



TRUST

PRACTICE
CHALLENGE



COMPENDIUM

Table of Contents

3	Foreword
4	Preface
5	Trust: A New Strategic Initiative
6	Overview of Trust Practice Challenge
7	Practice Categories and Judges
8	Winners' Circle
9	Communications/ Knowing Your Patient
17	Conversations/Support
34	Leadership
43	Misinformation
50	Patient-Centered Design
67	Transparency
72	Value/Affordability
77	Index

Foreword

Christine A. Sinsky, MD

Trust. We know instinctively that trust is essential for so much of the good that happens in health care. Trust between patients and their physicians, between physicians and their employers, and between delivery systems and payers/regulators, among others, will influence experiences and outcomes for all.

In the fall of 2017, the ABIM Foundation Board of Trustees made the bold decision that trust in health care would be our new strategic direction. We would advance the dimension of trust by raising awareness, catalyzing interest, supporting research, convening diverse stakeholders and promoting best practices.

As one part of our growing focus on trust, the Trust Practice Challenge has allowed us to identify and highlight some of the amazing practices to build trust that are already ongoing within the medical community. The diversity of ideas that our call for submissions unearthed has been inspiring, signaling that, as health care providers, we already have the elements we need within our community to foster greater trust in health care. Through this compendium we share some of these bright spots and hope to inspire others to adapt and adopt similar practices within their own institutions.

From patient-centered design and leadership to transparency and supportive communication, it is clear that many in health care are already working without fanfare in varied settings to build a reservoir of trust. Radiologists in Colorado explaining results immediately after a diagnostic test to alleviate waiting anxiety for patients, an organization in rural Iowa providing a special clinic sensitive to the needs of the LGBTQ community, a delivery system in Hawaii dedicated to “getting rid of stupid stuff” that interferes with clinicians’ ability to care for patients...these practices and more are highlighted within.

I am excited about the opportunities ahead for the ABIM Foundation. We have touched on an issue that clearly matters. And by elevating awareness and action on this important dimension of healthcare, the Foundation can put its experience, knowledge and relationships to work in promoting trust as an operating principle in health care.

Trust is likely a key ingredient, part of the secret sauce, that will allow us to achieve the Quadruple Aim: so well described by Catherine Lucey, MD, of the University of California, San Francisco, as care better than we’ve ever seen; health better than we’ve ever known; cost we can all afford, delivered by professionals who find joy in their work as they commit to serve others. What could be better than that?



Dr. Sinsky, a board certified internist, is Chair of the Board of Trustees of the ABIM Foundation. She also serves as Vice President of Professional Satisfaction at the American Medical Association; she practiced for 30 years at Medical Associates Clinic and Health Plans in Dubuque, Iowa.

Preface

Richard J. Baron, MD and **Daniel B. Wolfson, MHSA**

In November 2017, we began investigating the topic of trust in health care by conducting face-to-face interviews with scholars, researchers, policy wonks, chief executives and others in health care who we knew had been deeply engaged with the issue.

What better way to determine how best to address the decline in public trust in health care than to hear from colleagues familiar the phenomenon of society's diminishing trust in established institutions?

So, we embarked on a listening tour.

We didn't employ environmental scans with customized algorithms. We put our feet to the pavement and visited with leading voices in clinical practice and academia to discuss what might be done to counter this troubling trend. We shared in advance a list of questions we wanted to cover; we did not use a formal interview guide, preferring to let our interviewees begin the conversation on the point that was most compelling or of interest to them.

Some of the main messages we heard in these collegial discussions was a genuine excitement that the ABIM Foundation was considering ways it might be effective in addressing the issue, reminders that the topic of trust had reared its head during the "managed care era" of the 1990s, and caution that the current political rancor was likely a symptom rather than a cause of eroding trust in society in general.

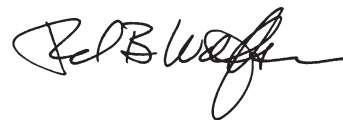
Some of the themes we identified from our conversations were the multiple meanings and definitions of trust, positive attributes such as teamwork and cooperative behavior that trust enables, and the various relational domains in which trust operates.

One of the most interesting and frequently made distinctions was between "emotional" (also called "intuitive") trust and "cognitive" (also called "deliberative") trust. These were described as different pathways through which trust was created, and everyone who made the distinction talked about how much more powerful the emotional/intuitive trust was than cognitive/deliberative trust. The latter would require greater monitoring of behaviors.

To conclude each interview, we came to the question of where the ABIM Foundation should focus its efforts regarding trust in health care. The most common responses were on organizational trust and trust and the media.

Armed with a great deal of wise commentary and advice, we returned with at least one clear thought: We would need to continue the conversation with an expanded audience of health care leaders from a variety of sectors and engaged in diverse activities. Our 2018 Foundation Forum, an annual gathering of respected voices in health care, gave us the opportunity to do just that.

From that meeting, we have begun developing our first initiatives, including the Trust Practice Challenge that has led to this compendium. The response to our open call for existing practices that have built or rebuilt trust in health care has energized our efforts and invigorated our thinking. We see this compendium as the first of many steps in collaborating with a broad array of organizations to help rebuild trust in health care. Working together, we can bring about change.



Dr. Baron is President and CEO of the American Board of Internal Medicine and the ABIM Foundation.

Mr. Wolfson is Executive Vice President and COO of the ABIM Foundation

Trust: A New Strategic Initiative

Trust is known to be an essential component for effective health care, and research has shown that the quality of health outcomes depends on a stable foundation of trusting relationships. Indeed, trust sits at the core of the patient-physician relationship, the most fundamental dyad in health care interactions.

Yet trust in health care has been in steady decline in the United States over the past several decades, with clear evidence that Americans' trust in the health care system is strained.

While 73 percent of Americans said they had great confidence in the leaders of the medical profession in 1966, only 34 percent said so in 2012. Eighty percent of Americans expressed a "great deal" or "quite a lot" of confidence in the medical system in 1975; by 2015, that number was 37 percent. And while the United States ranked highly (3rd out of 29 nations) in the satisfaction patients expressed in the care they received when they last visited a physician, we ranked 24th out of 29 in agreeing with the statement, "all things considered, doctors in the U.S. can be trusted."

In the fall of 2017, the ABIM Foundation's Board of Trustees selected trust as a renewed imperative in our work because of alarming evidence of a "trust gap" in health care. Promoting trust has been central to our mission to advance medical professionalism to improve health care. Trust is cited in many of the commitments outlined in the *Physician Charter*, such as maintaining trust by managing conflicts of interest, being honest with patients and preserving patient confidentiality.

The ABIM Foundation hopes to work with multiple stakeholders from all aspects of health care to help reverse the trends cited above. The Trust Challenge, and the ideas we hope it will generate for the field, is one such initiative. We are also exploring strategies to combat misinformation in health care, and partnerships to reach a critical mass in public discourse about ways to nurture trust and trustworthiness in health care practice.

One such collaboration is with JAMA (Journal of the American Medical Association), which has published 11 opinion articles developed from debate and work group discussions at the 2018 ABIM Foundation Forum, an annual meeting of the nation's leading voices in health care to examine a critically important concern.

With our successful *Choosing Wisely* campaign as a template, we hope to galvanize the health care community to look within for solutions, to work collaboratively to shape and share strategies that encourage trust, and to promote and engage in practices that create a strong foundation for trusting relationship throughout health care.

Trust Practice Challenge

Overview of Trust Practice Challenge

In January 2019, the ABIM Foundation officially announced the launch of its **Trust Practice Challenge**, an initiative to address the “trust gap” in health care by identifying practices that foster trust and trustworthiness in various aspects of the health care system.

Trust is known to be an essential attribute of effective health care, and research has shown that the quality of health outcomes depends on a stable foundation of trusting relationships. Yet trust in health care has been in steady decline in the United States over the past several decades.

The **Trust Practice Challenge** was open to anyone in health care and sought examples of existing practices that clearly build or rebuild trust. An open call for entries was extended to a wide spectrum of health care stakeholders, including health systems, group practices, health insurers, government and quasi-governmental agencies, foundations, regional healthcare collaboratives, medical professional associations, patient advocacy groups and employer coalitions.

In addition, supporting organizations such as the American Hospital Association, AcademyHealth, the Patient-Centered Primary Care Collaborative, the Society to Improve Diagnosis in Medicine, the Agency for Healthcare Research and Quality and the National Association of Accountable Care Organizations helped spread the word to their memberships and encouraged submissions.

The **Trust Practice Challenge** asked health care stakeholders to identify within their clinical sphere and/or organization, what practices have generated trust between them and patients, clinicians, health systems, hospitals or medical groups, commercial insurers, regulators and policy makers.

A “practice” could involve interactions between clinicians and patients, among clinicians, between clinicians and health systems/hospitals, or between patients and health systems/hospitals. Exemplary trust-building practices we knew of, among others, were disclosure of medical errors and subsequent apologies, guarantees of quality service levels and endorsement of clinicians during care transitions.

The Foundation assembled a seven-member panel of recognized leaders in health care to judge the Challenge submissions and select eight winners. (See List of Judges, page 7) The winners will present their submissions at the 2019 ABIM Foundation Forum, an annual gathering of many of the nation’s thought leaders in health care to discuss a topic of critical importance to the field.

The **Trust Practice Challenge** is the first step in the Foundation’s efforts to identify and disseminate practices that build and maintain trust, with the goal of offering a practical guide for those concerned about trust and trustworthiness in the health care system.

“Trust is indispensable to achieving high quality and effectiveness in modern health care,” said Richard J. Baron, MD, President and CEO of the ABIM Foundation and its partner organization, the American Board of Internal Medicine. “We want to promote practices that enhance certainty, confidence and reliability within crucial relationships that can significantly impact health outcomes.”

Trust Practice Challenge

Description of Practice Categories

The **Trust Practice Challenge** was designed with simple rules and guidelines to allow for the broadest interpretation of what actions and approaches build and maintain trust and trusting relationships throughout the health care system. In an organic way, the 68 submissions fell into some clear groupings that reflect many of the core attributes with which many have defined trust.

