Institute for Healthcare Improvement

Organizational Trustworthiness in Health Care

Innovation Report

ihi.org

Authors

Tricia Bolender, Improvement Advisor, Institute for Healthcare Improvement

Becka DeSmidt, Project Director, Institute for Healthcare Improvement

Kate Feske-Kirby, Research Associate, Institute for Healthcare Improvement

Keziah Imbeah, Senior Research Associate, Institute for Healthcare Improvement

Bhargavi Sampath, Senior Research Associate, Institute for Healthcare Improvement

This IHI innovation project was conducted from January to October 2022.

IHI's innovation process seeks to research innovative ideas, assess their potential for advancing quality improvement, and bring them to action. The process includes time-bound learning cycles (typically 30, 60, or 90 days) to scan for innovative practices, test theories and new models, and synthesize the findings (in the form of the summary Innovation Report).

Acknowledgments

The work presented in this report is generously funded by and completed in close partnership with the American Board of Internal Medicine (ABIM) Foundation. IHI is grateful to the ABIM Foundation for co-leading this work with us, particularly Daniel Wolfson, Tim Lynch, Leslie Tucker, Dana Levin, and Kelly Rand. We also thank Susan Edgman-Levitan for her thought leadership and partnership in this work.

The authors also extend our heartfelt thanks to the interviewees that shared their insights and experiences, with a special thank you to the following organizations for their generosity with their time and insights: AltaMed, Anne Arundel Medical Center, Bon Secours Mercy Health (Toledo – Tiffin and Defiance Hospitals), Brigham Health, Greater Baltimore Medical Center, M Health Fairview, Parkland Health and Hospital System, Southern Jamaica Plain Health Center, and Texas Health Resources.

How to Cite This Document: Bolender T, DeSmidt B, Feske-Kirby K, Imbeah K, Sampath B. *Organizational Trustiworthiness in Health Care*. Boston: Institute for Healthcare Improvement; 2022. (Available at www.ihi.org)

Institute for Healthcare Improvement

For more than 30 years, the Institute for Healthcare Improvement (IHI) has used improvement science to advance and sustain better outcomes in health and health systems across the world. We bring awareness of safety and quality to millions, accelerate learning and the systematic improvement of care, develop solutions to previously intractable challenges, and mobilize health systems, communities, regions, and nations to reduce harm and deaths. We work in collaboration with the growing IHI community to spark bold, inventive ways to improve the health of individuals and populations. We generate optimism, harvest fresh ideas, and support anyone, anywhere who wants to profoundly change health and health care for the better. Learn more at ihi.org.

Contents

Executive Summary

Trust between patients and clinicians, between clinicians and the health care organizations where they work, and between communities and their health care organizations is essential. Over the past 50 years, however, this trust has measurably declined, particularly in communities of color.

The Institute for Healthcare Improvement (IHI) partnered with the American Board of Internal Medicine (ABIM) Foundation to identify key organizational-level drivers and change ideas that repair, build, and strengthen trust between health care organizations and clinicians, and between health care organizations and the communities they serve. The project distinguished between interpersonal and institutional trust, the latter being the focus of this report, and centered equity by seeking to learn from and design for the experiences of historically marginalized communities.

This report describes a theory of how to repair, build, and strengthen trust, presented as a three-step approach with specific change ideas and associated measures for improvement.

Background

Trust at multiple levels — between patients and clinicians, between clinicians and the organization where they work, and between communities and their health care organizations — is essential for optimal functioning of the health care system.

Over the past half century, however, this trust has measurably declined. A 2020 background paper states: "In 1966, 73 percent of Americans said they had great confidence in the 'leaders of the medical profession'; only 34 percent said the same in 2012. In 2015, only 37 percent of the public told Gallup that they had a 'great deal' or 'quite a lot' of confidence in the medical system, compared with 80 percent in 1975."[1] All American institutions saw similar declines in trust over this period, according to the same Gallup poll, but the drop is greatest in the health sector.[1]

Medical mistrust is even deeper in communities of color. An October 2020 poll by The Undefeated and the Kaiser Family Foundation found that 70 percent of African Americans believe that people are treated unfairly based on race or ethnicity when they seek medical care.[2]

Research Project Aim, Approach, and Timeline

The Institute for Healthcare Improvement (IHI) partnered with the American Board of Internal Medicine (ABIM) Foundation on a research project to identify key organizational-level drivers and change ideas that repair, build, and strengthen trust between health care organizations and clinicians, and between health care organizations and the communities they serve. The research project distinguished between interpersonal and institutional trust, the latter being the focus of this report. The output of this work, as described in this report, is a theory of how to repair, build,

and strengthen trust, presented as a three-step approach with specific change ideas and associated measures for improvement.

Our research activities center equity by seeking to learn from and design for the experiences of historically marginalized communities — particularly communities and clinicians who are Black, Indigenous, and people of color (BIPOC). The initial vision of this collaboration between the ABIM Foundation and IHI was to identify opportunities to strengthen trust; in our interviews and literature review, we found that many health care organizations are beginning with a trust deficit, given the historical and current harms that marginalized groups and especially Black people experience. The framing in this report emphasizes the need to rebuild trust and design systems to prevent future harms.

The project used IHI's innovation cycle methodology to conduct research on organizational trustworthiness in health care. Innovation cycles are a reliable, efficient, and time-bound approach designed to answer specific research questions, assess their potential for advancing quality and safety in health care, and prepare them for action.

Innovation cycles involve a scanning phase (literature review), a focus phase (transitioning from an early descriptive theory to a normative theory that can be tested), and, finally, validation, summary, and dissemination (see Figure 1 and Table 1).

Figure 1. Organizational Trustworthiness in Health Care: IHI Innovation Cycle Timeline (January–October 2022)

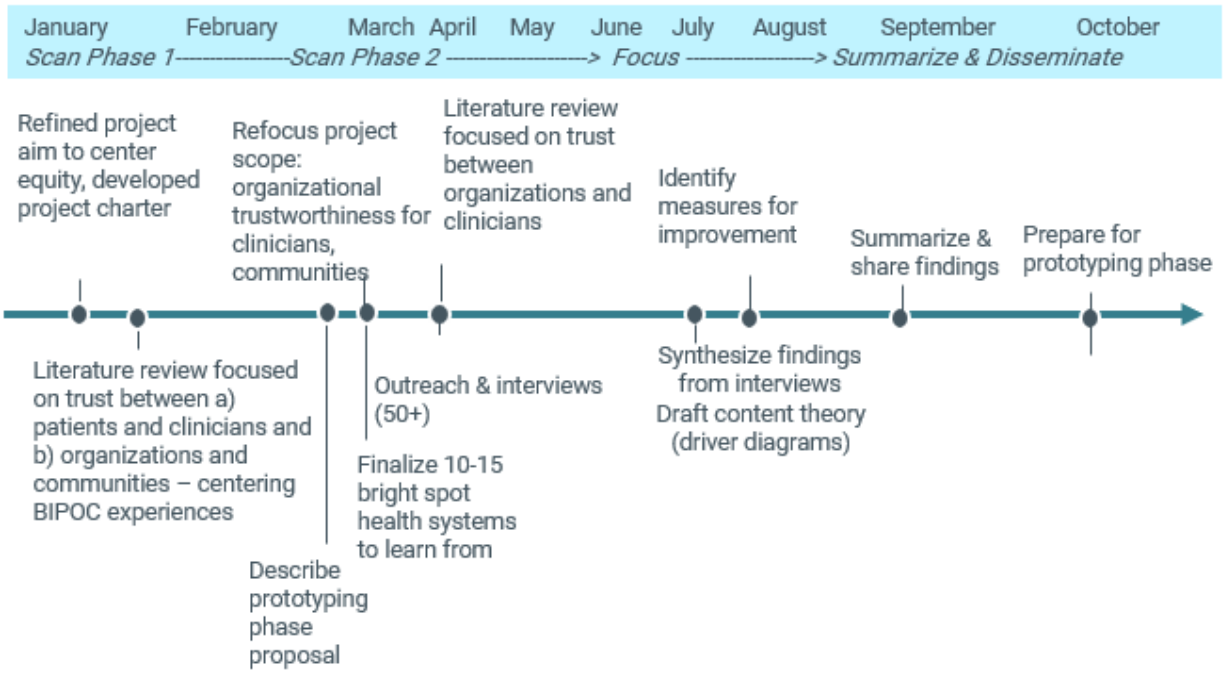


Table 1. Organizational Trustworthiness in Health Care: IHI Innovation Cycle Components

