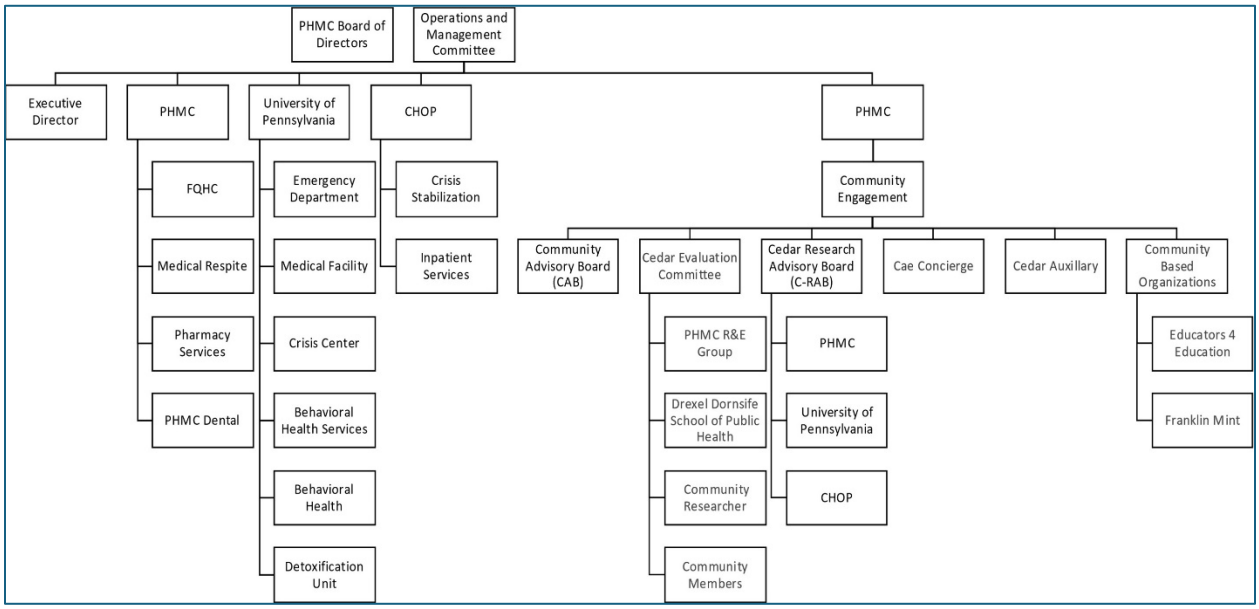

Figure 1. Organizational Chart

Researchers incorporated CBPR principles to support trust and center community voices in evaluating Cedar's impact by: (1) acknowledging West/Southwest Philadelphia residents as a defined community with shared history and health experiences; (2) recognizing Cedar sits on a historically mistrusted hospital site that neighbors remember; (3) leveraging the pre-existing network of PHMC's Director of Community Engagement with trusted leaders, faith-based groups, and local organizations when establishing CEC; (4) establishing a CEC to share in decision-making power (i.e., shape the evaluation design, survey development, interpretation of findings, and dissemination of results) (5) establishing feedback loops where data directly inform Cedar service modifications; (6) analyzing how awareness, trust, and willingness to use Cedar in neighborhoods with poverty, 57 chronic disease, and life expectancy gaps are connected to social determinants (poverty, safety, neighborhood tenure); (7) using findings to adapt engagement strategies (e.g., targeted awareness campaigns, trust-building interventions), followed by repeat measurement; (8) disseminating findings and knowledge gained by co-creating flyers,

infographics, community forums, social media, and written reports to community members; and (9) committing to a sustained partnership by continuing a CAB and CEC and by tracking outcomes beyond this first evaluation.