The practice categories as we identified them, based on the full collection of submissions, are as follows:

- **Communications/Knowing Your Patient** – practices that emphasize communications tools, models and channels for understanding the lived experience of patients, clinicians and other providers
- **Conversations/Support** – practices that encourage trusting relationships and interactions through the ways in which those providing care and those receiving care engage with each other
- **Leadership** – practices that demonstrate, cultivate and support efforts to nurture trust in clinical practice and relationships throughout the health care system
- **Misinformation** – practices that attempt to counter misinformation in health care and/or work to disseminate accurate information about medicine and health care
- **Patient-Centered Design** – practices that ensure consistency in clinical practice and focus on clinical practice approaches that position the varied interests/needs of patients as paramount
- **Transparency** – practices that reflect full disclosure of clinical and other information that would be important for good health care decision-making and effective health care delivery
- **Value/Affordability** – practices that promote awareness of and engagement involving the costs of health care and potential impact on patients and health systems

Trust Practice Challenge • List of Judges

Christine A. Sinsky, MD

Board Chair, ABIM Foundation and Vice President of Professional Satisfaction at the American Medical Association

Martha “Meg” Gaines, JD, LLM

Director, Center for Patient Partnerships

David Blumenthal, MD, MPP

President, The Commonwealth Foundation

Dhruv Khullar, MD, MPP

Researcher, Weill Cornell School of Medicine

Martín-J. Sepúlveda MD, ScD, FACP FAAP

IBM Fellow and Retired VP IBM Corporation

Virginia Tilden, PhD, RN

Senior Associate Dean for Research, Oregon Health & Sciences University

Robert Wachter, MD

Chair, Department of Medicine, University of California, San Francisco

Trust Practice Challenge

Winners' Circle

The ABIM Foundation is pleased to recognize the winners of its 2019 **Trust Practice Challenge**, a national initiative to identify and promote best practices that build trust among patients, physicians and health care organizations. Also recognized in this compendium are 22 meritorious entries that reflect the diverse and innovative ways that health care organizations are nurturing trust.

Graphic Medicine to Empower Patients to Trust Physicians Using Electronic Health Records

University of Chicago Medicine *Lolita Alkureishi, MD*

For the use of graphic medicine to foster better patient-physician interaction involving electronic health records **p. 10**

Relational Leadership Institute

Oregon Health & Science University *Brian Park, MD*

For building trust across teams through a learning collaborative focused on a relational approach to leadership **p. 18**

Voices of Duke Health Listening Booth and Podcast

Duke University School of Medicine, Department of Medicine *Anton Zuiker*

For building greater understanding through facilitated conversations among clinicians, medical students, residents, staff and patients **p. 20**

Colleges Advisory Program

Johns Hopkins School of Medicine *Robert Shochet, MD*

For developing a Colleges Advisory Program to model positive mentoring relationships between students and faculty **p. 35**

The Leader Index

Mayo Clinic and the Institute for Healthcare *Stephen Swensen, MD*

For creating an index to evaluate five key leader behaviors among clinicians and clinical staff that impact performance **p. 37**

Getting Rid of Stupid Stuff

Hawai'i Pacific Health *Melinda Ashton, MD*

For developing a process to identify practices that should be eliminated or modified in its electronic health record system **p. 51**

Prairie Parkway LGBTQ Clinic

UnityPoint Health *Kyle Christason, MD*

For developing a dedicated clinic program focused on primary care and special health care needs of the LGBTQ community **p. 53**

Trust in Transparency and Public Reporting

Wisconsin Collaborative for Healthcare Quality *Chris Queram*

For creating a data-sharing consortium of nearly 40 provider and dental organizations to improve clinical performance through transparency and public reporting **p. 68**

COMMUNICATIONS/ KNOWING YOUR PATIENT

Simple Gesture, Enormous Impact

Trust-building practices can be as straightforward as a firm handshake or as complex as a multi-modal team approach to patient care. The **Trust Practice Challenge** revealed the diverse ways that clinicians and other care providers are emphasizing trust as a fundamental principle of clinical practice. GreenField Health is an example of how simple efforts like proper name pronunciation can reap great reward. **p. 16**

WINNER COMMUNICATIONS/ KNOWING YOUR PATIENT

Practice Name: Graphic Medicine to Empower Patients to Trust Physicians Using Electronic Health Records

Author: Lolita (Maria) Alkureishi, MD, Associate Professor and Clerkship Director

Organization: University of Chicago Medicine

Practice Category: Communications/Knowing Your Patient

Relational Type: Trust between patient and physician

Description of Trust Practice

The University of Chicago developed a comic strip to foster better patient engagement involving electronic health record (EHR) systems based on published studies and systematic reviews on the impact of technology use on the patient-provider relationship and communication. By analyzing the literature, particularly those on patient perspectives, they identified three core advocacy behaviors that patients and family members should be aware of in order to promote a more collaborative and patient-centered EHR interaction with their providers.

The comic is entitled “Computers in the Clinic: YOUR ROLE!” and is listed in an easy-to-read ABC format. The first advocacy behavior is “A – Ask to see the screen,” and the comic depicts a patient feeling left out of the clinic visit because their provider is not sharing the screen and being transparent about what they are doing on the computer. On the second frame, the comic depicts a more ideal interaction where the patient lets the provider know they are feeling left out of the conversation and asks to see the screen, to which the physician responds by facilitating shared viewing to show the patient the EHR.

The second advocacy behavior is “B – Become Involved. Review your records with your doctor and ask questions,” and the comic depicts a scene where a patient notices that the EHR lists a medication they are not taking and tells the provider about the discrepancy. The provider thanks the patient for catching the error and they are able to correct it together.

The last advocacy behavior is “C – Call for Attention. If you have something sensitive to discuss, speak up and ask for your doctor’s full attention.” The comic shows a scene where the patient wants to discuss something difficult with their provider, who is more focused on the computer screen than on the patient. When the patient speaks up and asks the provider to pay attention to them, the physician turns away from the screen and gives the patient their complete focus.

The comic aims to orient patients to their role with respect to the EHR and actively invites them to try concrete behaviors that can help promote patient-doctor-EHR engagement. Research has found that when technology is used as an educational tool to promote discussion and dialogue, patients understand their medical conditions better, there are opportunities for shared-decision making and patient satisfaction improves.

Skills/Competencies

- Trust and engagement
- Fluency/facility with EHR
- Familiarity with patient education tools
- Effective workflow design

“At its core, our practice relies on trust. A patient needs to trust that their relationship with their provider is one that allows them to ask questions without fear of upsetting their provider or appearing as a challenging or “difficult” patient. Patients need to feel that their providers will be receptive to their questions. Patients need to trust that their engagement will be viewed as a positive by their health care team, and trust that the benefit of this involvement is increased understanding of their health and improved satisfaction with the decisions they make with their provider.”

Proof of Concept

Survey results show that patient-centered EHR advocacy is having an impact. Seventy-two percent (224/313) of pediatric parents and 70 percent (114/162) of adult patients agreed the comic effectively encouraged them to be more involved in the EHR during their visits. Sixty-seven percent (105/157) of adult patients and 57 percent (164/286) of pediatric parents said their provider was less distracted by the computer and more focused on them. Furthermore, 61 percent (98/160) of adult patients and 55 percent (158/286) of pediatric parents stated they understood more about their/their child’s health or treatment plan because of how their provider used the computer to provide education. Fifty-five percent (79/144) of adult patients and 47 percent (131/281) of pediatric parents were more satisfied with their relationship with their physician because of how they used the computer with them.

African American and Hispanic parents were more likely than White parents to ask to see the screen and become involved with the EHR due to the comic ($p=.023$, $p=.006$). Adult African American and Hispanic patients were more likely to ask to see the screen as a result of the comic compared to White patients ($p=0.010$). Lower education levels were associated with higher rates of self-advocacy behaviors in both groups including: asking to see the screen ($r_s=-0.180$, $p\leq.003$; $r=-0.2732$, $p=0.0008$ respectively), asking to be involved ($r_s=-0.193$, $p\leq.001$; $r=-0.2442$, $p=0.0028$ respectively), and calling for providers’ attention ($r_s=-0.125$, $p\leq.040$; $r=-0.1624$, $p=0.0494$ respectively). Adult female patients were more likely than male patients to ask to be involved with their doctor’s computer use ($z=2.176$, $p=0.0295$).

On telephone follow-up, all pediatric parents (50/50) and 90 percent (45/50) of adult patients remembered the comic. When asked about their behaviors at subsequent doctors’ visits, pediatric parents reported significant increases in asking to see the screen (median 3 vs. 4, $z = 5.178$, $p<.001$); calling for attention (median 3 vs. 4, $z=4.661$, $p<.001$); and feeling empowered to get more involved with computer use (median 3 vs. 4, $z=4.123$, $p<.001$). Adult patients reported an increase in asking to see the screen (median 3 vs. 4, $z=2.746$, $p<0.01$) at their subsequent doctors’ visits.

Replicability/Scalability

The patient engagement comic was designed to be easily read and understood by people with a range of literacy and educational levels. It is compact enough that it can be distributed on a small card and can be featured in other high-visibility settings such as in waiting rooms, clinic TV screens, etc. The team that developed the comic supports its reproduction and dissemination free of charge. Further, the comic requires no explanation and can be quickly read prior to a patient’s visit. The comic can be translated into other languages, making its use appropriate for a variety of different settings and patient populations.

For more information, contact Dr. Lolita Alkureishi at malcocev@peds.bsd.uchicago.edu

Practice Name: Choosing Wisely*

MERITORIOUS

Author: Tim Lynch, Senior Director of Programs

Organization: ABIM Foundation

Practice Category: Communication/Knowing Your Patient

Relational Type: Trust between patient and physician

Description of Trust Practice

Choosing Wisely, a multi-phase initiative now in its seventh year, began as a campaign to heighten awareness about medical overuse and to normalize conversations between patients and health care providers about appropriate care. Through education and clinical interventions, the campaign promotes evidence-based decision-making, helps patients talk with clinicians about the necessity of particular tests and treatments, and supports clinicians' efforts to build trusting relationships with patients and guide them toward smart and effective care choices.

The ABIM Foundation teamed with specialty societies to develop and disseminate evidence-based lists of five overused tests or treatments within their specialties. Partnering with the specialty societies grounded the campaign in collaboration and gave clinicians a leading and trusted role. More than 80 specialty societies have joined the campaign since its launch in 2012, creating more than 600 recommendations across the spectrum of specialties, including nursing, pharmacy and more. In addition, Consumer Reports, the Foundation's consumer partner for most of the campaign, created "Five Questions to Ask Your Doctor" as a patient tool to start conversations, and translated over 150 recommendations into plain language.