IHI Innovation Cycle Component	Activities
Literature Review	Question: What repairs, builds, and strengthens trust between health care organizations and the communities they serve, and between organizations and clinicians? Centering experiences of BIPOC communities and clinicians
Identify High- Performing Health Systems	Survey data crosswalk to identify hospitals that perform highly on measures related to trust: • NRC Health loyalty database (scores hospitals based on consumer loyalty) • HCAHPS (measures patient experience) • SOPS (measures patient safety culture)
Interviews	In-depth interviews with leadership teams from 8 health care organizations, totaling 50+ interviews with high-performing health system leaders, thought leaders, and context experts
Content Theory	• Develop and refine driver diagrams to organize our theories of community and clinician trust in health care organizations • Monthly check-ins with ABIM Foundation partners and project faculty for input • Surface impactful change ideas and promising areas of overlap
Finalization	• Identify measures for improvement • Design approach to test change ideas through prototyping Collaborative • Finalize deliverables and distribute report

Integrating Expert Insights

Through monthly touchpoints with the ABIM Foundation team, one-to-one and team meetings with faculty experts, Jessica Greene and Dawn Johnson, and conversations with IHI leaders and Innovation Team colleagues, we integrated feedback on the process and findings.

Activities included:

- Clarifying key questions
- Prioritizing a balanced list of health care organizations to learn from
- Identifying key roles of leaders to interview
- Refining interview guide
- Surfacing themes and key takeaways from interviews
- Synthesizing findings into working theories

Methodology

Anti-Racist Research Approach

IHI acknowledges that in its work to improve health and health care around the world, there is a risk of exacerbating inequities if we are not intentional about addressing them. As one of our partners described it, we need to "explicitly" but not "exclusively" focus on race — that is, take an intersectional approach with anti-racism at the center.

Racism is deeply implicated in the topic of trust. Systemic and structural racism is embedded in all levels within health care and informs the past and present experience of mistrust in health care by BIPOC individuals and communities. Without acknowledging this reality, it is difficult if not impossible to rebuild trust with those communities.

Several strategies were employed in this project to reduce the risk of widening existing inequities in clinicians' and communities' trust in health care organizations (see Table 2).

Table 2. Research Strategies to Reduce the Risk of Exacerbating Inequities

Research Activities	Potential Risks of Inequities	Approaches to Mitigate Risk
Literature Review	Peer-reviewed published papers may miss health systems that have earned a high degree of trust with BIPOC individuals/communities	Expanded search beyond just peer-reviewed articles to grey literature, blogs, and others
Data Analysis	Health care systems that earn high levels of trust with BIPOC individuals/communities may not appear at top of list of data analysis	Leveraged relationships and qualitative sources (IHI staff, project faculty, interviewees) to identify additional health systems to learn from
Interviews	• Overemphasis on content experts vs. context experts • Risk of lack of racial diversity in interviews • Interview strategy prioritizes C-suite members in initial scope of work	• Ensured diversity in interviewees (>50% POC) • Learned from patients, community members, and clinicians — in addition to health system leaders

Interviewee Quotes:
"Trust is… [downstream] of a reparations model; acknowledgment of unbelievable wickedness that's taken place from 1619 to now."

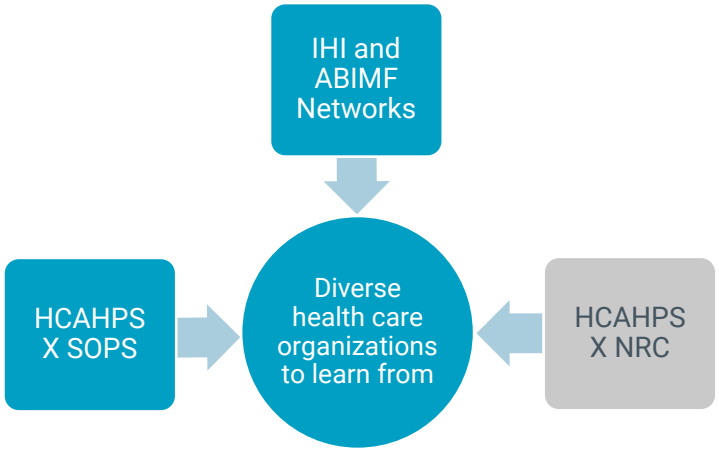
"We couldn't possibly have a conversation about trust if we're not talking about racism in medicine… For 87% of history, we were codifying white supremacy."

"As a clinician, one of the things I think about a lot is the use of race in clinical algorithms and how that perpetuates racial disparities in the care we provide… They use race as a biomedical construct and not a social construct."

Identifying High-Performing Health Care Organizations

We sought to identify a balanced selection of high-performing health systems (see Figure 2) using a two-pronged approach: 1) drawing on a data crosswalk to surface organizations that scored high on patient experience using Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys, Agency for Healthcare Research and Quality Surveys on Patient Safety Culture (SOPS), and NRC Health consumer loyalty surveys; and 2) leveraging IHI and ABIM Foundation networks.

Figure 2. Method to Identify a Balanced Set of High-Performing Health Care Organizations



This two-pronged approach enabled the team to identify and learn from varied organizations of differing sizes, locations, and academic affiliations, and which serve diverse populations.

Leaders at the seven health care organizations listed below engaged in in-depth interviews:

- AltaMed, Los Angeles, CA
- Anne Arundel Medical Center, Anne Arundel, MD
- Bon Secours Mercy Health (Toledo – Tiffin and Defiance Hospitals), OH
- Brigham Health & Southern Jamaica Plain Health Center, Boston, MA
- M Health Fairview, Fairview, MN
- Parkland Health and Hospital System, Dallas, TX
- Texas Health Resources, TX

We spoke with 50+ individuals in the following roles:

- C-suite members: CEO/President, COO, CNO, CMO, Chief Innovation Officer, Chief Equity Officer

- Vice Presidents and Directors: Operational Excellence; Patient and Family Experience; Quality and Safety; Community Health/Partnerships/Advancement; Civic Engagement; Resiliency; Organizational Ethics
- Clinicians
- Community Members/Patients
- Patient/Family Advisory Council Members
- Thought Leaders/Researchers on trust, burnout, workforce well-being

Literature Review

The ABIM Foundation conducted a thorough literature review of trust across many relationships in health care (patient to clinician, clinician to clinician, public to researchers). In addition to building on that foundational resource, the research team (see Appendix A) scanned academic and grey literature to strengthen understanding of what erodes and enables trust in clinicians and community members' experiences of the health care organizations where they work and/or receive care.

In our focus on community experiences, the literature review explored themes of rebuilding, repairing, and restoring trust with historically marginalized communities; the clinician-focused literature review surfaced themes of power, decision-making, and values alignment. The team also drew on learnings from previous IHI innovation cycles and project work on equity, community health, and workforce well-being.

Designing the Interview Guide

An interview guide was iteratively designed with the input of the core research team, faculty, and ABIM Foundation leaders and researchers. The interview guide featured three versions with questions aimed at health care leaders, clinicians, and community members (see Appendix B).