An initial evaluation planning year focused on activities to inform an evaluation plan. The evaluation plan included: 1) conducting key informant interviews (KII) to identify strengths/gaps in the P service partnership, develop an understanding of shared goals, and to define success for Cedar; 2) administering an intercept survey (IS) to capture attitudes, beliefs and experiences of community members about Cedar and the former healthcare institutions at the site; and 3) implementing group model building (GMB), a participatory system dynamics method to integrate perspectives and mental models across parties to understand and tackle complex problems.10 , 11 In GMB, participants work with facilitators to complete a series of scripted activities to identify a shared understanding of the factors contributing to a complex system. The method has increasingly been shown as an effective means to improve problem understanding and facilitate effective intervention design.12 Researchers held two 8-hour GMB sessions, one including Cedar providers, administrators, and institutional partners and the other including community residents and representatives of community-based organizations, including Cedar CAB members. Sessions focused on the factors contributing to access to high-quality, well-coordinated care in the Cedar area and resulted in a series of systems maps depicting key factors, how they related to each other, and potential levers for action. Trust and service coordination emerged as critical factors; detailed GMB results were publicly posted. Results of the year 1 evaluation efforts informed development of the community resident survey.

The purpose of this paper is to describe how preliminary data informed a representative community resident survey and the results of that survey. The Cedar evaluation included both quantitative and qualitative data to examine healthcare access, service utilization and delivery, community trust levels, and collaboration between leadership, staff and the community. Evaluators aimed to determine how sociodemographic and health-related factors were associated with respondents' awareness, willingness to use, and trust in Cedar. Additionally, factors associated with trust were identified and measured to better understand how trust influenced residents' willingness to use Cedar services.

METHODS

Researchers assessed awareness by capturing the attitudes, health status, and other characteristics of residents living in 10 randomly selected block groups within a mile radius of Cedar campus (out of 79 statistical block groups in the area). The demographic profile of residents in the 79 block groups was very similar to those in the 10 selected aggregated block groups (according to Claritas census data). For example, 69.9% of adults across the 79-block groups area Census-identified as Black race, compared to 69.4% of the 10-block group area used in the cluster sample. There was some deviation in the survey sample on socioeconomic demographics within the 10 block group area. About 3,500 households received a letter in the U.S. mail inviting residents to complete the survey online, over the telephone, or in person at Cedar. In all, researchers received 510 valid surveys, for a response rate of 14.8%. Weighted adjustments were employed to more accurately reflect the 79- block group's adult population demographics based on 2024 Census estimates. The weighted variance was an acceptable 1.7.

The 15-minute survey asked residents about demographic characteristics (e.g., age, neighborhood tenure, gender, race, education, income), usual sources of healthcare, and lifetime diagnoses of health conditions, such as heart disease, diabetes and high cholesterol. The survey captured three dependent variables: (1) awareness of Cedar campus, (2) willingness to try the campus, and (3) trust in the campus. The survey asked respondents if they were aware the Cedar had opened on the site of the former hospital (Yes/No). Next, they captured one dimension of willingness by asking: "Would you or a member of your household be willing to try services at Cedar?" Response options included "not at all willing," "slightly willing," "neutral," "moderately willing," and "very willing." Analysts coded: "not at all willing" and "neutral" responses as No, while "slightly," "moderately," and "very willing" were coded Yes.

Survey questions asked respondents which of six factors contributed to their willingness to try Cedar services; check all that apply response options were professionalism, highly rated staff, modernity of the facility, relationship with the health provider, institution's reputation, and ease of making appointments (Checked responses were coded 1 for "yes" and unchecked were coded 0 for "no" in the analysis). Similarly, trust was measured by asking respondents which of 10 factors contributed most to their trust in Cedar; respondents could select up to two : personal experience with Cedar; prior personal experience with the previous hospital located on the Cedar site; health providers skills; the facility's reputation; staff transparency and communication; safety and cleanliness; staff's cultural competency; having a patient-centered approach; having ethical standards; and other. The same coding scheme for Yes/No was used. Other dimensions of trust were captured [(n=45); weight adjusted (n=53)] was too small for multivariable analysis.

Analysts used SPSS v27 to conduct univariate and bivariate analyses and to run logistic regression models. Stepwise entry method was used with groups of demographic and health-related variables as predictors of willingness to use Cedar or awareness that it replaced a former hospital. Variables achieving statistical significance ($p<.05$) and variables ($p <=.10$) were entered into the final regression model. Due to missing data on a combination of demographic and outcome variables, the regression model included a final sample size of 301 respondents for willingness and 379 for awareness. One predictor variable (poverty level) received imputations for the missing data based on 22.0% not providing family income level in the past year.