To foster implementation, the ABIM Foundation, with support from the Robert Wood Johnson Foundation, has funded several pilot projects to understand the best ways to implement recommendations and the impact of community collaboration on implementation efforts. Each project worked in a particular region and included at least one multi-stakeholder organization, two health systems with large shares of patients in the region, and at least one clinical education group. The seven communities and 14 delivery systems addressed 42 recommendations; the systems achieved reductions for 36 of the 42, three-quarters of them by 20% or more.

Skills/Competencies

- Interpersonal and communications skills
- Medical knowledge
- Systems-based practice

"Communicating well with patients is essential to build patient trust that a recommendation against obtaining a particular test or treatment is in the patient's best interest. Clinicians who master the recommendations within their sphere of practice can provide evidence-based care that gives patients the care they need in an efficient and effective ways that promote patient safety."

* Not eligible to be a winner of the Challenge

Proof of Concept

There is considerable evidence that *Choosing Wisely* is building trust. First, the campaign's success in generating more than 600 recommendations strongly suggests that our specialty society partners trust its value and effectiveness. Second, the campaign operates a learning network that disseminates information about implementation, engendering trust among multiple organizations. Competing delivery systems have shared their lessons learned through this network, a true example of collaboration and trust. Third, there is substantial evidence to support the idea that *Choosing Wisely* is changing practice, which would be extremely difficult to achieve in the absence of trust. Health systems have used *Choosing Wisely* to achieve substantial reductions in unnecessary services. In addition, physicians report that the campaign has been helpful in their relationships with patients. One study found that 75% of physicians in a large medical group felt more comfortable discussing unnecessary care with their patients due to the campaign.

Replicability/Scalability

Choosing Wisely has been highly responsive to changes in the health care system and forged critical partnerships around overuse, an increasing focus in medical training. Health systems and clinicians are finding *Choosing Wisely* to be a useful resource as they adjust to a new emphasis on appropriate care and value-based care from public and private payers. The Foundation works with the American Hospital Association, the Transforming Clinical Practice Initiative, the Patient-Centered Primary Care Collaborative and other organizations to spread *Choosing Wisely* in practice. Finally, the Foundation has inculcated stewardship principles in medical education through programs like *Choosing Wisely* STARS (Students and Trainees Advocating for Resource Stewardship)—which educates medical students about overuse and prompts them to lead institutional projects—and a grant program to support projects to teach residents about appropriate care.

For more information, contact Tim Lynch at tlynch@abim.org

Practice Name: Communication and Resolution Program (CRP) Certification Program

MERITORIOUS

Author: Thomas Gallagher, MD, Professor and Associate Chair, Department of Medicine

Organization: University of Washington

Practice Category: Communication/Knowing Your Patient

Relational Type: Trust between patient and organization

Description of Trust Practice

The Communication and Resolution Program Certification initiative takes a novel approach to improve a trust practice by providing in-depth expert review and feedback to organizations about the use of a Communication and Resolution Program (CRP). A CRP is a rapidly emerging trust-building practice for responding to an unexpected harm event in health care by giving providers, health care institutions and patients the opportunity to collaborate early, communicate effectively and reach resolutions expediently following an event. CRPs utilize a common set of essential commitments, elements and steps to improve safety and quality through event analysis and shared learning. CRPs ensure that patients and families harmed by health care have their needs met and promote learning within and across health care providers and institutions to prevent recurrences. Nearly 300 health care institutions nationally are currently implementing a CRP.

Incomplete implementation of CRPs, such as applying just some of the elements of a CRP to a case, is a significant challenge for the field. The CRP Certification Program improves implementation by providing feedback on how a CRP is functioning for an individual harm event. Institutions receive assessments of their response to an individual CRP case from a neutral panel of reviewers. Review panels include clinicians, risk managers, patient safety and quality improvement experts, and patient representatives. The application asks for detailed information on each aspect of the response, providing an opportunity for the submitting institution to reflect on its CRP. The panel reviews and discusses each element, and individuals from the submitting institution may anonymously join the meeting by phone to answer any unresolved questions. The review panel then decides whether to certify the case, or to certify with contingency, allowing the submitter to address gaps in its practice. A formal report is returned to the submitting institution, highlighting strengths and offering suggestions for improvement.

Skills/Competencies

- Transparent and empathic communication
- Peer support
- Event analysis

“A key part of this process has involved creating a secure application submission and review process that does not conflict with institutions’ peer review and quality improvement protections.”

Proof of Concept

The CRP Certification Program is providing useful feedback to submitting institutions, improving their CRPs, and building trust in the CRP process, which leads to higher trust among patients and families after harm events. To date, six of the seven participating institutions have submitted more than one case for review. The University of Washington also conducted interviews with 16 stakeholders, including representatives from submitting institutions, to assess their impressions of the program. They feel that the CRP Certification Program provides education on improving CRPs. Submitters find the feedback valuable, as it identifies gaps in their CRPs. Going through the certification process makes their program more robust, which improves the experience for patients and families.

Replicability/Scalability

The CRP Certification Program launched in Washington State in 2016. Since then, the concept has been adopted by BETA Healthcare Group, the largest professional liability insurer of hospitals on the West Coast. A national CRP Certification Program is planned in partnership with one or more national patient safety organizations. These partnerships will allow the CRP Certification Program to reach a wide, national audience and further strengthen this important trust practice.

For more information or to contact the program, visit communicationandresolution.org

Practice Name: Proper Name Pronunciation

Author: Charles Kilo, MD, CEO

Organization: GreenField Health

Practice Category: Communications/Knowing Your Patient

Relational Type: Trust between patient and physicians

MERITORIOUS

Description of Trust Practice

“I’m putting my trust in you, my doctor. So please know me, please remember me and part of that is getting my name right. Please remember how to pronounce my name.”

While patients might not explicitly make such statements, they commonly feel this way. Patients rely on clinicians to know them. Trust grows when an individual feels known – the depth of trust is related to the depth of the relationship that patients have with their physicians and the rest of the clinical team.

Getting someone’s name right is a very basic, but important component of clinical practice. In its electronic health record (EHR), GreenField Health registers patients under their official, formal names. However, if someone’s formal name is Robert, how does everyone on the team know that he prefers to be called Robert, Rob, Robbie, or Bob? And with complex names, sometimes first names but more often last names, being able to consistently pronounce an individual’s name correctly is equally important. To address this, GreenField Health puts each patient’s preferred name and the phonetic spelling of the name, when needed, in the EHR banner so that it is visible to everyone interacting with the patient’s chart. This allows everyone in the organization to correctly address the patient. It responds to the very human request to “please know me.”

Skills/Competencies

- Attentiveness
- Caring

“This simple trust practice relies on everyone’s diligence in addressing patients by their preferred names and pronouncing their names correctly, as a starting point and sustaining component in fostering trust.”

CONVERSATIONS/ SUPPORT

Gathering Round the Table

Acclaimed author and speaker Stephen M.R. Covey advises “Listen first” in his list of the 13 behaviors for building trust. Many meritorious entries in our **Trust Practice Challenge** – like Open Honest Questions – center on supportive discussions and systems. The Center for Courage & Renewal uses a specific form of inquiring in community trainings on how to develop trust. **p. 26**

WINNER CONVERSATIONS/ SUPPORT

Practice Name: Relational Leadership Institute (RLI)

Author: Brian Park, MD, Assistant Professor

Organization: Oregon Health & Science University

Practice Category: Conversations/Support

Relational Type: Trust among team members

Description of Trust Practice

The Relational Leadership Institute (RLI) at Oregon Health and Science University (OHSU) is a three-month leadership learning collaborative that combines executive leadership skills (focused on the “what” and the “how” of work) with relational leadership skills (focused on the “who” and the “why”). A relational approach to leadership emphasizes emotional intelligence, strength-based engagement with others and cultivation of trust and psychological safety on teams. It runs counter to the prevailing hierarchical model of leadership in health care, favoring practices that are collaborative, nurturing, and optimally engage all team members in a trustful environment. Evidence has shown that relational leadership practices characterize the highest performing teams in health care, leading to improved quality of care, patient satisfaction and provider satisfaction.

RLI delivers a 10-session curriculum to an inter-professional, cross-generational cohort, utilizing a mixed methods process to engage all learning styles, including large group didactics, small group activities, one-on-one skill practice, opportunities for reflection, assigned readings and the application of skills in participants’ professional settings. Each participant is assigned to a small group (6–8) that remains intact throughout the course and is facilitated by two prior RLI participants. Session trainers (subject matter experts) and small group facilitators actively model RL practices to engender trust and psychological safety. Participant feedback is regularly elicited and acted upon, with each session concluding with a group discussion of takeaways and opportunities for program improvement. A leadership pathway from participant to small group facilitator to session trainer has been developed, and participants are supported through curricula focused on relational facilitation skills and group activities to foster a sense of “community within a community.” The pathway provides a mechanism for participants to continue developing their RL skills by applying and teaching newly learned RL skills in a safe and supportive learning environment. It also builds local capacity for accelerated spread of RL.

Skills/Competencies

- Self-management
- Teamwork
- Coaching
- Advocacy

“The curriculum for RLI draws on key insights from existing literature and experience in relational leadership, community organizing, social psychology, anthropology, and sociology. RLI complements traditional healthcare leadership practices by emphasizing the four competency domains.”

Proof of Concept

We have completed a mixed-methods evaluation of the two pilot cohorts of RLI (RLI 1 and 2), including assessments post program and six months post program. In evaluating the overall course, 100 percent of participants of both RLI 1 and 2 agreed or strongly agreed with the statements, “I’ve learned practical skills that will help me in my work” and “I plan to use skills I have learned in the future.” At six months post program, 50 percent of participants of both RLI 1 and 2 agreed or strongly agreed with the statement, “I have reached out and connected with members of my RLI learning collaborative.” Participants reported a significant increase in self-assessed competence for all 11 competencies, many of which connect to trust, in the four course domains (p-value range: 0.013 to <0.001).

Participants also reported a significant positive shift in their level of agreement with eight of nine statements reflective of RL attitudes (p-value range: 0.041 to <0.001). The most marked shifts occurred in attitudes related to working in teams and supporting others. The proportion of participants who agreed or strongly agreed with the following statements shifted from 50 percent pre-RLI to 95 percent post-RLI: “I am confident that I can help launch a team and handle difficulties when they arise” and “I am confident I can support the growth and development of my colleagues.” Participants seemed to retain these skills and mindsets long term; six months post course, approximately 50 percent of participants reported that they were “moderately” or “fully” applying skills. Qualitatively, participants reported applying RL skills to increase self-awareness at work, enhance trust and collaboration on teams, and advance projects impacting systems and social change.