Key interview topics included the following:

- Understanding trust within a leader's role and organizational priorities and strategies;
- Drivers of trust and loss of trust between clinicians and communities;
- Exploring communication, decision-making, feedback channels, prioritizing quality care, and processes to redress harm as trust-building activities with clinicians;
- Exploring community engagement, processes to redress harm, and power dynamics in relationships with historically marginalized communities; and
- Measurement of trust.

Findings: Reasons Behind Community and Clinician Lack of Trust

As previously stated, trust in American health care organizations has measurably declined in the past 50 years. The experiences of BIPOC communities, in particular, has resulted in significant mistrust of health care organizations and is rooted in structural and institutional racism. It is important to understand the reasons and experiences behind this lack of trust to inform efforts to repair and rebuild trust.

Based on our research, Figure 3 outlines the reasons behind a lack of trust for health care organizations among communities and clinicians. Both groups cited personal experience, unclear motivations and decision-making, and misaligned values as key reasons for the lack of trust in health care organizations.

Figure 3. Key Reasons for Community and Clinician Lack of Trust for Health Care Organizations

Misgivings from **personal and/or historical experience**	• For communities, a consequence of **who** health systems have historically prioritized and neglected and **what** harm they have experienced over time • For clinicians, a consequence of **who** is affected by lack of support from the organization and resulting outcomes
Misdoubts about **motivation and/or decision-making**	• For communities, uncertainty about **why** health systems seek to promote trust • For clinicians, uncertainty about **what** inputs and motivations inform decisions by health system leaders
Misalignment in **values**	• For communities, concerns regarding **how** health system leaders will engage in building trust • For clinicians, concern about divergence between organizational and clinician values (the **why** of the work)

Interviewee Quotes:

"There are employees in their 60s who could not be born [at the hospital] — a horrible legacy to overcome."

"People of color, women [recognize] that there will be a certain standard of care that you get that's not optimal. You kind of can't hold the system to the highest standard because it will fall short of that. You give a lot of grace. Getting optimal care is unlikely, so you fight for it, and forgive a lot — which is why Black patient experience scores are so high: 'Well, you didn't kill me, so I will give you a pass.'"

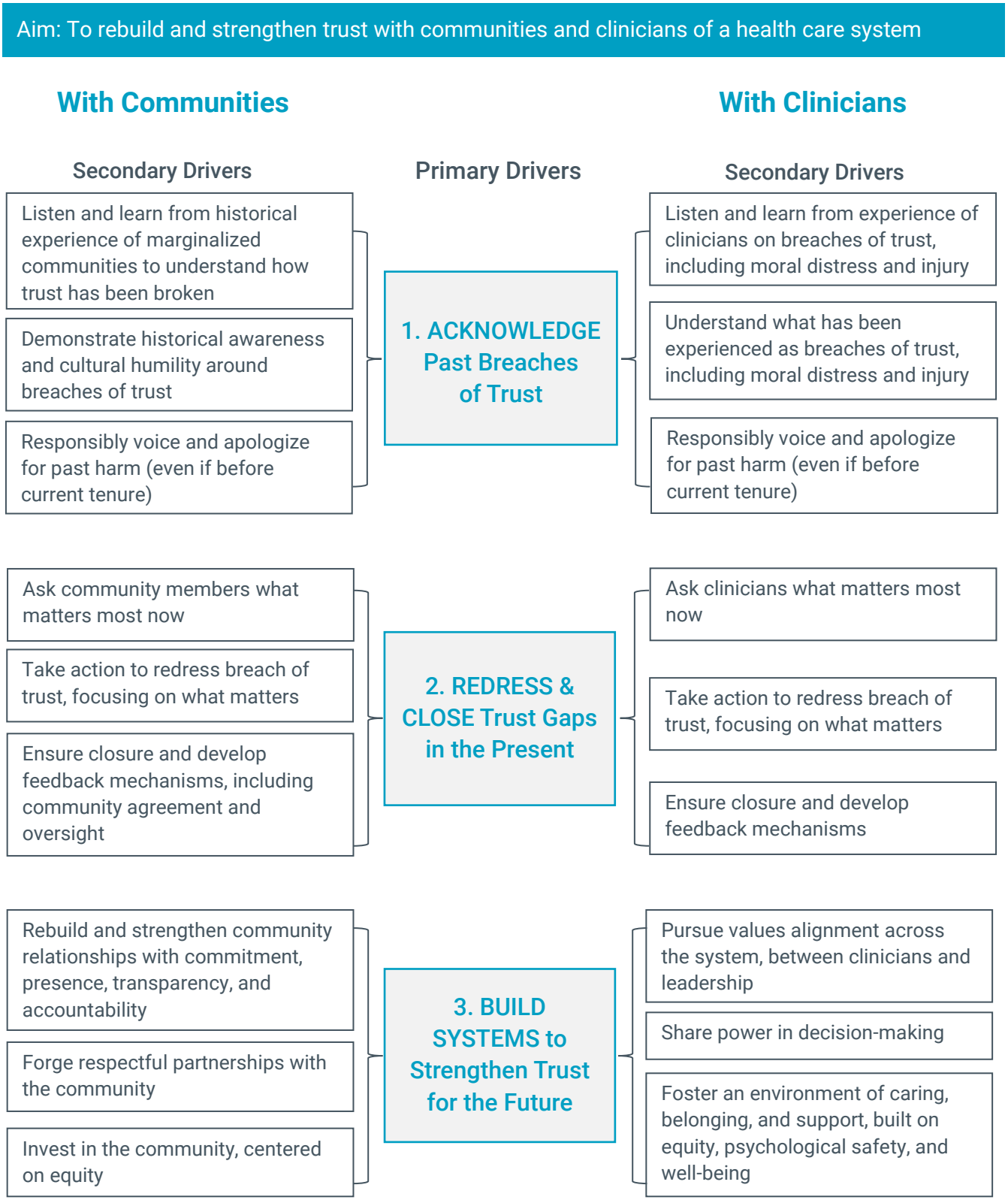
Three-Step Approach to Rebuild and Strengthen Trust

The three-step approach to rebuild and strengthen trust is inspired by the work of Michelle Morse, MD, MPH, and Bran Wispelwey, MD, MPH, who designed and tested a model called Healing ARC to address systemic racism leading to inequitable patient outcomes at Brigham Health in Boston, Massachusetts.[3]

In the Healing ARC, organizational leaders first acknowledge breaches of trust; second, redress broken trust by offering direct solutions to current harms and reparations for past harms; and third, seek closure through conversation with affected groups to ensure that they are satisfied with the solution and new systems in place to prevent future trust ruptures.

The three-step approach that IHI and ABIM Foundation developed based on our research (see Figure 4) adapts the Healing ARC in the context of trust and adds an emphasis on building systems to strengthen trust for the future. The approach is depicted in Figure 4 as a driver diagram, a visual display that shows the relationship between the overall aim of the project, the primary drivers that contribute directly to achieving the aim, the secondary drivers that are components of the primary drivers, and specific change ideas to test for each secondary driver (see tables that follow). See Appendix C for articles and other resources that informed the driver diagram and change ideas described below.