The respondents' profile differed from the wider area by race, gender, and education. Missing values were imputed for proper weighting. For example, whereas Black adults comprised 69.9% of the Census 2024 estimate for the 79-block group area, 58.8% of the sample after imputing for missing variables was Black/African American (56.0% w/o imputation). For gender the under-represented males were weighted higher (33.3% unweighted and 43.0% weight-adjusted). Respondents with college degrees were over-represented (48.0% unweighted, 30.8% weight adjusted, which comes close to the census benchmark of 29.4% for the 79-block group area. Weighted adjustment met design effect limitations. Overall, after weighting adjustments to accurately reflect the wider area, 67.7% of respondents identified as African American, 20.9% as Caucasian, and r4.9% as Latino of any race (not shown). Forty-four percent of respondents identified as women, 41.3% as men, and 4.6% as non-binary (not shown).

The study was determined by PHMC's Institutional Review Board (IRB) not to meet the definition of human subjects' research; therefore no further IRB review was required.

RESULTS

At the time of data collection, almost six in 10 respondents were unaware Cedar had opened on the former hospital site, while a little over four in 10 were aware it had done so. Among those unaware, 58.8% were willing to try Cedar services, 31.8% were neutral, and only 9.4% were unwilling. Only 10.3% were very willing, suggesting the importance of needing to develop trust in Cedar before making use of their services. Willingness to try Cedar was higher among respondents who were unaware the campus operated on the site of the former hospital (59.2%) compared to those who were aware (46.8%).

Respondents' Characteristics and Awareness of the Public Health Campus

Overall, 67.0% of respondents identified as African American, 20.9% as Caucasian, and 4.9% as Latino of any race (not shown). Fifty-four percent of respondents identified as women, 41.3% as men, and 4.6% as non-binary (not shown). Forty eight % of Latino respondents, 44.6% of African Americans, and 33.7% of Whites were aware of Cedar. More men (48.0%) than women (36.0%) were aware, and adults between age 55 and 64 (54.5%) were more aware than the youngest respondents, aged 18 to 24 years (28.3%). The percentage of adults who were aware the campus operated on the formal hospital site was had opened than those not receiving such benefits (37.5%). to use it (84.6%). Respondents below or near the poverty line who are most likely to need services, were less likely (48.8% vs. 58.8%) to utilize Cedar services.

[TABLE 2]

The percentage of people expressing willingness to use Cedar was higher among those with at least a college degree (61.5%), receiving local, state, or federal benefits (62.5%), living in the neighborhood between two and 10 years (58.1%), and working part- or full-time (60.2%). Smaller percentages of people with heart condition or high cholesterol were willing to use Cedar

(27.8% and 41.6%, respectively) than those with asthma (64.4%). A greater percentage of people who felt safe in their neighborhood (58.4%) were willing to use Cedar than those who did not feel safe (40%), and the percentage of willing respondents was higher among those who reported exercising three or more times per week (60.5%) than those who did not (48.4%).

Factors Contributing to Willingness to Try and Trust in Cedar

Professionalism (40.3%), highly rated staff (36%), and the ease of making an appointment or relationship with their provider (27.0%) were selected as factors that affected their willingness to use Cedar the most. Respondents who were unaware the campus operated on the former hospital site choose the same factors as those who were aware. Among the 65 respondents who indicated they were aware and willing to use the campus, 37.3% also cited the modernity of the facility as an important factor in their willingness to try Cedar.

The factors most often cited as contributing to respondents' trust were the health provider's skill (39.6%), facility's safety and cleanliness (36.3%), and the facility's reputation (29.6%). Over one-third of aware and unaware respondents cited health provider skills as a top factor in contributing to their trust in Cedar (35.7% and 42.7%, respectively); some cited the facility's reputation. However, 29.7% of those aware Cedar operated on the former hospital grounds also cited personal experience with Cedar as a factor contributing to their trust.

[TABLE 3]

Respondents who were aware of and unwilling to try Cedar (n=74) reported experience with Cedar as an important factor contributing to trust, and 28.9% of the 25 respondents who were unaware of and unwilling to try Cedar reported transparency as an important trust factor.