Replicability/Scalability

Launched in 2017, RLI is currently completing its fourth cohort and has enrolled over 100 participants in Portland, Oregon. The results of our RLI pilot demonstrate that RL skills and practices can be successfully learned, retained and applied by its participants. Our experience also suggests that a local community of practice can be fostered, creating a powerful force to help spread the practices and deepen participants’ engagement in the material.

The RLI content and curriculum is optimally positioned to be scaled and reproduced in other settings. Based on its early successes, RLI expanded to the University of North Carolina – Chapel Hill in April 2019, and plans are already underway for (Students and Trainees Advocating for Resource Stewardship) the University of Utah and the University of Colorado in integrating RLI within their institutions. A RLI National Collaborative team has formed with representative stakeholders from each of these institutions participating to identify how to most effectively scale and spread RLI across the country. Due to interest from existing, intact clinical care teams, PCP and OHSU are developing and piloting a program that would bring RL skills learning to their clinical settings. Key insights and evaluations from this clinical team pilot will enhance our understanding of other ways to effectively scale and disseminate RLI and RL practices in other settings.

For more information, contact Dr. Brian Park at parbr@ohsu.edu

WINNER CONVERSATIONS/ SUPPORT

Practice Name: Voices of Duke Health Listening Booth and Podcast

Author: Anton Zuiker, Communications Director

Organization: Duke University School of Medicine, Department of Medicine

Practice Category: Conversations/Support

Relational Type: Trust among team members

Description of Trust Practice

Voices of Duke Health, an initiative of the Duke Department of Medicine (School of Medicine) and the Duke Health Office for Patient Safety and Clinical Quality (Duke University Health System), invites Duke Health providers, staff, students, trainees, patients and visitors to have one-on-one conversations about what is meaningful in their lives, work and relationships through facilitated discussion in a listening booth.

These conversations are recorded and offered to participants for their own use and for sharing with family and friends. With the consent of the speakers, conversations also are aired in a podcast that is public and available to anyone. Audio recordings, photos and conversation transcripts are posted to our website (listeningbooth.info), and the podcast is promoted through newsletters, social media and posters. In addition, a mobile recording cart is regularly taken into the medical center hallways and to special events to invite people to answer a question of the day, often around gratitude or inspiration. These shorter sound bites are collected into themed segments for the podcast.

Podcast conversations have involved medical students, psychiatry residents, physicians, nurses, and other providers, as well as hospital presidents, staff, patients, spouses and children. The episodes have covered the death of the son of a beloved palliative care physician and his subsequent grief and interactions with hospital colleagues; the proper use of a stress ball; and medical student-faculty projects on patient communication and caregiver burnout. Episodes focus on stories of resiliency, inspiration, compassion, diversity of experience and empathy. The Voices team plans to grow this trust practice dramatically over the next few years, setting an ambitious goal of recording 5,000 voices by 2025.

Skills/Competencies

- Listening
- Sound editing and production
- Multimedia storytelling
- Journalism/communications

“At the heart of the Voices of Duke Health project is our passion for the art of listening. We know that health care, and life in general, is fast-paced and full of stressors. The listening booth fosters conversations between people, and provides time and space to slow down and listen to each other. The podcast similarly invites listeners to slow down and be informed and inspired by others. This project is informed by *What Patients Say, What Doctors Hear* by Danielle Ofri, MD, which explores the importance of listening to health care interactions.”

Proof of Concept

Duke believes one of the most important ways to build trust is to listen and to encourage listening. Voices of Duke Health reflects trust in these ways:

- Trust is strengthened between those participating in a conversation, which is facilitated by a host who listens, engages and ensures participants have a meaningful time in the listening booth.
- The review and approval process builds trust between participants and the Voices team because they publish the podcast episode only after all participants approve and feel good about how their words are being shared.
- Sharing, supporting and celebrating the stories of people validates their experiences, emotions, vulnerabilities and strengths.
- Building on the research and training expertise of colleagues in the Duke Patient Safety Center, the Voices team focuses on the positive emotions of well-being, especially gratitude. “When we listen to participants, we are conveying our trust in our colleagues and patients to be themselves,” said Anton Zuiker.

Replicability/Scalability

Most hospitals and academic medical centers have staff with the skills and competencies to replicate this project. Many may already be collecting voices for their videos or multimedia projects. The team that produces Voices of Duke Health includes a freelance radio journalist with sound editing and production skills; a third-year medical student with an interest in multimedia storytelling; a manager with 25 years of experience in journalism and communications; and a physician leader for patient quality and safety as well as provider wellness and resiliency.

For more information, contact Anton Zuiker at anton.zuiker@duke.edu

Practice Name: 3rd Conversation

MERITORIOUS

Authors: Jennifer Sweeney and Christine Bechtel, Co-Founders X4 Health;
Andrew-Morris Singer, Morris-Singer Foundation

Organization: X4 Health and 3rd Conversation

Practice Category: Conversations/Support

Relational Type: Trust between patient and physician

Description of Trust Practice

The 3rd Conversation is a three-hour facilitated convening that takes place in the evening with a group of 12–24 front-line clinicians and patients/family caregivers who live in the same community (and work/are treated at the clinic/site). From start to finish, the conversation centers on human connection, empathy and sharing authentic experiences and perspectives about receiving and delivering care in contemporary clinician practices. The conversation leaves all participants feeling inspired and helps them uncover innovative solutions to the burnout and frustration so many feel. Clinician and patient participants sit knee-to-knee, not only learning about one another's lived experiences, but exploring one another's values and needs. They collectively imagine how health care would look if the needs of both patients and clinicians (and their relationship in general) were valued and prioritized and they feel inspired to individually and together create change.

Skills/Competencies

- Active listening
- Appreciative inquiry
- Storytelling
- Vulnerability

“The 3rd Conversation draws on active listening, appreciative inquiry and storytelling to reinvent the relationship between patients and clinicians.”

Proof of Concept

Since May 2018, 3rd Conversations have been piloted in four communities: Rockville, MD; Atlanta, GA; South Huntington, MA; and Allentown, PA. In post event surveys, more than 70 percent of participants reported feeling safe being emotionally vulnerable, feeling understood and valued by other participants, and being better informed about the realities of working in the system (clinicians) and receiving care (patients). Participants also expressed changes in beliefs and intentions, such as patients setting out to ask after their clinicians' well-being at the next visit or to write thank you notes to their clinicians. Some clinicians stated they planned to make changes to their workflows to facilitate more eye-to-eye contact and authentic human connection with patients. These outcomes are a critical part of repairing and rebuilding a trusting relationship between patients and clinicians. In addition, nearly all participants (more than 9 in 10) expressed a desire to continue the conversation with the same group of people. To date, some have done so, indicating trust in one another.

Replicability/Scalability

X4 Health and 3rd Conversation are in the process of developing concrete plans for scale and sustainability. They will work with up to 10 sites to help finalize the model and make available a suite of tools that will enable future 3rd Conversation innovation sites to be self-led, including in-person and online trainings, facilitator guides, an event planning toolkit, a Theory-U style model of change and more. These tools and trainings will help expand and scale dramatically. The catalyzing events are not overly resource intensive. They can be organized and completed in four weeks, once the host team is trained. The direct costs of the event itself are less than \$1,000, although the labor hours are notable to organize and host a series of events.

For more information, contact Jennifer Sweeney at jsweeney@x4health.com

Practice Name: AOTA Communities of Practice

Author: Sandra Schefkind, Pediatric Practice Manager

Organization: American Occupational Therapy Association (AOTA)

Practice Category: Conversations/Support

Relational Type: Trust among members of a team

Description of Trust Practice

Communities of Practice (CoPs) are “groups of people who share a concern, a set of problems, or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an ongoing basis.”¹ They are social learning groups that offer a trusting environment to discuss practice challenges and needs. During regularly occurring virtual meetings, occupational therapy practitioners mentor each other as they reflect on the evidence to support their practices. They share their knowledge by exchanging resources and practice tips. During monthly calls, the AOTA members learn new information by inviting guest speakers and by taking turns facilitating discussions. As their knowledge and networks deepen, they develop new resources together such as FAQs and journal articles.

Skills/Competencies

- Collaborative learning and knowledge building
- Sharing experiences regarding a domain of practice
- Networking
- Reflecting and critical thinking

“The inclusive nature of welcoming newcomers fosters a sense of belonging and trust. Group objectives include increasing member learning, satisfactions, social networking, engagement, leadership, and identity. CoPs offer a promising model for knowledge translation and capacity building.”²

Proof of Concept

There is evidence to suggest that the CoPs are building trust among members and also with AOTA as a whole. Their growth indicates strong member interest and satisfaction, including positive member testimonials. A primary investigator from Columbia University is collaborating with AOTA to conduct a pilot study. A pre-test survey has been administered along with quarterly fidelity checks. A post-test survey will be administered in spring/summer 2019. The study examines any potential changes in knowledge, skills, and beliefs from participation.

1 Wenger, E., McDermott, R., & Snyder, W. M. (2002). *Cultivating communities of practice: A guide to managing knowledge*. Boston: Harvard Business School Press.

2 Barwick, M. A., Peters, J., & Boydell, K. (2009). Getting to uptake: Do communities of practice support the implementation of evidence-based practice? *Journal of the Canadian Academy of Child and Adolescent Psychiatry*, 18 (1), 16-29.

Replicability/Scalability

CoPs serve as an analysis strategy and practical tool that enables practitioners to build leadership and trust in their practices. As practitioners collaborate with one another, their professional growth and confidence may advance.³ CoPs provide a “training ground” to discuss evidence-based practices; this approach can be applied to any discipline-specific or interdisciplinary group and aligns with the goals of inter-professional practice: to be able to work effectively as members of clinical teams by providing safe, high quality, accessible, patient-centered care. Although the literature suggests that CoPs have been implemented in the healthcare sector, a lack of clarity in CoP operations (i.e., definitions, facilitation, quality indicators) may compromise its integrity and sustainability.⁴ The AOTA’s systematic approach of building CoPs as a member-to-member trust practice may inform others.

For more information, visit www.aota.org/Practice/Manage/SIS/communities-of-practice.aspx or contact Sandra Schefkind at sschefkind@aota.org

3 Wilding, C., Curtin, M., & Whiteford, G. (2012). Enhancing occupational therapists’ confidence and professional development through a community of practice scholars. *Australian Occupational Therapy Journal*, 59 (4), 312-318.