Figure 4. Driver Diagram: Three-Step Approach to Rebuild and Strengthen Trust in Health Care Organizations



Change Ideas to Rebuild and Strengthen Trust with Communities

1. ACKNOWLEDGE Past Breaches of Trust

Secondary Drivers	Change Ideas
Listen and learn from historical experience of marginalized communities to understand how trust has been broken	• Leadership and workforce learning circles to understand the history of the region, health care locally, and the institution and its impact on the community, historically and in the present • Listening tours with leadership and workforce going to communities (especially historically marginalized communities) and asking about breaches of trust (e.g., Coming to the Table)
Demonstrate historical awareness and cultural humility around breaches of trust	• Health system leaders show up with vulnerability, sharing their personal history and reflections of own biases and growth in becoming aware of and sensitive to historic and present-day realities • Acknowledge historical harm, naming the specific events, practices, and policies that give cause for distrust and address how this harm contributes to existing power imbalances • Commit to and take part in collective reflection among the workforce to understand personal and institutional biases and the gaps in knowledge, skills, and capabilities needed to advance equity
Responsibly voice and apologize for past harm (even if before current tenure)	• Name the injustice committed, acknowledge the harm to and conflict with the local community, and apologize when appropriate

2. REDRESS & CLOSE Past Breaches of Trust

Secondary Drivers	Change Ideas
Ask community members what matters most now	• Set up accessible meetings with key stakeholders and community members to discover what matters most now
Take action to redress breach of trust, focusing on what matters most now	• Take specific action based on what ongoing experiences constitute harm to the community and what matters most now • Share the specific action plan or steps with the community and welcome feedback
Ensure closure and develop feedback mechanisms, including community agreement and oversight	• Ask the community what can help restore and rebuild trust • Develop a mutual agreement on how to address and close current trust gaps with the community • Integrate feedback mechanisms to measure and ensure progress in closing trust gaps

3. BUILD SYSTEMS to Strengthen Trust for the Future

Secondary Drivers	Change Ideas
Rebuild and strengthen community relationships with commitment, presence, transparency, and accountability	• Articulate a clear institutional commitment to building trust, specifically naming the communities historically marginalized by health care systems whose trust must be earned (what) • Transparently share institutional and personal motivations behind prioritizing trust with specific community (why) • Create and embed transparency and accountability systems, including role definition, processes, tools, public reporting, and information disclosure • Define the role of executives and the workforce in fostering trust both within the organization and with the community • Create processes to respond to and repair relationships for instances of harm to community members (e.g., restorative justice coordinator) • Provide tools and resources to enable ongoing reflection and learning, both individually and within teams • Publicly report on organizational performance on health equity and meeting community needs • Ensure information disclosure with the public is always relevant, accessible, timely, and accurate
Forge respectful partnerships with the community	• Share community member and/or patient stories at leadership meetings to ground everyone in why this work matters • Invite patients and community members to join health system meetings to share their experiences and perspectives • Launch Community Advisory Councils, partner with community ambassadors, and invite community members into formal positions on organizational teams to gather community feedback • Co-create culturally relevant messaging with community members • Cultivate authentic, mutual relationships with local leaders and organizations, bringing humility and recognizing the power and assets of the community • Secure funding and compensation for community partners and organizations • Engage in inclusive or community-directed decision-making • Demonstrate public institutional support for social justice and commitment to serving historically marginalized communities • Use institutional power and platform to support and advocate for local community interests

Invest in the community, centered on equity	• Co-design with community programs to meet unmet social needs (e.g., transportation needs, day care, housing insecurity, food insecurity) • Recruit and retain a diverse workforce so the organization represents the demographics of the local community as much as possible • Leverage institutional role as local employer and purchaser to hire, buy, and invest locally to build wealth in community • Evaluate how the health system has been and continues to be a part of the community and removed from the community (where the facilities are located, who tends to receive care, who makes up the workforce, who makes up the leadership, whose voices are elevated)

Bright Spot Examples

During interviews with health care organizations, we gleaned examples of how some of these organizations have worked and are working to rebuild and strengthen trust with communities.

M Health Fairview: Resorative Justice Coordinator

- An innovative role in the Equity Strategy Office designed to support patients and employees to resolve conflict, with a focus on equity
- Restorative justice practices focus on repairing harm by giving "those affected by wrongdoing the opportunity to decide what repair looks like"
- One of the first health systems to hire a full-time coordinator role to offer "support, training, and leadership development" and build capacity across M Health Fairview
- Recognizes the harm that comes from incidents like microaggressions
- Creates standard processes to address and reduce incidents of discrimination and racism

"Mandela's Truth and Reconciliation Commission taught us a lot about what it's like to do restorative justice. What are the processes required? Hearing the story [that's been] excluded [and] reconciling it with our own." —Chief Equity Officer

"[This is] not just the patient complaints department… [this addresses issues when] patients or employees haven't received justice based on racism." —Quality Manager

Parkland Health and Hospital System: Community Health Workers

Community health workers (CHWs) are health promoters embedded in the communities they serve to identify and understand gaps in the community and respond to emerging needs. The program involves:

- Developing a 160-hour curriculum to train and develop CHWs
- Equipping CHWs to assist in delivery of services that address the social determinants of health, and bridging gaps between communities, individuals, and providers

- Providing CHWs with the tools to conduct community outreach and education
- Channel to address vaccine hesitancy, tackle misinformation, and promote community health

"You cannot move the needle in a space of equity without truly engaging and working alongside the community you serve." —Director, Community Social Impact

M Health Fairview: East Side Health and Well-Being Collaborative

A dedicated program designed to share power and responsibility in the interest of equitably improving the health and well-being of the community, the Well-Being Collaborative consists of the following:

- Sustainable partnerships among community leaders to develop a long-term strategy on producing health and self-sufficiency in the community
- Cultural Broker Program: Compensated community partners who are members of the community (Hmong, Latinx, and African American) and dedicated to serve as bilingual, bicultural navigators for staff and community members
- East Side Table: 13 community organizations working together to make the preparation of meals at home easier for neighbors and cultures in the community
- Policy Work Committee: Foster power among and within the Collaborative and with partners and community members to better engage with policies that affect the health and well-being of East Side residents

"We are doing 'with' not 'to' the community. We need a model that is sustainable as needs and opportunities change in a community." —VP, Community Advancement

"Building trust and improving equity have to begin with acknowledging that trust has been broken — by our organizations and by sites writ large." —System Executive Director, Community Health Equity and Engagement

AltaMed Health Services: Civic Engagement and Advocacy

Initiatives foster civic engagement among overlooked and underserved communities, focusing on dismantling policies and systems that negatively impact residents.

- Get Out the Vote: Educate and mobilize community members to increase voter turnout in priority precincts
- Workforce Development: Cultivate socially aware, culturally competent physicians and health care leaders
- COVID-19 Response, Testing, and Vaccines: Developed a responsive model for testing and vaccination to support local communities of color
- Protecting the ACA and Medi-Cal: Advocating for the protection and expansion of access to essential health coverage

"When I first took this role in working toward building community partnerships, we heard ways in which we were perpetuating health inequities. We had to be vulnerable and ask our communities, 'We hear you and what can we do better?'" —Chief Operating Officer

"We aren't outsiders delivering care to the community. We are community members delivering care to the community… To build trust we have to show up and advocate on issues that matter locally." —VP, Health Services Operations Quality

Change Ideas to Rebuild and Strengthen Trust with Clinicians

1. ACKNOWLEDGE Past Breaches of Trust

Secondary Drivers	Change Ideas
Listen and learn from experience of clinicians on breaches of trust, including moral distress and injury	• Listening tours with clinicians (especially BIPOC clinicians) and asking about breaches of trust and where they may be asked to do work in conflict with their values
Understand what has been experienced as breaches of trust, including moral distress and injury	• Open and honest conversations with clinicians to learn and understand specific areas constituting moral distress and injury that affect their work and well-being
Responsibly voice and apologize for past harm (even if before current tenure)	• Name the injustice committed, acknowledge the harm to and conflict with values, and apologize when appropriate

2. REDRESS & CLOSE Past Breaches of Trust

Secondary Drivers	Change Ideas
Ask clinicians what matters most now	• Set up one-to-one and small group meetings with clinicians to discover what matters most now, ensuring safe space for open and honest discussion • Ask clinicians what values matter most to them and their work
Take action to redress breach of trust, focusing on what matters most now	• Take action to redress breaches of trust and misalignment with values
Ensure closure and develop feedback mechanisms	• Ask clinicians what success looks like around trust and build feedback mechanisms to measure and ensure this • Develop agreements with clinicians to address current gaps in trust • Encourage open, candid communication within traditionally hierarchical and power-imbalanced clinician relationships (e.g., between physicians and nurses, residents and attendings, etc.)