Predicting Awareness of and Willingness to Use the Public Health Campus

Logistic regression results revealed the odds of being aware were 2.89 times higher (CI=1.29-7.18) for residents living there more than two years than for newer residents, and the odds of being aware were 1.77 times higher (CI=0.89-2.73) for African Americans than Whites. The odds of being aware were 1.62 times higher (CI=1.01-2.61) for adults indicating personal experience with Cedar as an important factor contributing to their trust than for those who did not. The odds of being aware Cedar operated on the site of the former hospital were .59 (CI= 0.37 – 0.92) lower for people who cited provider skills as an important trust factor than for those who did not.

[TABLE 4]

When controlling other significant predictors of willingness, the odds of being willing to use Cedar were 4.27 times lower (CI=0.07-0.51) among those with heart conditions than those without. By contrast, odds of being willing to use Cedar were 3 times higher (CI=1.65-6.09) for adults who had asthma than those who did not. Likewise, the odds of being willing to try for adults indicating transparency and provider skills contributed to their trust in Cedar were 1.89 times (CI=0.98-3.53) higher than the odds of those who did not. Indicating cultural competency of staff was important to one's trust in Cedar did not predicted unwillingness to try Cedar.

Community-Level Effects

The results are representative of approximately 31,500 community members' health status, health behaviors and attitudes towards Cedar, after weighting adjustments and recoding of a small number of outliers resulting in a Design Effect meeting acceptable standards. The

information gained will be used to inform health programs and related outreach with the aim of improving health outcomes and better supporting the relationship between the community and Cedar campus. In addition to providing measurable outcomes related to awareness, willingness, and trust, the evaluation process likely created important community-level effects such as increased awareness of Cedar resulting from attending local events, distributing materials, engaging neighborhood leaders, receiving the questionnaire and other related outreach, although that effect was not measured.

DISCUSSION

Philadelphia's safety-net hospital closures are indicative of a national trend that destabilizes access and erodes institutional trust in low-income, communities with Rv predominantly racial minorities. Closures increase access strain, disrupt continuity of care, increase mistrust, and reduce utilization.13 A public health campus model like the one at Cedar with a co-location of services and cross-system partnership is a plausible countermeasure to hospital closures. Although co-location does not necessarily result in cross- sector collaborations or better outcomes, co-location coupled with deliberate collaboration and user- 14 Predictors of willingness and trust—provider centered operations does improve engagement skill/communication, safety and cleanliness, appointment ease, reputation, and transparency—are consistent with the literature. Others have found provider competence and communication increase trust, satisfaction, adherence, and re-patronage15; cleanliness/ambience increases trust and willingness to return;16 transparency (open communication about performance, uncertainty, processes) increases greater accountability and trust ;17 cultural competence/humility and

diversity-sensitive care improve experiences for Black patients and offer the potential to reduce disparities, 18 outreach and targeted digital campaigns can raise awareness and help-seeking.19

Our finding that many unaware residents are willing/neutral is congruent with outreach literature. Informational exposure is necessary for engagement; however, the messaging needs reinforcement via access, credibility, and user experience to drive utilization.20 Our results differ from the literature in two ways: higher income/higher education correlates with lower trust and co-location of services does not always result in better outcomes. Higher education/higher income correlates with lower trust. Much of the trust literature shows direction of the relationship between education/income and trust can vary by context. In urban settings with the closure of hospitals and damaged institutional reputations, more affluent residents are more scrutinizing about quality (reputation) and less trusting until performance data are visible. This interpretation is consistent with transparency, research and patient choice theory.21 Co- location benefits are not automatic. Some studies report improved awareness/engagement with co-located services, but others only show gain with explicit integration strategies and role clarity. This suggests Cedar vi must operationalize co-location (shared workflows, warm handoffs, data-sharing) to convert physical proximity into trust and use.22

A multi-pronged strategy that operationalizes significant predictors to maximize Cedar's co- location of services is supported by the literature. Additionally, Cedar is seeking to implement a referral system linking ED use to primary care. This initiative was born directly from the results of the Cedar evaluation. Based on the evidence, Cedar and similar initiatives should employ the following practices:

1. Promote provider skills. Publicize provider qualifications, specialty experience, &

quality/process metrics on campus signage and digital channels 15

2. Highlight safety & cleanliness. Treat environmental services as a trust-building intervention, and measure & share results (e.g., clean & infection-prevention audits).16

3. Maintain transparency. Share wait times, appointment availability, complaint resolution stats, "you said—we did" changes and normalize disclosing diagnostic uncertainty. 17

4. Prioritize cultural humility & representation. Provide continuous training, hire locally and 8 ,18. co-design scripts & spaces with community partners

5. Offer easy access. Optimize appointment systems (same-day slots, walk-in windows, text scheduling) and market the ease of access ("ease of making appointments" predicts willingness.)14,17

6. Target awareness campaigns. Micro-target specific subgroups & engage with trusted community messengers.19

7. Operationalize co-location, Formalize warm handoffs, shared case conferences, and data-sharing agreements so co-located services feel seamless to patients 14,22.