4 Ranmuthugala, G., Plumb, J.J., Cunningham, F.C., Georgiou, A., Westbrook, J. I., & Braithwaite, J. (2011). How and why are communities of practice established in the healthcare sector? A systematic review of the literature. *BioMedCentral Health Services Research*, 11 (273), 1-16.

Practice Name: Open Honest Questions

MERITORIOUS

Author: Hanna Sherman, Director, Health & Health Care, CCR and Past Co-Chair, 100MLives

Organization: Center for Courage & Renewal (CCR) and 100 Million Healthier Lives (100MLives)

Practice Category: Conversations/Support

Relational Type: Trust among team members

Description of Trust Practice

Open Honest Questions is a form of inquiry without a predetermined answer in mind, establishing an atmosphere free of judgment or constraint. The practice supports self-reflection, increases self-knowledge and avoids imposing opinions or advice. This way of questioning can be used in any setting but is particularly useful in reflective practice, for collaboration, in developing leadership skills, when providing feedback and when examining an issue or co-creating as a group. To learn and practice Open Honest Questions, a presenter briefly describes a situation in their life or work that would benefit from self-exploration with the help of questions they might not think of themselves. Learners then practice drafting Open Honest Questions for the presenter to consider. The presenter does not answer the questions but responds first as to whether they are open and honest and how they felt. If the question isn't open and honest, the presenter guides how it might be changed and invites the learner to rephrase it. Once group members have initial competency, they apply the tool to support deep listening, inner learning and open exploration in pairs, small groups and large group dialogue.

Skills/Competencies

- Compassion
- Active listening
- Openness

“Fundamentally, the use of Open Honest Questions helps one person better understand the thought processes, experiences and perspectives of another person in whatever role or relationship (leader-staff, faculty-student, clinician-patient or clinician-clinician).”

Proof of Concept

100MLives' SCALE initiative (Spreading Community Accelerators through Learning and Evaluation) uses Open Honest Questions and other practices to train communities over a series of in-person leadership academies. The SCALE Evaluation team uses mixed methods to document the development of relationships and trust (a core outcome of SCALE). Open and Honest Questions was one of the core relational skills that participants were taught across training and technical assistance. A session during the third training on using Open and Honest Questions to approach health equity discussions was in the highest rated decile on value and practical application among all sessions across trainings. After trainings, a modified version of the Sense of Community Scale¹ was used twice to determine whether communities developed a sense of trust and ability to collaborate with each other, and created an index score. Each time scores were high, with no statistically significant change between project phases. While not directly attributable to the use of Open and Honest Questions, trust levels are continuing to be built within and between communities.

¹ Abfalter, D., Zaglia, M. E., & Mueller, J. (2012). Sense of virtual community: A follow up on its measurement. *Computers in Human Behavior*, 28(2), 400-404.

Replicability/Scalability

The practice of Open Honest Questions has spread through the alumni of the Center for Courage & Renewal's leadership development programs for the past 20 years. It has been applied in schools, medical and surgical residency programs, faith-based communities, business and other sectors. In 100MLives, the practice is well-established in its transformative SCALE communities. Community leaders have taught it within their communities, and youth change agents are using it and teaching it to other youth in their schools and communities. It is also being taught through an open access online platform, CHAI, which is being used by the Robert Wood Johnson Foundation's Health Policy Research Scholars. The Institute for Healthcare Improvement has incorporated Open Honest Questions into their Psychology of Change framework as a practice that helps encourage "co-production in authentic relationship."

For more information, contact Hanna Sherman at hanna@couragerenewal.org

Practice Name: Peer Support

Author: Jo Shapiro, MD, FACS

Organization: Brigham and Women's Hospital

Practice Category: Conversations/Support

Relational Type: Trust between clinician and organization

Description of Trust Practice

The peer support program at the Brigham and Women's Hospital was created to help support clinicians faced with significant emotional stress such as involvement in an adverse event, caring for trauma victims, patient aggression or facing potential litigation. The program, which serves as a model for programs nationally and internationally, involves training clinician peers to provide support to colleagues. It relies on specifically trained clinician colleagues rather than mental health professionals to provide support. Connection with a clinician peer can help to mitigate the fear, shame and isolation that too often accompany involvement in adverse and other stressful events.

Skills/Competencies

- Understanding of fundamentals of peer support
- Establishing strong case for need
- Identifying and creating relationships and processes to build a program

“Building an institutional peer support program requires the ability to ‘make the case’ to your organization that peer support is essential to support both patient safety and physician wellbeing, an understanding of the core relationships and structures necessary to build and sustain a successful program, and recognition of the fundamentals of peer support in addressing the emotional needs of physicians and other health care team members.”

Proof of Concept

Although we know that a shame and blame culture is antithetical to improving safe practice and the wellbeing of healthcare team workers – by eroding trust between the involved clinicians and the patients, institution and society – we have yet to abandon this culture and move fully towards a culture of safety which is predicated on trust. Multiple studies have documented the sometimes devastating emotional fallout experienced by the involved clinicians. Studies also indicate that when faced with certain events such as medical error, physician resilience is facilitated by discussing the event with physician colleagues and that after medical errors, physicians overwhelmingly want to receive support from physician colleagues rather than mental health practitioners. Peer support moves clinicians toward a culture of trust by showing that when things go wrong, health care institutions will provide support for physicians and other health care team members. This support helps clinicians learn from the event and begin the process of healing and recovery.

Replicability/Scalability

This model of peer support has been adopted by dozens of healthcare organizations, both nationally and internationally. This includes a wide variety of organizations including academic medical centers, private practices, both rural and urban organizations and risk insurers. The resources needed to develop and sustain this program are relatively small and the need is great.

For more information, contact Dr. Jo Shapiro at jshapiro@bwh.harvard.edu

Practice Name: Respect for People

MERITORIOUS

Author: Gary Kaplan, Chairman and Chief Executive Officer

Organization: Virginia Mason Medical Center

Practice Category: Communication/Knowing your patient

Relational Type: Trust among team members

Description of Trust Practice

Virginia Mason Medical Center's Respect for People (RFP) initiative seeks to embed a culture of respect by supporting behaviors that encourage open communication, teamwork and recognition, thus enhancing trust among all members of the team. RFP launched in 2012 and was recently refreshed to encompass the language and lenses of diversity, equity and inclusion, as they are intrinsically tied to team members' and patients' self-identity, self-awareness, and experiences. This refresh involved listening sessions, communications and learning events to build awareness and provide foundational knowledge in diversity, equity, inclusion and respectful behavior, all in support of advancing the program vision: "We believe in a culture where everyone experiences respect."

In 2018, Virginia Mason (VM) trained over 5,500 participants using theatrical vignettes, activities and self-reflection; ongoing training ensures our efforts are sustained. Its 10 Foundational Behaviors explicitly embed concepts supportive of building trust; they include: be a team player, listen to understand, share information, keep one's promises, speak up, connect with others, walk in another's shoes, be encouraging, express gratitude, and grow and develop.

Skills/Competencies

- Self-reflection and situational awareness
- Understanding the impact of "second-hand" respect—the notion that the effects of an interaction radiate beyond the individuals directly involved, to everyone who witnesses and experiences it
- Incorporating diversity, equity, and inclusion

"Team members' skills and competencies were developed through opportunities to practice delivering feedback, speaking up to support team members, calling out disrespect, providing critiques, and being an "up-stander" rather than a "bystander." Guided exercises provided specific language tools to assist building skills in addressing disrespectful behaviors and enhancing trust."

Proof of Concept

There is a strong relationship between trust among teams and the ability to share feedback and feel respected. Results from the third quarter 2018 pre-RFP Summit baseline survey (n=1,292) showed that fewer than half of respondents agreed or strongly agreed that they know how to share feedback with others when they see or experience disrespect. Nearly 30 percent said they only somewhat agreed (or lower) that members of their work teams valued and respected one another's contributions.

In the post training survey, strongly agree/agree responses increased by 19 percent for knowing how to share feedback with others; by 10 percent for “I say thanks as soon as possible in response to respectful behavior,” and by six percent for “the members of my work team value and respect each other’s contributions.” Nearly three-quarters (72 percent) of respondents to the post training survey said that one or more respect behaviors had increased on their teams since the training. Thirty percent of survey respondents said their teammates were more likely to express gratitude and act as team players after the Respect for People training.

Replicability/Scalability

Any health care organization committed to building trust could follow the steps VM has taken to build and reinforce a respectful culture. In fact, VM has worked with its training affiliate, the Virginia Mason Institute, to develop a training plan for other organizations to develop their own set of respect behaviors and identify an implementation and communication plan for organization-wide training and capacity-building related to respectful behavior.

A culture characterized by joy in the workplace, team member well-being and respectful behaviors toward others is foundational to achieving remarkable patient and team member experiences, reliability and physical and psychological safety, all attributes of an environment that supports trust. This practice is scalable with commitment from the highest levels of an organization’s leadership and unrelenting perseverance to effect organizational culture change.

For more information, contact Lynne Chafetz at Lynne.Chafetz@VirginiaMason.org

Practice Name: Third-Year Student Professionalism Essay Assignment

MERITORIOUS

Author: Richard Frankel, PhD, Professor of Medicine and Geriatrics

Organization: Indiana University School of Medicine

Practice Category: Conversations/Support

Relational Type: Trust among team members

Description of Trust Practice

Third-year medical students on their medicine rotation at Indiana must post at least one essay describing a positive or negative experience that has influenced their understanding of professionalism. At the end of each rotation, students gather in groups of 12–15 with a faculty facilitator and receive a compilation of the stories their classmates have written that month. Students review the stories and select a few that particularly attracted their attention; they read these to the group, which discusses the professionalism themes embedded in the stories. Trust is a frequent topic of these discussions. For example, in a recent session, a student selected a story about a resident who falsely claimed to have performed a physical examination on attending rounds. This resident also copied and pasted another student’s note and signed it as his own. The group’s discussion focused on trust relationships where there is a power differential, and the risks and benefits of calling attention to a superior’s unprofessional behavior. There were strong differences of opinion among the students about one’s obligation as a physician in training to “blow the whistle” on a more advanced trainee or attending. By design, there was no resolution to this discussion, which was not about being right or wrong but rather about the students’ lived experience. In addition, there was an energetic exchange about the issue of cutting and pasting medical records, including a concern that students were facing discipline for doing it while residents and attendings were not. Again, the issue of trust in the context of power came to the fore; this time, all participants agreed a systematic approach was needed. The group happened to include the third-year class president, who joined with classmates to bring this issue to the dean, which prompted a system-wide effort to address the risks of cutting and pasting, including a memo addressing the educational implications that went out to all residents and teaching faculty.