3. BUILD SYSTEMS to Strengthen Trust for the Future

Secondary Drivers	Change Ideas
Pursue values alignment across the system, between clinicians and leadership	• Enlist staff participation in setting vision and critically analyzing organization's mission and goals[4] • Facilitate conversations between clinicians and administrators or leaders to co-design department's values • Co-create clear, reciprocal expectations between clinicians and administration (e.g., Virginia Mason's physician compact)[5] • Give clinicians resources and time to lead their own quality initiatives based on what matters most to them • Build strong institutional ethics committee to prevent moral distress/injury • Ask questions and listen deeply to uncover and address underlying fears and assumptions when communicating policy changes
Share power in decision-making	• Tailor communication processes to the concerns and working styles of clinicians • Engineer consensus-building into administrative decision-making • Invite clinicians to sit on decision-making committees to ensure their interests are represented (e.g., to define best practices or review policy changes or technology implementations for their impact on clinician workflows) • Increase clinician autonomy and workflow control through optimizing staffing composition, exploring alternative scheduling, and improving workflow to reduce cognitive burden
Foster an environment of caring, belonging, and support, built on equity, psychological safety, and well-being	• Create a process to quickly attend to clinicians' emotional needs after adverse event, bullying, or workplace violence • Ensure leaders have the time and capacity to effectively listen to and act on clinician concerns • Demonstrate care for clinicians by prioritizing their needs and experiencing the front lines with them (e.g., attending nursing council meetings, coming into hospital during COVID) • Follow through on issues clinicians raise to demonstrate reliability and commitment to solve problems and reliability • Stratify employee satisfaction data according to different demographics (e.g., race/ethnicity, gender, level, etc.) • Offer small, affinity-based peer support groups • Destigmatize failure by highlighting learning gained through challenges in work; use the power-distance index (i.e., distance in power between people in different roles) and encourage those with more power to set the tone for open communication and valuing the opinions of others

Bright Spot Examples

During interviews with health care organizations, we gleaned examples of how some of these organizations have worked and are working to rebuild and strengthen trust with clinicians.

Brigham Health: Inclusivity and Belonging

Investment in diversity-informed and -oriented trainings and culture builds trust between clinicians and health systems by creating a sense of inclusivity and belonging. The Brigham Health Center for Diversity and Inclusion:

- Aims to enhance workforce diversity through career advancement, professional development, and increased recruitment and retention of diverse clinicians and staff
- Includes unconscious bias training, diversity and inclusion dialogues and trainings, mentorship, and advisory committees

The Office of Diversity, Equity, and Inclusion (DEI):

- Supports the organizational efforts to increase diversity at all levels through the creation and maintenance of a culture of respect and belonging
- Includes Brigham's Leadership Development curricula on core DEI principles, employee resources groups, and practices for increasing underrepresented minorities for hiring, retention, and promotion across the organization

[On building inclusive culture]: "Each step of the way, reminding people, [the] words we use, signs we put up, [it] all makes a difference." —Vice Chair for Diversity, Equity, and Inclusion

Texas Health Resources: Structural Changes for Clinician–Hospital System Trust

The organization's perspective is that if providers are well cared for, they care well for their patients. Therefore, investing in and reinforcing trust between clinicians and leaders is essential, as the following initiatives demonstrate:

- Integrated Service Line Model: The system service line committee structures pair clinical and operational leaders to have shared responsibility for achieving clinical outcome goals. These service line committees also provide a channel for clinicians to delineate practice recommendations, vet new ideas and innovations, and promote physician buy-in and accountability through peer-to-peer interactions.
- Physician Leadership Council: Built on current medical staff structures, physician leaders are elevated to serve on a system-level group that focuses on medical staff policies and processes as well as other matters pertinent to clinical practice within the delivery organization.
- Physicians Lead!: A 10-month skill development program structured to strengthen physicians' leadership capability in their everyday work; 280 physicians have thus far completed the program.

[On responsiveness]: "One of the things I love about Texas Health… if someone from any department sends you a note to say, 'I'm concerned about this,' you respond. We have been recognized for our workplace culture; that shared responsibility is one of the reasons." —Chief Medical Officer

Parkland Health and Hospital System: Institutional Ethics Committee

Since the COVID-19 pandemic, this committee has emphasized organizational support for clinicians, while also considering patients and patients' concerns. Committee aims include:

- Building relationships with clinicians: Considering how to disseminate standards of care, listen and mitigate clinicians' concerns
- Presence and accessibility: Members of the committee are available, in the units and on the floors, while also showing that whatever crisis protocol they create will need to fit within the institution
- Leveling the power dynamic: A support system for providers and patients that can mitigate emotional and moral distress and take that load off clinicians

[On the pandemic helping the Ethics Committee earn trust]: "Went from, 'Oh gosh, ethics is involved…' to 'Oh great, ethics is involved'. [The committee is] a visible way to build resilience for clinicians [and address] the moral injury, residue of the pandemic, emotional distress. [Having a resource to] call for assistance feels like someone had your back and you were making a good decision based on good policy, good education, interdisciplinary decisions… [serves as an] antidote to [cognitive and mental load]." —Chair for Ethics Committee

Measurement for Improvement of Organizational Trustworthiness

In improvement science, measurement is a critical part of testing and implementing changes. Measures tell a team whether the changes they are making lead to improvement.

Three types of measures guide improvement work:	
Outcome Measures	• Voice of the customer or patient • How is the system performing? What is the result?
Process (and Infrastructure) Measures	• Voice of the workings of the system • Are the parts/steps in the system performing as planned?
Balancing Measures	• Looking at a system from different directions/dimensions • Are changes designed to improve one part of the system causing new problems in other parts of the system?

Measurement Guidance

Design Principles

Three design principles will be critical to refine and strengthen measurement of trust:

- **Align measurement strategy to existing organizational priorities and requirements**
  Simple, rapid assessments of clinician and community member trust should complement other metrics collected less frequently, such as quarterly or annual employee engagement surveys, patient experience scores, statistics on staff retention, patient utilization of services, and so on.
- **Minimize survey burden and prevent survey fatigue among respondents**
  Keeping measurement simple is essential to sustainably track progress in improvement efforts, and to demonstrate respect for the time and energy of individuals whose trust health care organizations aim to earn.
- **Stratify data by race, ethnicity, gender identity, sexual orientation, zip codes, and other demographic factors to identify and address inequities**
  Centering equity in this work requires that organizations understand which demographic groups may be experiencing the most harm and the least trust, so they can focus efforts accordingly.

As work to improve organizational trustworthiness moves forward, we will need to evaluate the feasibility and utility of measures, revise, and refine them in close collaboration with participating health care organizations. This includes collecting feedback on operational definitions of measures, phrasing of survey questions, and experiences of collecting data. Data collection of qualitative measures is also encouraged so we can more deeply understand how respondents understand questions and what experiences drive their scores.

Align with Existing Outcome Measures

We do not only seek to improve trust for its own sake. Decades of research has made the case that improving trust can increase patient experience and patient outcomes, priorities that are central for health care organizations.

To the degree possible, efforts to improve trust should align with measures hospitals report publicly such as quality, patient experience, and health equity data. Many health care organizations may begin this work by selecting outcome measures they are already tracking and seeking to improve — for example, through community health work, efforts to engage and retain their workforce, health equity initiatives, and/or diversity, equity, and inclusion programs.

Most health care organizations already implement surveys that measure proxies of trust among community members and clinicians. Health care organizations may also identify outcome measures from surveys like the ones listed below.