8. Embed CBPR structure long-term. Use CCPH/CBPR principles to maintain equitable governance, co-learning, iterative cycles, and community-led dissemination to rebuild trust in healthcare and improve health outcomes for the community. 23

This evaluation study advances the literature by examining trust-building on a legacy health care site. Few studies examine trust formation when a new public health hub opens on the grounds of a historically mistrusted hospital. Baseline findings, which show how site history

interacts with awareness and willingness, can guide other cities facing post-hospital closure or redevelopment. The evaluation also examined trust and identified which attributes drive trust and willingness locally, thereby contributing to the broad trust literature and providing a template for campus-level dashboards. Finally, by pairing a co-located campus with a CEC and CAB, Cedar tests whether operationalized co-location plus shared governance can rebuild trust after institutional trauma. To our knowledge, this method of trust building is underrepresented in the literature.

This manuscript is novel for adding a post-hospital closure setting with reputational baggage where trust, awareness and willingness are measured creating a 3-part intervention pathway with an outreach 14 plan to increase trust, raise awareness and increase willingness to utilize Cedar services. Second, the work provides actionable predictors that translate directly into operations and communications plans. Lastly, we provide a community-governed evaluation that demonstrates how CBPR/CCPH principles can be operationalized on a complex, multi-institution campus.

A few limitations of this study are worth noting. To reduce respondent burden, more than half of the questionnaire items were optional, resulting in missing data to key income questions. Poverty data was Imputed based on other demographic variables, which reduced the analytic sample and may have a attenuated the significance of poverty in multivariate models. Future evaluations may preserve sample size and improve model precision.

These findings hold relevance for other urban communities experiencing hospital closures and systemic mistrust of healthcare institutions. The trust building approaches identified in this evaluation offer a framework for health care institutions to rebuild trust with stronger

community engagement and deliver more equitable service delivery to ultimately transition from being service providers to becoming trusted community anchors.

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Table 1. Characteristics of Respondents Who Were Aware or Unaware of the Health Campus (n = 379)[1,2]

	Unaware %	Aware %		Unaware %	Aware %		Unaware	Aware
Race/Ethnicity*			**Ever Had Asthma**			**Heart Condition**		
African American	55.4	44.6	Diagnosed	54.2	45.8	Diagnosed	56.4	43.6
White/Caucasian	66.3	33.7	Not Diagnosed	59.6	40.4	Not Diagnosed	58.4	41.6
Latino (any race)	52.0	48.0						
Gender**			**Health Status**			**High Cholesterol**		
Male	52.0	48.0	Fair or Poor	59.7	40.3	Diagnosed	62.5	37.5
Female	64.0	36.0	Good to Excellent	59.4	40.6	Not Diagnosed	58.0	42.0
Age Group*			**Length of Residency***			**Quality of Life**		
18-24	71.7	28.3	< 2 years	76.9	23.1	Unsatisfied	62.5	37.5
25-34	65.6	34.4	2-10 years	59.9	40.1	Neutral	59.0	41.9
35-54	54.9	45.1	11-20 years	54.9	45.1	Satisfied	58.8	41.2
55-64	45.5	54.5	>20 years	55.4	44.6			
65+	61.2	38.8						
Education*			**Mental Health**			**Fruit and Veg. per Day**		
Less than BA/BS	55.1	44.9	Diagnosed	64.9	35.1	0-2 Servings	60.3	39.7
BA/BS and Higher	66.2	33.8	Not Diagnosed	56.2	43.8	3+ Servings	55.9	44.1
State or Federal Benefits*			**Needs Help with ADLs***			**Physical Activity**		
Received Benefits	50.8	49.2	Needs Help	45.3	54.7	0 - 2 Times per Week	62.1	37.9
Did Not Receive	62.5	37.5	Does Not Need Help	61.0	39.0	3+ Times per Week	55.4	44.6
Poverty Status			**Arthritis**					
Below 150% poverty	61.6	38.4	Diagnosed	61.2	38.8			
Above 150% poverty	57.5	42.5	Not Diagnosed	57.4	42.6			
Employment			**Neighborhood Safety**					
Employed full/part time	60.9 56.0	39.1	Felt Safe	56.3 59.6	43.7			
Not employed		44.0	Did Not Feel Safe		40.4			