Skills/Competencies

- Creating a context that invites reflection
- Facilitating a safe space
- Confidentiality
- Non-judgmental, active listening

“Creating a safe space is a challenge in a context in which the students continually feel they are being evaluated. One approach is to have each of the student introduce themselves, say where they grew up, where they went to college and one thing about themselves that others would find unusual or surprising.”

Proof of Concept

During the 15 years that this program has been in operation, the quality and quantity of student writing has increased substantially, in part because the students have found this a worthwhile exercise and developed a level of trust that their essays and concerns will be taken seriously. The strongest evidence that the approach is building trust comes from Association of American Medical Colleges exit questionnaire data focusing on students' experience of the medical school curriculum and their relationship with the school's administration. When the program began in 2005, Indiana was well below the national average in both of these domains, which are good proxies for trust or lack of trust. Indiana is now well above the national average on both measures.

Replicability/Scalability

This low-cost, high-yield practice is easily scalable in other settings. Individual schools such as The University of Virginia, the Cleveland Clinic Lerner College of Medicine, and the University of Massachusetts have developed similar narrative practice approaches. Interpreting the results of these programs can be difficult given the fact that the evaluation metrics vary from study to study. Dr. William Branch at Emory University has developed a longitudinal faculty development program that uses reflective writing to explore topics such as relational trust and how to model it at the bedside and in teaching. Branch has successfully replicated the curriculum in a number of medical schools each of which has demonstrated positive outcomes using the same outcome measures. Dr. Branch's studies are of note because they include multiple institutions and the results are much more credible in terms of reproducibility and scalability. It is not too far-fetched to imagine a consortium of interested schools or health systems using a narrative practice approach to provide a rich picture of trust in our health care institutions and to use analyses of the narratives to develop large-scale interventions to improve trust across the board.

For more information, contact Dr. Richard Frankel at rfrankel@iu.edu

Practice Name: Trust-Busters Card Sorting Activity
Author: Mary Jane Kornacki and Jack Silversin, Partners
Organization: Amicus, Inc.
Practice Category: Conversations/Support
Relational Type: Trust among team members

Description of Trust Practice

The trust-busters card sorting activity is typically led by a facilitator working with members of a work team or unit using materials Amicus developed and provides. People aren't especially comfortable calling out what goes on in their work environment that erodes their trust. This is compounded when levels of hierarchy exist. This card activity allows identification of trust-busters in a psychologically safe environment. Decks of cards are handed out to individuals or pairs. Each card identifies a common trust-buster, such as "inconsistent messages" or "great performance not appreciated." Participants sort the cards based on which problems are most prevalent and in need of being addressed in their workplace.

A poster listing the items on the cards is put on a wall or flip chart and individuals [or pairs] "vote" by placing sticky dots next to their items of greatest concern. Once all "votes" are assigned, the facilitator leads discussion of what the results mean, what has to change and who will need to do what to eliminate the top trust-busters. If done across multiple departments or teams, the summation can be helpful to top management to understand trends that need to be addressed.

Skills/Competencies

- Ability to facilitate potentially charged discussions
- Support and follow-through from someone who can implement change

“Successful follow up of the activity relies on someone with the status and authority to meet with and hold to account the person or persons whose behavior is breaking down trust in the group or policies that need modification.”

Proof of Concept

Amicus reports that it has used the activity to positive effect in a number of organizations to which it has provided consulting services.

Replicability/Scalability

The cards are freely available through Amicus. Effectiveness requires sanction at the highest level of the organization, as some of what may contribute to distrust could be structural or ineffective local leadership.

For more information, contact Maryjane@consultamicus.net, Amicus, Inc., Cambridge, Massachusetts, 617-354-7983

LEADERSHIP

The Power of Story

Leadership comes in many forms, including storytelling. Narrative Leadership is a practice taught at Primary Care Progress that empowers clinicians – through a structured framework – to both share their own story and elicit the stories of others – all in an effort to translate values into actions that drive better health care choices. **p. 39**

WINNER LEADERSHIP

Practice Name: The Colleges Advisory Program

Author: Robert Shochet, MD, Associate Professor of Medicine, Director of the Colleges Advisory Program

Organization: Johns Hopkins School of Medicine (JHSOM)

Practice Category: Leadership

Relational Type: Trust among team members

Description of Trust Practice

The Colleges Advisory Program (CAP) is a student-faculty learning community (LC) using a relationship-centered framework for advising, mentoring and clinical skills training. Each incoming class (120 students) is randomly sorted into groups of 30, and distributed to one of four colleges. Colleges consist of student cohorts from each class year, facilitating vertical integration. Once in a college, students are subdivided into learning units of five, and each unit, referred to as a 'molecule,' is paired with a CAP faculty advisor. The 24 molecules of each entering class form the learning teams for the immersive 16-week CAP first-year course, Clinical Foundations of Medicine (CFM), which covers communication skills, history and exam skills, and professionalism, with emphases on team process and reflective practice.

Students meet quarterly in molecules throughout medical school for faculty-facilitated discussions to reflect on their journeys, emergent roles and identities. Faculty maintain longitudinal connections with each student, meeting multiple times per year for academic and career advising, using a learner-centered, appreciative advising framework.¹ Faculty host students at their homes to deepen these relationships. The CAP hosts class-wide advising programs at curricular transitions to recognize and celebrate student milestones across the four years.

Peer-to-peer connections are fostered through the social and service programs in the CAP. Each college has a student leadership structure and hosts a variety of social, community service, and peer advising events to foster support and vertical integration among students. All 24 CAP faculty members receive 0.2 FTE support from the School of Medicine to make a three to five year commitment serve in these longitudinal teacher-advisor roles. There is a competitive application process for these positions, and students play an active role in interviewing and selecting CAP faculty. This flattened hierarchy promotes transparency and trust, and yields a passionate, high-performing, and diverse faculty. The CAP faculty have become their own relationship-centered LC, sharing common values, appreciating others' strengths, and supporting one another. Monthly faculty development meetings offer wonderful opportunities for sharing experiences and co-creating knowledge about best practices in student advising.²

Skills/Competencies

- Relationship-centered communication and leadership
- Adult and learner-centered teaching and advising
- Small group facilitation
- Reflective practice
- Collaborative and experiential learning

1. Bloom JL, Hutson BL, He Y. *The Appreciative Advising Revolution*. Champaign, IL: Stipes Publishing, LLC, 2008.

2. Shochet RB, Cayea D, Levine R, Wright, SW. Using medical student case presentations to help faculty learn to be better advisors. *Acad Med* 2010; 85: 578-579.

“Every CAP teaching session and meeting involves sitting in circles and begins with ‘check-ins,’ a time of welcome and personal sharing before the formal work commences. Student leaders are mentored by faculty and encouraged to utilize relationship-centered leadership strategies in student-run meetings. CAP faculty become adept in using relationship-centered communication skills, and teach first-year students in these principles in a clinical context within the CFM course.”

Proof of Concept

We believe that the CAP LC has had an important impact on students’ experience of the learning climate and sense of trust at JHSOM, as CAP faculty provide personalized advising and mentorship to support their professional development and success in medical school. As a program, CAP offers a scaffolding of social and academic support with students describing an enhanced sense of community, social integration and high quality advising.⁴

In 2017–18, CAP faculty held over 2,100 individual advising meetings, a mean of 3.6 per student. A recent survey of JHSOM students’ experiences (N=351) with their CAP advisors showed that most students are forming trusting relationships, with 96 percent and higher agreeing or strongly agreeing that their advisor is genuinely interested in their welfare and well-being, that meetings meet their needs and that their advisor is non-judgmental and embraces their uniqueness.

On average, faculty devote 4.5 years as advisors in the program, and one-third of the current 24 members have been affiliated for 10 or more years. CAP faculty describe the value of participation as “finding my people” and connecting deeply with the other faculty, their students and their teaching roles.⁵ This is consistent with a multi-school study of LC faculty reporting comparatively higher work satisfaction in their LC roles relative to clinical and other teaching roles.⁵ Individual annual meetings provide opportunities for bi-directional feedback, followed by a letter to the department chair describing their accomplishments along with appreciative student comments as evidence of the value and meaning of their work.

Replicability/Scalability

The practice of constructing smaller communities in medical school to provide longitudinal learning and advising relationships between students and faculty seeks to mend fragmented and isolating learning environments and offer opportunities for continuity, intimacy and trust. LCs embody a relationship-centered, deliberately developmental educational system to enhance social and informal learning and support each student in their professional formation.⁶

LCs in undergraduate medical education have gained in popularity over the past 10–15 years.⁷ To support this growing movement, a coalition of medical school faculty founded the not-for-profit **Learning Communities Institute (LCI)** in 2012 to foster collaboration for LCs across institutions and support other medical schools in developing similar programs. In 2017, the LCI formed a research network to build evidence for the use of LCs in medical education and allied health professional schools.

For more information, contact Dr. Robert Shochet at rshoche1@jhmi.edu

3. Levine RB, Shochet RB, Cayea D, et al. Measuring medical students’ sense of community and satisfaction with a structured advising program. *Int J Med Ed.* 2011; 2: 125-32.

4. Ngo TL, Whipple M. Faculty benefits from medical student learning communities: A junior and senior members’ perspectives. *J Med Educ Curr Devel.* 2019; 6: 1-2.

5. Wagner JM, Fleming AE, Shochet RB, et al. Benefits to faculty involved in medical school learning communities. *Med Teach.* 2014 Aug 27: 1-6.

6. Shochet RB, Fleming A, Colbert-Getz J, et al. Defining learning communities in undergraduate medical education: A national study. *J Med Educ Curric Devel.* 2019; 6: 1-9.

7. Smith S, Shochet R, Keeley M, et al. Learning Communities in Undergraduate Medical Education. *Acad Med* 2014; 89(6): 928-33.

WINNER LEADERSHIP

Practice Name: The Leader Index

Author: Stephen Swensen, MD, Former Director Leadership and Organization Development, Mayo Clinic; Professor Emeritus, Mayo Clinic College of Medicine and Science

Organization: Mayo Clinic

Practice Category: Leadership

Relational Type: Trust between clinician and organization

Description of Trust Practice

Physician leader performance is formally assessed each year at the Mayo Clinic through its Leader Index, an evaluation of five key leader behaviors based on a 12-question staff-wide survey.