Surveys Commonly Used by Health Care Organizations

Population: Clinicians or Health Workers

- Employee Experience, Employee Engagement, Engagement and Likelihood to Recommend Health System: Press-Ganey, Gallup, Mayo Clinic Leadership Dimensions Assessment
- Safety Culture and Psychological Safety: Surveys on Patient Safety Culture (SOPS)
- Burnout and Well-Being: Maslach Burnout Inventory, Mini-Z, Stanford Professional Fulfillment Index, ProQOL, Copenhagen Burnout Inventory

Population: Community Members

- NRC Health Loyalty Index

Population: Patients

- Patient Experience: Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)
- Patient-Reported Outcomes: Patient-Reported Outcomes Measurement Information System (PROMIS)

Suggested Measures

Outcome Measures

Two simple measures can also offer regular insight into clinician and community member trust in the health care organization, as described below.

Measure Name	Operational Definition
Clinician trust in the health care organization	Measure the level of trust clinicians have in the health care organization at which they work or are employed **Question:** What is your level of trust in the organization's administration? **Numerator:** Rating on a 0–10 scale **Denominator:** Sample size **Calculated as:** Average score (numerator/denominator) **Balancing Measures:** Stratify by the department and demographic factors (race, ethnicity, sexual orientation, gender identity, zip code, etc.) **Reported:** Quarterly using a run chart for each stratum
Community trust in the health care organization	Measure the level of community trust in the local health care organization **Question:** What is your level of trust in the local health care system? **Numerator:** Rating on a 0–10 scale **Denominator:** Sample size **Calculated as:** Average score (numerator/denominator) **Balancing Measures:** Stratify by the department and demographics **Reported:** Quarterly using a run chart for each stratum

Infrastructure Measures

Infrastructure measures are types of process measures that help an improvement team understand how the system is working to achieve intended results. Infrastructure measures are binary — they show whether or not activities or system features are in place. Below are a few examples (this list is not comprehensive).

Measure Name	Operational Definition
Formal process for incorporating clinician and/or community member input into decision-making	Develop a formal process for incorporating clinician and/or community member input into strategic decision-making and/or conversations about values **Measure:** Completion status (yes/no) **Numerator:** Number of care units that have completed **Denominator:** Number of care units **Reported:** Percentage of care units
Standardized approach for collaborative meetings	Conduct meetings with community members and/or clinicians using a standardized facilitation approach which promotes transparency, a balance of advocacy and inquiry, and has a clear decision-making rule **Measure:** Completion status (yes/no) **Numerator:** Number of care units that have completed **Denominator:** Number of care units **Reported:** Percentage of care units
Clear institutional commitment to building trust	Articulate a clear institutional commitment to building trust, specifically naming the historically marginalized communities whose trust must be earned **Measure:** Completion status (yes/no) **Numerator:** Number of care units that have completed **Denominator:** Number of care units **Reported:** Percentage of care units
Process for publicly reporting on health equity and meeting community needs	Publicly report on organizational performance on health equity and meeting community needs **Measure:** Completion status (yes/no) **Numerator:** Number of care units that have completed **Denominator:** Number of care units **Reported:** Percentage of care units
Document outlining the role of executives and workforce in fostering trust	Define the role of executives and the workforce in fostering trust both within the organization and with the community **Measure:** Completion status (yes/no) **Numerator:** Number of care units that have completed **Denominator:** Number of care units **Reported:** Percentage of care units

Process Measures

Teams will identify process measures linked to the specific change ideas they are testing. Below are a few examples (this list is not comprehensive).

Measure Name	Operational Definition
Executive leadership rounds	Process measure of the number of opportunities to listen and learn from the experience of clinicians **Task:** Executive rounds by leaders to listen and learn from experience of clinicians on where trust has been broken and to ask what matters to clinicians **Measure:** Count of number of rounds **Calculated as:** Count of rounds **Reported:** Monthly using run chart
Updates provided to clinicians on action items aimed at increasing trust	Process measure of the number of times updates are provided to clinicians on action items aimed at increasing trust **Task:** Action item progress **Measure:** Count of updates provided on action items aimed at increasing trust **Calculated as:** Count of updates **Reported:** Monthly using run chart
Share stories of community experiences in leadership meetings	Process measure of how often leadership meetings include a community member story to ground the team in why this work matters **Task:** Share stories of community member experiences **Measure:** Count of meetings at which a community member story was shared **Calculated as:** Percent of meetings **Reported:** Monthly using run chart

Appendix A: Research Project Team

Leslie Pelton, MPA, Vice President

Leslie Pelton, MPA, Vice President, Institute for Healthcare Improvement (IHI), has more than 20 years of experience managing, leading, and facilitating successful organization transformation and performance improvement with health care delivery organizations. She works with leaders in health systems, academic medical centers, community hospitals, and community health centers to develop and implement improvement strategies, especially as they relate to design and implementation of equitable, accessible, and effective care. In addition to advising leaders and teams, she conducts individual leadership development coaching with a specialization in supporting physicians as leaders. She brings to each of these individuals and organizations in-depth experience with strategic planning, leadership and team development, and organizational change.

Becka DeSmidt, MPH, Project Director

Becka DeSmidt, MPH, Project Director, IHI, collaborates with and coaches health care organizations on quality improvement, change management, and workforce well-being, and has designed and delivered impactful online educational content on quality, safety, and leadership to learners across the world. She was previously a consultant in business planning at MassGeneral Brigham (formerly Partners Healthcare) where she supported leadership across the health system with data analytics and strategic planning on projects related to population health management. As a former researcher at Advisory Board, a health care research, consulting, and technology firm that serves over 3,000 hospital members in the US and worldwide, she partnered with health system clients on service line strategy and clinical technology investment decisions.

Bhargavi Sampath, MPH, Senior Research Associate

Bhargavi Sampath, MPH, Senior Research Associate, IHI, designs and leads rapid-cycle innovation projects, examining intractable challenges in health care and developing frameworks and tools to support quality improvement. She conducts research initiatives and develops content to inform IHI's varied projects and programs, with a particular focus on climate action in care delivery, health equity, and whole system quality. Prior to joining IHI, she was a researcher at the Advisory Board Company, leading international health system research projects on value-based care, complex patient management, and patient flow. She holds a Master of Public Health from the Boston University, with a focus on Health Policy and Management and Maternal and Child Health, and graduated with a degree from the University of Michigan, Ann Arbor, in Neuroscience and Anthropology.

Keziah Imbeah, MSc, Senior Research Associate

Keziah Imbeah, MSc, is a Senior Research Associate on the IHI Innovation Team, which serves as the organization's internal engine for research and development of new care models. Her work includes rethinking how science of improvement and research methods can further equity and antiracism in health care, developing programs for health equity officers, and surfacing practices related to workforce safety in health care. She also co-leads IHI's internal equity and

culture team. Prior to working at IHI, her work has focused on chronic disease management and mental health policy in sub-Saharan Africa. During her time at the Chatham House's Centre on Global Health Security (now the Centre for Universal Health), she contributed to a project looking at universal health coverage in Ghana. She completed her Masters in Global Health and Development from University College London and her Bachelors in Molecular and Cell Biology from Harvard University.

Kate Feske-Kirby, MA, Research Associate

Kate Feske-Kirby, MA, Research Associate, IHI, works on a variety of research projects with the IHI Innovation Team, including patient safety. Previously, she was a clinical research coordinator and assistant at the Center for Violence Prevention at the Children's Hospital of Philadelphia, where she supported pediatric research on community violence and trauma-informed support.

Morgen Stanzler, MPH, Senior Project Manager

Morgen Stanzler, MPH, Senior Project Manager, IHI, is a global public health professional with project management experience in low- and middle-income countries, a passion for collecting and analyzing data to solve problems, and a commitment to continuous quality improvement.