1. Symbols indicate the following: * is for p< .05 , ** is for p <. 01, *** is for p<.001.
2. The n of 379 includes those who answered the Willingness questions to enable comparison of the same cases in Table 2.

This subsample is more likely to have higher socioeconomic status than those set at missing, but not enough to warrant further weighting adjustments.

Table 2. Characteristics of Respondents Who Were Willing or Unwilling to Use the Health Campus (n = 379)

	Unwilling %	Willing %		Unwilling %	Willing %		Unwilling	Willing
Race/Ethnicity*			Ever Had Asthma			Heart Condition***		
African American	35.8	64.2	Diagnosed	35.6	64.4	Diagnosed	72.2	27.8
White/Caucasian	44.8	55.2	Not Diagnosed	45.6	54.4	Not Diagnosed	41.5	58.5
Latino (any race)	27.8	72.2						
Gender			Health Status			High Cholesterol**		
Male	44.7	55.3	Fair or Poor	52.8	47.2	Diagnosed	58.4	41.6
Female	45.8	54.2	Good to Excellent	44	56	Not Diagnosed	40.1	59.9
Age Group*			Length of Residency*			Quality of Life		
18-24	54.1	45.9	< 2 years	41.9	58.1	Unsatisfied	35.8	64.4
25-34	35.4	84.6	2-10 years	38.3	61.7	Neutral	54.5	45.5
35-54	42.3	57.7	11-20 years	45.8	54.2	Satisfied	45.2	54.8
55-64	52.4	47.6	>20 years	51.7	48.3			
65+	54.9	45.1						
Education			Mental Health			Fruit and Veg. Daily		
Less than BA/BS	48.3	51.7	Diagnosed	39.3	60.7	0-2 Servings	49.2	50.8
BA/BS and Higher	38.5	61.5	Not Diagnosed	46.3	53.7	3+ Servings	39.2	60.8
State or Federal Benefits*			Needs Help with ADLs			Physical Activity*		
Received Benefits	49.2	50.8	Needs Help	56.4	43.6	0 - 2 Times per Wk	51.6	48.4
Did Not Receive	37.5	62.5	Does Not Need Help	43.4	56.6	3+ Times per Wk	39.5	60.5
Poverty Status *			Arthritis					
Below 150% poverty	45.1	54.9	Diagnosed	51.7	48.3			
Above 150% poverty	37.9	62.1	Not Diagnosed	41.7	58.3			
Employment *			Neighborhood Safety**					
Employed full/part time	39.8	60.2	Felt Safe	41.6	58.4	40		
Not employed	54.2	45.8	Did Not Feel Safe	60				

1. Symbols indicate the following: * is for p< .05 , ** is for p <. 01, *** is for p<.001.

Table 3. Respondents' Top Three Factors Contributing to Their Willingness to Use the Health Campus and to Develop Trust in Cedar by Subgroups[2]

Factors Contributing to W7111ngness
Respondents (n =305)
Professionalism (40.3%)
Highly Rated Staff(36%)
Ease of making Appointments/Relationship w1thProvider (27%) (tied)

Factors Contributing to Trust
Respondents (n = 305) Health Provider's Skill (39.6%) Safety & Cleanliness (36.3%)
Facility's Reputation (29.6%)