A team at Mayo has identified appreciation, transparency, partnership, interest in colleagues' career aspirations, inclusion and respect as trust-generating leader behaviors. They have shown that the behaviors of the Leader Index positively impact physicians' professional fulfillment, satisfaction and burnout. The team has determined that it is possible to measure the behaviors, and develop and select leaders for them.

Under this trust practice, an organization computes a Leader Index for every work unit leader based on the annual staff survey. The Leader Index is shared with every physician leader, and physician leaders receive feedback on the impact of their behaviors. Each leader is offered support to improve his or her performance, and consequently physician trust, satisfaction and burnout measurements progress as behaviors improve.

The Leader Index process is transparently shared with all physician leaders. Leaders understand the behaviors and the survey questions. As part of each leader's annual review, the Leader Index findings are presented to each department and division chair to discuss opportunities for improvement. Each Chair then creates a personal improvement plan, including executive coaching, leadership development programs and emotional intelligence assessment workshops.^{1,2}

Skills/Competencies

- Include: Nurture a culture where all are welcome and psychologically safe
- Inform: Transparently share what you know with the team
- Inquire: Consistently solicit input and ideas of associates
- Develop: Support professional development and career aspirations of staff
- Recognize: Express appreciation and gratitude in a meaningful way to colleagues

“We believe that trust in an organization is fundamentally related to trust in its leaders. And there is no more important leader than the one to whom physicians directly report. Trust is nurtured when there is belief in the authenticity and caring of leadership. Trust is developed when there is confidence in the transparency, character and ability of that leader. Trust is fostered when leaders create a psychologically safe work environment. Participatory management practices, career mentorship and authentic appreciation cultivate a culture of trust.”

Proof of Concept

In published findings, Mayo Clinic has demonstrated the importance of front line leadership on the well-being and professional satisfaction of physicians. It observed that leadership ratings had a strong association with burnout and satisfaction at the level of individual physicians (after adjusting for age, sex, duration of employment at Mayo Clinic and specialty area). For every point upward on a 60-point scale, there was 9% greater staff satisfaction and 3.3% less burnout. At the department and division level, 11% of the variation in burnout and 47% of the variation in satisfaction with the organization was explained by the Leader Index of the chairperson.³

The leadership qualities, behaviors and actions that Mayo Clinic evaluated are specific and teachable. For example, it found it possible to improve leader performance in these ways: keeping colleagues informed, encouraging staff to suggest ideas for improvement, having career development conversations, providing feedback and coaching and recognizing a job well done.

Research has shown that the leadership qualities of physician supervisors have a direct positive effect on the personal well-being of the physicians they lead. These findings have important implications for the selection and training of physician leaders. The results also provide new insights into organizational factors that impact physician trust in leadership and their well-being.

Replicability/Scalability

Based on its success with physician leaders, Mayo Clinic leadership decided to expand the Leader Index practice to all ~3,300 point-of-care leaders (e.g. – nurse managers, pharmacist chairs, accountant supervisors, etc.). The Leader Index practice was successfully diffused within Mayo Clinic, a large multi-state system with 22 hospitals, varied practice settings (including academic and community-based models) and physicians from all specialties who are distributed in five different states. Mayo has first-hand experience with scalability and reproducibility in different work settings (community and academic) and with different professionals and disciplines.⁴

Deployment of a Leader Index is feasible in all organizations with employed physicians. And it is relevant and useful for all organizations, regardless of relationship with physicians. Even if annual staff surveys are not utilized and individual Leader Indices not calculated, organizations can help leaders understand the value of these five behaviors for interactions with all colleagues.

For more information, contact Dr. Stephen Swensen at swensen.stephen@mayo.edu

1. Swensen, S., et al., Leadership by design: intentional organization development of physician leaders. *Journal of Management Development*, 2016. 35(4): p. 549-570.
2. Swensen, Shanafelt. *Organizational Framework to Bring Back Joy in Practice*. *The Joint Commission Journal on Quality and Patient Safety* 2017
3. Shanafelt, T., et al., Impact of Organizational Leadership on Physician Burnout and Satisfaction. *Mayo Clinic Proceedings*. 4/2015 90(4): p. 432-440
4. Swensen, S., et al.

Practice Name: Narrative Leadership

Author: Matthew Lewis, Senior Strategic Consultant

Organization: Primary Care Progress

Practice Category: Leadership

Relational Type: Trust between patient and physician

Description of Trust Practice

Narrative Leadership is a practice taught at Primary Care Progress that empowers clinicians – through a structured storytelling framework – to both share their own story and elicit/listen to the story of others. The teaching includes a mixture of didactic training, story modeling, pair-and-share practice and a large group debrief to articulate the lessons learned and engage in a discussion of practical applications. Ultimately, as a practice, Narrative Leadership demonstrates that the humane art of storytelling is a tool available to *all* clinicians (we need not be experts), in a variety of ways and is a resource available even to those who are not artistically inclined. Why is storytelling a Relational Leadership practice we focus on at Primary Care Progress? Because stories are how we learn to make choices. Stories are how we learn to access the moral and emotional resources we need to face the unknown and the unexpected. What's more, because stories can help translate our values into action, they teach us not only how we ought to act, but also inspire us with the courage to act.

Skills/Competencies

- Willingness to try something new
- Willingness to be a learner

“There is often a dismissive myth that sometimes emerges that stories amount to the ‘soft stuff.’ The reverse is actually true; we’re hard-wired for story.”

Proof of Concept

Heightened activity in the brain can persist after exposure to a powerful narrative (see Lisa Cron’s *Wired for Story*). This is akin to muscle memory, enabling us to *feel* storytelling like a somatic presence – well after the story ends. As a result, character-centered, emotional stories create better understanding of nuance and detail. It’s no surprise, then, that medical case studies – stories of disease and therapy – are central to education in the health professions. But stories do more than just teach – they have the power to create connections that motivate cooperation. In effect, they have the power to build community. When listeners find themselves in the thrall of another’s story, they come to understand and feel the speaker’s value, thus igniting many of the most important yet often ineffable emotional dimension: compassion, resilience, humility, longing and vulnerability. The story becomes a vehicle to transmit deeper emotions, conflicts and desires that help build connection and invites bi-directional commitment. This leads to trust. Trust naturally sparks empathy. When empathy is triggered, so is action.

Replicability/Scalability

Institutions and change-making efforts have already adopted Narrative Leadership with enthusiasm and energy. We have seen scale and replication occur through institutional acceptance that, over time, shifts culture and individual commitment to a new way of practicing care. Adoption has also been individual, organic, emergent and iterative. A student attends the Primary Care Progress Leadership Summit and returns to her home university excited and equipped to host a storytelling workshop for her fellow medical students. A resident learns, and then repeats the Narrative Leadership skill of authoring out loud the shared purpose of her care team. A physician 20 years into his primary care practice encourages his colleagues to share little stories about who they are as a means of creating trust in the exam room.

For more information, contact Matt Lewis at lewismatt@gmail.com

Practice Name: Personal and Professional Development (PPD)

Author: Rob Meyer, MD, Primary Care Pediatrician, Cambridge Health Alliance;
Assistant Professor of Pediatrics, Harvard Medical School

Organization: Massachusetts General Hospital

Practice Category: Leadership

Relational Type: Trust among team members

Description of Trust Practice

Personal and Professional Development (PPD) is a reflective practice curriculum, based on the Circle of Trust[®] concept developed by Parker Palmer and the Center for Courage and Renewal. It fosters individual reflection within community: about the joys, challenges, achievements and frustrations of the residency experience.

Pediatric and Medicine-Pediatrics interns meet monthly for three hours, and curriculum topics include the physician-patient relationship, vulnerability, medical error, abundance and scarcity, and handling the loss of a patient. Attendance is required for those not post-call or on vacation. The curriculum is introduced during intern orientation and begins with Touchstones, guidelines for creating and protecting safe space for discussion, adapted from the Circles of Trust[®] process. Maintaining strict confidentiality and attentive listening are essential to the success of the program.

Each session begins with “Check-in” during which participants can share any experiences or issues with the group. Check-in generally lasts 30–45 minutes and then transitions to a planned-topic discussion, unless a complex issue merits longer discussion. Check-in builds trusting relationships within the class and demonstrates that experiences and feelings are shared by others. The planned topics for each session are introduced via a prompt that facilitates conversation and could include poems, articles, TED talks or artwork. Discussing a difficult topic such as feeling fraudulent can be facilitated by first sharing a poem or article on that subject before revealing one’s inner emotions.

Skills/Competencies

- Group facilitation
- Flexibility
- Patience
- Ability to create cohesive relationships among different groups

“When we developed and introduced this practice, we inherently knew that it was something that interns needed: to have a dedicated time and place to reflect on their individual and collective experiences of residency.”

Proof of Concept

What Massachusetts General has come to realize over the six years of PPD is the extraordinary manner in which it has enhanced community and furthered feelings of mutual trust. While the culture of the residency program has always been one of collaboration and mutual support, they have witnessed this culture of community grow and thrive, both in the everyday routine of the residency program and in the sessions themselves.

Replicability/Scalability

PPD (and the Circle of Trust[®] process) is definitely scalable and reproducible in other settings, including but not limited to: other residencies, medical students, hospital teams, clinic staffs, departmental faculty and established medical practices. Massachusetts General has applied these practices and principles in many of those contexts, be it medical students reflecting on the challenges of their first year, an outpatient site undergoing the challenge of implementing a new medical record, or practicing pediatric providers reflecting on their work environments. What is needed are facilitators who can hold space for vulnerable discussion; institutional support to provide time and space; and, most importantly, institutional prioritization of professional wellness.

For more information, contact Dr. Rob Meyer at rmeyer1@partners.org or Dr. Susan Hata at shata@mgh.harvard.edu

MISINFORMATION

Truth and Consequences

In their 2019 book, two philosophers of science – UC Irvine professors Cailin O’Connor and James Owen Weatherall – have posited that we are in “The Misinformation Age,” arguing that changes in our ways of social interaction have affected our ability to form reliable beliefs. ALS Untangled, Journalist’s Resource and the Vaccine Education Center at The Children’s Hospital of Philadelphia all work to separate fact from fiction in the practice of medicine. **p. 44–49**

Practice Name: Journalist’s Resource

MERITORIOUS

Author: Carmen Nobel, Program Director

Organization: Journalist’s Resource, Harvard Kennedy School’s Shorenstein Center on Media, Politics and Public Policy

Practice Category: Information/Misinformation

Relational Type: Trust in the media/social media

Description of Trust Practice

As traditional models for journalism have struggled, the quality of reporting on complex topics has declined. Too often, journalists are charged with reporting on topics they know little about – from health care policy to gun violence. Many journalists don’t know how to use serious research in their reporting, don’t know how to understand or analyze the data in academic studies or don’t even think to seek out expert scholars for interviews.