Tricia Bolender, MA, MBA, Innovation Lead

As a global health care consultant and executive coach, Ms. Bolender advises Fortune 500 companies, governments, multilaterals, major foundations, nonprofits, and impact investors around strategy and impact. She serves as Faculty at the Institute for Healthcare Improvement, where she partners with governments in low- and middle-income countries around systems improvement. She received her BA from Harvard University, MBA from Columbia Business School, and MA in International Affairs from Columbia University. Her current focus is on behavior change, leadership, and innovation.

Dawn Johnson, MSN, RN, Faculty

With 25+ years of health care leadership, management, and clinical experience, Ms. Johnson is recognized as a dynamic executive leader with a proven record of advancing transformational change resulting from creating, interpreting, and managing health programs. Her work focuses on building equitable and sustainable pathways for healthy communities, and mentoring and supporting the next set of leaders and community champions by enhancing skills in policy, health care delivery, research, and health equity. She is the President and CEO of DHJ Services, which specializes in the intersectionality of policy, health equity, and the socioeconomic status of communities that have been historically marginalized. Ms. Johnson's professional experience includes more than 10 years of management consulting with health systems, payers, and providers, and 15 years of work with federal and state agencies on population health, program implementation, and policy and strategy development. She earned her Bachelors and Masters in Nursing Administration from the University of Maryland.

Jessica Greene, PhD, Faculty

Jessica Greene, PhD, is a Professor and the Luciano Chair of Health Care Policy at the Marxe School of Public and International Affairs at Baruch College, City University of New York. Her

mixed methods research focuses on patients' interactions with the health care system, and most recently has focused on what builds patient trust in clinicians and health care institutions. Prior to joining the faculty at Baruch College, she was a faculty member at George Washington University and the University of Oregon.

Todd Hatley, PhD, MBA, MHA, SSMBB, Senior Improvement Advisor

In addition to being a Senior Improvement Advisor at IHI, Dr. Hatley is the CEO of Integral Performance Solutions (IPS), a management consulting, coaching, and training firm, and is the Lead Faculty for the Zeis Extension's Programs for Improvement and Innovation at North Carolina State University. For over 20 years, he has helped organizations use process improvement methods to improve their performance. Also, he has served as an Adjunct Assistant Professor in the Department of Emergency Medicine at the University of North Carolina and as an Adjunct Undergraduate and Graduate Faculty for the Department of Health Science at Western Carolina University. His formal education includes an Associate of Sciences degree in Emergency Health Sciences, a bachelor's degree in Business Administration, a master's degree in Business Administration and Healthcare Administration, and a doctoral degree in Organizational Systems. His current research centers around how the concepts of adult development can support organizational improvement efforts. Dr. Hatley participated in numerous national projects and organizations, including serving as the Past President of the National EMS Management Association, Faculty Member for the National Highway Traffic Safety Administration's (NHTSA) Quality Management Initiative, and the NHTSA EMS Compass project. He is a member of the Society for Research in Adult Development (SRAD), member of the North Carolina Society for Industrial and Organizational Psychologists (NCIOP), and a senior member of the American Society for Quality (ASQ). He is a contributing author to the National EMS Physician Association's "Improving Quality in EMS" and Hubble and Hubble's "Advanced Trauma Care."

Appendix B: Interview Guide

Introduction

Thank you for taking the time to speak with us. The Institute for Healthcare Improvement (IHI) and American Board of Internal Medicine (ABIM) Foundation are partnering on a research effort to understand the actions leaders of health care organizations can take to build trust with clinicians and communities (with an emphasis on communities of color), and foster strong relationships between patients and clinicians.

We have identified highly trusted health care organizations by reviewing top performers on the NRC consumer loyalty index, SOPS (Surveys on Patient Safety Culture), and HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) — which are all strong proxy measures for trust.

We also seek to learn from health care organizations who serve diverse patient populations, are leading meaningful efforts to partner with historically marginalized communities, and are committed to diversity, equity, and inclusion within and outside their facility walls.

The goal of this interview is to understand how leaders at your organization understand their role in earning the trust of clinicians and community members, the strategies and practices in place toward that goal, and how you measure trust across those relationships.

During this interview, we will keep our conversations confidential within our research team and reach out to you for explicit consent to share any identifying information in our final report.

Are you comfortable with us recording the call for note-taking purposes?

For Health System Leaders

1. What does trust mean to you in your role at your organization?
2. Does trust factor into organizational priorities and strategies?
3. How is trust incorporated into strategies such as:
    - Safety culture
    - Clinician morale, well-being, engagement, and retention
    - Diversity, equity, inclusion, and access
    - Patient experience
    - Community outreach, engagement, and partnerships

Measurement

1. Do you measure trust at your organization?
2. Between the community and the organization?
3. Between clinicians and patients?
4. Between clinicians and the administration?
5. Between clinicians (physician and non-physicians; licensed and non-licensed, residents and attendings)?

Clinician Focus

1. In your view, what builds trust between clinicians and their employers?
2. What erodes trust?
3. Are there strategies that your organization uses to earn the trust of clinicians?
4. Do the design and impact of these strategies differ between executive clinicians, managers, and non-management direct care clinicians?
5. Do initiatives differ between physicians and non-physicians? Licensed and non-licensed?
6. How do you communicate the organization’s mission, strategies, and changes to clinicians?
7. Do you involve clinicians in decision-making? If so, how?

8. We have heard that clinicians have higher trust in an organization when they feel confident that the organization enables them to provide high-quality care to patients. How do you know your organization is reliably producing high-quality care?
9. How do you get feedback from clinicians? (Probe: How else beyond surveys?)
10. How do you know when there are problems with clinician morale? How about physical or psychological safety? Concerns about quality of care?
11. What systems are in place to address instances of psychological harm that clinicians experience — especially racism or other forms of discrimination?
12. How does this differ when the harm comes from a patient or family member, a colleague/peer, or a manager/leader?

Trust in Organization

First, we'd like to talk about the importance of trust between you and your organization/ employer.

1. What does it mean to you to trust your employer/organization?
2. Which roles do you consider when you think about your employer/organization? (For example, system-level leadership, clinical leadership, administrators, unit-level management, etc.)
3. How important is it to you to trust your employer/organization?
4. On a scale of 1 to 5 (5 being high), how trustworthy do you find your organization? Why?
5. What increases your trust in your organization?
6. What undermines your trust in your organization?
7. What could your organization do to earn your trust?
8. For clinicians who are Black, Indigenous, and people of color (BIPOC): How do you hold the tension of working as a BIPOC clinician in a primarily white organization and in a field that has been shaped by and tasked with upholding white supremacy?

Community Focus

1. How does your organization work to earn the trust of the local community?
2. Does your organization integrate community members into strategy and planning conversations?
3. Are there strategies at your organization to earn the trust of historically marginalized communities, especially Black, Indigenous, People of Color (BIPOC) communities?
4. Historically, what has eroded trust between historically marginalized communities and your organization?
5. What are current factors that undermine trust with historically marginalized communities?

6. Are there approaches in place to redress harm?
7. How do you think about power dynamics in building relationships with the community?
    - Do you feel it is different for different ethnicities? (Black, Hispanic, Asian, Native American, others)
    - What approaches have you found effective to balance the power dynamics between the institution and historically marginalized communities?

For Community Members

As a member of [name of] community/resident of [city/geographic area], we are interested in hearing your perspective on [health system].