"Unaware and Sub-gronps" Unaware (n =166)	%	"Aware" and Subgroups Aware (n = 139)	%o	"Unaware and Subgroups" Unaware (n = 1i	%	'"Aware" and Subgroups Aware (n = 139)	%
Highly Rated Staff	38.5	Professionalism	46.9	Health Provider's Skills	42.7	Health Provider's Skills	35.7
Professionalism	36.6	Highly Rated SWI	3L5	Safety & Cleanliness	38.4	Cleanliness/Safety	33.8
Ease of making Appointments	30.3	Relationship with Provider	31.5	Facility's Reputation	30.3	Experience w Cedar-&Rep[1]	29.
Unaware and Willing (n = 141)		**Aware and W11ling (*n* = 65)**		**Unaware and Wiling (*n* = 141)**		**Aware and W11ling (*n* = 65)**	
Highly Rated Staff	47.9	Professionalism	52.3	Health Provider's Skills	51.3	Health Provider's Skins	47.5
Professionalism 41.9		Highly Rated Staff	38.6	Safety & Cleanliness	4!6.2	Facility's Reputation	40.0
Ease of Making Appointments	28.7	Modem Facility	37.3	Facility's Reputation	35.3	Safety & Cleanliness	30.1
Unaware and Um,•illing (*n* = 25)		**Aware and Unwilling (n = 74)**		**Unaware and Unwilling (*n* = 25)**		**Aware and Unwilling(n=74)**	
Ease of Making Appointments	51.8	Professionalism	44.8	Health Provider' s Skills	46.3	Safety & Cleanliness	42.5
Professionalism	23 _5	Relationship with Provider	38..6	Facility's Reputation	34.3	Facility's Reputation	38.2
Highly Rated Staff	18.7	Highly Rated Staff	25.8	Transparency & Communication	28.9	Experience with Cedar	30.3

1. Of the 507 respondents, 305 (60.1%) answered all three of the "awareness", "willingness", and "trust" questions are added in this table. Of those aware of Cedar, (66.5%) answered willingness and trust questions, and of those unaware, 55.7% answered them.
2. Reputation of Cedar Campus was ranked a close fourth to experiences with Cedar at 29.3%.

Table 4. Stepwise Logistic Regression Results with Strongest Predictive Effects of Awareness Cedar Replaced Former Hospitals and Willingness to Use It[1]

	Percent with Attribute	Adjusted Odds Ratio[2]	p.- value (Wald)
Awareness.the.Campus.Replaced.Previous.Hospitals.(n.±.9❸❺).....			
Living there more than two years	89.8%	2.89	0.014
African American	67.0%	1.77	0.023
3+servings fruits/veg. daily	36.8%	1.78	0.015
Personal experience w/campus important to trust	24.7%	1.62	0.047
Provider skills are important to trust	39.7%	0.59	0.019

	Percent with Attribute	Adjusted Odds Ratio[2]	p.- value (Wald)
Willingness.to.Use.the.Health.Campus.(n.±.966).	.		
...Family below 150% of the poverty line (imputed).	42.6%	0.66	0.100
Ever had heart condition	11.7%	0.23	0.002
Ever had asthma	24.2%	3.00	0.001
3+servings fruits/veg. daily	36.8%	1.96	0.014
Transparency important to trust	21.1%	1.89	0.050
Provider skills important to trust	39.7%	1.84	0.022
Cultural competency important to trust	6.5%	0.40	0.069

1. Logistic regrssion is based on revised sample sizes due to listwise deletion of missing data from a combination of the variables in the model. Since 22.7% of respondents failed to provide income data, researchers imputed the poverty variable using the other demographic variables, in order to avoid a large drop in sample. No other variable had 10% or more missing. If poverty level is excluded from the model, then "safety of the residential area," which is highly correlated with poverty level, makes inclusion in the model.

2. An adjusted odds ratio with no predictive effect is 1. If in reverse order where the presence of an attribute leads to the decline of willingness or awareness, the adjusted odds ratio is less than 1. Thus, for the strongest predictor, heart problems, which had an adjusted odds ratio of .234, one can say the odds of an adult with a heart condition is .234 of the odds of a respondent without a heart condition to be willing to use Cedar, controlling for 150% poverty level, having asthma, fruit and vegetable consumption,and three factors importantto trust. This odds ratio can be reversed by taking its inverse: 1/.234 = 4.27 which would be stated as “The odds of an adult with a heart condition is 4.27 times

greater to be unwilling to use Cedar than the odds of someone without a heart condition, controlling for 150% poverty level and the other prementioned variables." This is significant at p=.002.