1. What interactions have you had with [health system]?
    - Have you received care there? Has your family received care there?
    - If you received the care more than 3 years ago, was there a reason you haven't received care there, besides COVID?
    - [If yes]: How was your experience?
2. What is your overall perception of [health system]?
3. On a scale of 1 to 5 (5 being high), how much do you trust [health system]?
    - Why?
    - [For low trust (1-3)]: What makes you not really trust [health system]?
    - [For high trust (4-5)]: What makes you trust [health system]?
4. Would you say that your level of trust is similar to others in your neighborhood or community? If not, why?
5. What could [health system] do to better earn your trust?
6. Do you feel there is a lack of trust of [health system] among your community? Do you have a sense of the reasons for that lack of trust? Do you have a sense of if that differs by race, language, or other factors?
7. We'd like to learn your thoughts on specific strategies or programs that [health system] has led to partner with and better serve the community.
8. What is your perception of [specific strategies or programs of the health system that we've learned in interviews with health system leaders]?
9. If you're comfortable sharing, how do you identify in terms of your race, ethnicity, cultural identity, socioeconomic status, gender identity?

Appendix C: Resources That Informed the Driver Diagram and Change Ideas

- BuildingTrust.org (an initiative of the American Board of Internal Medicine Foundation)
- Taylor L, Nong P, Platt J. *50 Years of Trust Research: A Synthetic Review*. American Board of Internal Medicine Foundation; 2022.
- Greene J, Ramos C. A mixed methods examination of health care provider behaviors that build patients' trust. *Patient Education and Counseling.* 2021;104(5):1222-1228. 10.1016/j.pec.2020.09.003
- Greene J, Samuel-Jakubos H. Building patient trust in hospitals: A combination of hospital-related factors and health care clinician behaviors. *Jt Comm J Qual Patient Saf*. 2021;47(12):768-774. 10.1016/j.jcjq.2021.09.003
- Aitken M, Cunningham-Burley S, Pagliari C. Moving from trust to trustworthiness: Experiences of public engagement in the Scottish Health Informatics Programme. *Science and Public Policy*. 2016;43(5):713-723. 10.1093/scipol/scv075
- Bachmann R, Gillespie N, Priem R. Repairing trust in organizations and institutions: Toward a conceptual framework. *Organization Studies*. 2015;36(9):1123-1142. 10.1177/0170840615599334
- Baker DW. Trust in health care in the time of COVID-19. *JAMA*. 2020;324(23):2373. 10.1001/jama.2020.23343
- Boulware LE, Cooper LA, Ratner LE, LaVeist TA, Powe NR. Race and trust in the health care system. *Public Health Reports*. 2003;118(4):358-365. 10.1016/S0033-3549(04)50262-5
- Çelik M, Turunç Ö, Begenirbaş M. Role of organizational trust, burnout and interpersonal deviance for achieving organizational performance. *International Journal of Business and Management Studies*. 2011;3(2).
- Cramer S. Creating stronger bonds between health managers and clinicians. *HealthManagement.org*. 2015;15(1).
- Cunningham PJ. High medical cost burdens, patient trust, and perceived quality of care. *J Gen Intern Med*. 2009;24(3):415-420. 10.1007/s11606-008-0879-3
- Huang ECH, Pu C, Chou YJ, Huang N. Public trust in physicians—health care commodification as a possible deteriorating factor: Cross-sectional analysis of 23 countries. *Inquiry*. 2018;55:004695801875917. 10.1177/0046958018759174
- Kazemian S, Fuller S, Algara C. The role of race and scientific trust on support for COVID-19 social distancing measures in the United States. *PLoS ONE*. 2021;16(7):e0254127. 10.1371/journal.pone.0254127
- Larson HJ, Clarke RM, Jarrett C, et al. Measuring trust in vaccination: A systematic review. *Human Vaccines & Immunotherapeutics*. 2018;14(7):1599-1609. 10.1080/21645515.2018.1459252

- Linzer M, Neprash H, Brown R, et al. Where trust flourishes: Perceptions of clinicians who trust their organizations and are trusted by their patients. *Ann Fam Med*. 2021;19(6):521-526. 10.1370/afm.2732
- Linzer M, Poplau S, Prasad K, et al. Characteristics of health care organizations associated with clinician trust: Results from the healthy work place study. *JAMA Netw Open*. 2019;2(6):e196201. 10.1001/jamanetworkopen.2019.6201
- LoCurto J, Berg GM. Trust in healthcare settings: Scale development, methods, and preliminary determinants. *SAGE Open Medicine*. 2016;4:205031211666422. 10.1177/2050312116664224
- Miller F, Miller P. Transgenerational trauma and trust restoration. *AMA Journal of Ethics*. 2021;23(6):E480-486. 10.1001/amajethics.2021.480
- Musa D, Schulz R, Harris R, Silverman M, Thomas SB. Trust in the health care system and the use of preventive health services by older black and white adults. *Am J Public Health*. 2009;99(7):1293-1299. 10.2105/AJPH.2007.123927
- Nelson KE, Hanson GC, Boyce D, et al. Organizational impact on healthcare workers' moral injury during COVID-19: A mixed-methods analysis. *JONA: The Journal of Nursing Administration*. 2022;52(1):57-66. 10.1097/NNA.0000000000001103
- Parayitam S. The effect of competence-based trust between physicians and administrative executives in healthcare on decision outcomes. *Management Research Review*. 2010;33(2):174-191. 10.1108/01409171011015856
- Perlo J, Balik B, Swensen S, Kabcenell A, Julie L, Feeley D. *IHI Framework for Improving Joy in Work*. Cambridge, MA: Institute for Healthcare Improvement; 2017. https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx
- Rozenblum R, Lisby M, Hockey PM, et al. The patient satisfaction chasm: the gap between hospital management and frontline clinicians. *BMJ Qual Saf*. 2013;22(3):242-250. 10.1136/bmjqs-2012-001045
- Rural Health Value. *How Hospital Leaders Can Build Good Working Relationships with Physicians*. Univeristy of Iowa, Rupri, and Stratis Health; 2013.
- Rushton CH, Nelson KE, Antonsdottir I, Hanson GC, Boyce D. Perceived organizational effectiveness, moral injury, and moral resilience among nurses during the COVID-19 pandemic: Secondary analysis. *Nursing Management*. 2022;53(7):12-22. 10.1097/01.NUMA.0000834524.01865.cc
- Succi MJ, Lee SY, Alexander JA. Trust between managers and physicians in community hospitals: The effects of power over hospital decisions. *Journal of Healthcare Management*. 1998;43(5):397-415.
- Sullivan LS. Trust, risk, and race in American medicine. *Hastings Center Report*. 2020;50(1):18-26. 10.1002/hast.1080

- Wispelwey B, Morse M. An antiracist agenda for medicine. *Boston Review*. March 17, 2021. https://bostonreview.net/articles/michelle-morsebram-wispelwey-what-we-owe-patients-case-medical-reparations/
- Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. Cambridge, MA: Institute for Healthcare Improvements; 2016. https://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx

References

[1] Lynch T. Background Paper. ABIM Foundation Forum; 2018. https://abimfoundation.org/wp-content/uploads/2018/07/2018-ABIM-Foundation-Forum-Background-Paper.pdf

[2] Hamel L, Lopes L, Muñana C, Artiga S, Brodie M. *Race, Health, and COVID-19: The Views and Experience of Black Americans*. KFF; October 2020. https://www.kff.org/report-section/kff-the-undefeated-survey-on-race-and-health-main-findings/

[3] Wispelwey B, Morse M. An antiracist agenda for medicine. *Boston Review*. March 17, 2021. https://bostonreview.net/articles/michelle-morsebram-wispelwey-what-we-owe-patients-case-medical-reparations/

[4] Perlo J, Balik B, Swensen S, Kabcenell A, Julie L, Feeley D. *IHI Framework for Improving Joy in Work*. Cambridge, MA: Institute for Healthcare Improvement; 2017. https://www.ihi.org/resources/Pages/IHIWhitePapers/Framework-Improving-Joy-in-Work.aspx

[5] Improving Your Organization's Relationship with Your Physicians. Virginia Mason Institute. May 30, 2012. https://www.virginiamasoninstitute.org/part-1-would-you-like-to-improve-your-organizations-relationship-with-your-physicians