Realizing a need and an opportunity to improve journalism (and prevent misinformation) by bridging the gap between academia and journalism, the Shorenstein Center on Media, Politics and Public Policy created *Journalist’s Resource* (journalistsresource.org), an open-access website with an audience of practicing journalists who use our articles and tip sheets to understand public policy and health-related research and use it in their news reporting.

Journalist’s Resource publishes multiple posts each week, in several categories:

- Curated roundups and accessible summaries of studies on news-related topics, written clearly and concisely with journalists in mind;
- Journalistic articles about standout studies, which include interviews with the researchers;
- Tip sheets on how to understand and report on research; and,
- Tip sheets aimed at improving coverage of communities that are commonly misunderstood by journalists.

Skills/Competencies

- Written communication – the ability to summarize complicated health care journal articles into clear, succinct summaries for an audience of journalists
- Research curation – identifying high-quality research and avoiding low-quality research
- Journalistic news sense combined with an understanding of research methods and the importance of research

“We rely on the subject matter expertise of the researchers with whom we collaborate to create tip sheets and research roundups for our website.”

Proof of Concept

There's a measurable demand for the service *Journalist's Resource* provides: More than 50,000 people subscribe to its weekly e-mail newsletter and just as many follow it on Twitter. Tens of thousands of external web pages link back to its website. Many local, national, or international news stories include a relevant link to one of its articles to provide additional information to readers.

Qualitatively, the *Journalist's Resource* team takes pride in having been accepted as a legitimate information source by groups that traditionally don't trust journalists. For example, it created a straightforward tip sheet of facts that journalists should keep in mind when reporting about guns and gun violence, including simple facts like the difference between a bullet and a cartridge. Shortly after publication, the gun-rights publication *Bearingarms.com* wrote: "Every so often, social media pops up with a joke image that is supposedly a journalist's guide to firearms. Everything shown is labeled 'AK-47' except for the AK, which was labeled 'AR-15.' It's a routine joke for those of us who understand guns and who often see journalists mangle the facts when it comes to firearms. It's awful, painful even. Now, a website called *Journalist's Resource* has decided to give its readers some tips on how to report on firearms more effectively. It actually doesn't suck."

Replicability/Scalability

Following the recent hire of an economics reporter, *Journalist's Resource* now has four full-time employees, including one reporter dedicated to health and health equity issues. The team hopes to hire an additional beat reporter in the coming year. It eventually would like to serve as a responsive research desk – responding directly and immediately to the research requests of reporters on deadline. Program Director Carmen Nobel believes every research institution would benefit from hiring a journalist who works independently of the institution's public relations office and who translates the findings of medical studies into accessible language for a mainstream audience and/or an audience of journalists.

For more information, contact Carmen Nobel at carmen_nobel@hks.harvard.edu

Practice Name: Untangling the ALS X-Files

Author: Richard Bedlack, MD, PhD, Professor of Neurology at Duke University

Organization: ALSUntangled

Practice Category: Information/Misinformation

Relational Type: Trust between patient and physician

Description of Trust Practice

ALSUntangled (ALSU) is a social networking-based system by which the community of ALS clinicians and scientists systematically assess alternative and off-label treatments (AOTs), with the goal of helping patients with ALS (PALS) make more informed decisions about their care. ALSU has three components: learning about the AOTs that PALS are considering, standard operating protocols by which these AOTs are objectively investigated by a team of ALS clinician scientists and public release of the results of the investigations.

The first part utilizes Twitter; the second part utilizes an email list-serve; and the third part utilizes free access publications via the journal *Amyotrophic Lateral Sclerosis*. The learning phase uses Twitter, through which people with ALS or their caregivers can introduce an AOT by putting it into a short text message along with the hashtag [#ALSUntangled](#). The ALSU group uses the Twitter search function to find such “tweets.”

Once AOTs have been identified, the ALSU group imports them into the Open Reviews section of their website (www.alsuntangled.org). Topics are prioritized according to votes from the public and a multiplier that is based on the amount of useful, disclosable information available for each AOT. One clinician or scientist is assigned to write the first draft of a review using specific standard operating procedures designed to make this as objective as possible.

These include the use of a Table of Evidence through which every AOT is reviewed in terms of the following specific categories: mechanistic plausibility, preclinical models, cases, trials and risks. Within each category, a letter grade ranging from A to F is assigned, according to the specific type of evidence that is found. The draft is then crowd sourced across the team of participating clinicians and scientists, and when an agreement is reached this is published in a peer reviewed medical journal and on the Completed Reviews section of their website. All ALSU reviews are “free open access” meaning patients never have to pay to read these.

Skills/Competencies

- Research training and experience
- Crowd-sourcing
- Social networking

“Clinicians and scientists have years of knowledge, training and experience that can facilitate careful scientific review of AOTs, but they may not have the time or interest in conducting such reviews for patients. I built a virtual bulletin board that patients can use to submit and vote for AOTs they are interested in learning more about, standard operating protocols by which an international team of volunteer clinicians and scientists can review these AOTs, and an agreement with a peer-reviewed journal to publish the final reviews via “free open access.” In this way, patients and clinicians can have concise, crowd-sourced opinions on AOTs that can guide decision making and enhance trust.”

Proof of Concept

ALSU currently has more than 3,700 Twitter followers and receives requests for new AOT reviews from patients around the world multiple times each month. There are nearly 400 AOTs listed on the Open Reviews section of its website, www.alsuntangled.org. Since its start in April 2009, the review team has grown to include 120 clinicians and scientists from 10 different countries. Its publications currently comprised eight of the 10 most-read articles in the journal Amyotrophic Lateral Sclerosis and Frontotemporal Degeneration, including all of the top six. Their most popular reviews have more than 30,000 downloads. In fall 2018, they completed their first-ever follow-up trial (of Lunasin) from an ALSUntangled review, and this was the fastest enrolling trial in ALS history. They also have partnered with CReATe Consortium to develop [ALSUntangled podcasts](#), garnering hundreds of downloads a month.

Replicability/Scalability

Duke University has supported ALSUntangled through Institutional Review Board approval. The ALS Association and Motor Neuron Disease Association provide financial support that covers wages, computer and website support. For more information, contact Dr. Richard Bedlack at Richard.bedlack@duke.edu

Practice Name: Vaccine Education Center at The Children’s Hospital of Philadelphia

MERITORIOUS

Author: Charlotte Moser, Assistant Director

Organization: Vaccine Education Center at Children’s Hospital of Philadelphia

Practice Category: Information/Misinformation

Relational Type: Trust in science and evidence

Description of Trust Practice

The Vaccine Education Center (VEC) at The Children’s Hospital of Philadelphia provides accurate, comprehensive and up-to-date information about vaccines and the diseases they prevent. Through its websites, videos, informational tear sheets, e-newsletters, webinars and speaker programs, the Center seeks to dispel some of the common misconceptions and misinformation surrounding vaccines. Launched in October 2000, it offers information about vaccines, including how they are made, how and why they work, who recommends them, whether they are safe, whether they are necessary and when they should be given.

The Center has also developed programs for specific audiences:

- Parents PACK (Possessing, Accessing, and Communicating Knowledge about Vaccines) – This program focuses on ways to reach parents with scientifically valid information that answers their questions about vaccines and vaccine safety. Highlights of this effort include a monthly e-newsletter, mobile app, and an online trivia game.
- Vaccine Update for Healthcare Providers – This program seeks to support healthcare providers in their conversations about vaccines and vaccine safety by providing timely and accurate information that parents and patients are requesting. Program highlights include a monthly e-newsletter and a popular free webinar series that offers continuing education credits.
- Vaccine Makers Project – This newest effort aims to provide accurate and engaging, standards-aligned and free educational resources for elementary, middle, high school and college students. The lessons and resources relate to infectious diseases, the immune system and vaccines.

Skills/Competencies

- Consistency in message
- Quality information
- Approachability

“The success of this effort relies on a team approach to consistently providing accurate information based on current scientific understanding in a way that is easy to understand, non-judgmental and empathetic.”

Proof of Concept

Use of the Center’s resources continues to increase. In the last five years, visits to its websites have ranged from 500,000 to 825,000. In 2018, its VEC and Parent Pack websites enjoyed 1.4 times the traffic of the prior year. Pages related to vaccine safety issues, such as autism, use of fetal cells in vaccine manufacturing and some specific vaccine ingredients (e.g., aluminum and mercury) are consistently top-performing pages, as are pages such as prevent-HPV, the vaccine schedule and historical information related to vaccine development. In addition, PDF downloads have increased from about 18,500 per year to more than 30,000 per year. Requests for personal or clinical practice information continue to rise, and email inquiries have increased over the last five years from about 1,000 annually to nearly 2,500 in 2018. The Center’s information has continued to rise in Google search rankings, and in some cases, is featured in the Google information box, such as for “vaccines and aluminum” and “history of vaccines timeline.”

Replicability/Scalability

Misinformation about health and science is an ongoing issue. Because the Center is national and international in scale, it is fair to say that it has demonstrated its scalability. However, any similar program would require commitments of time and resources to become a trusted source of any type — not something that can happen “overnight.”

For more information, visit www.vaccine.chop.edu

PATIENT-CENTERED DESIGN

A New Path, More Traveled

An individual's specific health care needs and desired outcomes have become a driving force behind quality improvement initiatives in recent years. Through the Immediate Results Delivery Program, radiologists at Diversified Radiology report their findings directly to outpatients immediately after their CT and ultrasound imaging exams – creating a circle of trust among physicians, patients and these specialists. **p. 57**

WINNER PATIENT-CENTERED DESIGN

Practice Name: Getting Rid of Stupid Stuff

Author: Melinda Ashton, MD, Chief Quality Officer

Organization: Hawai'i Pacific Health

Practice Category: Patient-Centered Design

Relational Type: Trust between clinician and organization

Description of Trust Practice

In its program, “Getting Rid of Stupid Stuff,” Hawai'i Pacific Health (HPH), a not-for-profit health care system of medical centers, clinics, physician and specialty groups and other care providers, invites clinical staff who use its electronic health record (EHR) system to identify documentation and other practice requirements that should be eliminated, changed or modified. The program signaled and emphasized that leadership sincerely wanted to engage staff in rooting out items at work that would cause an individual to think “why do I bother?” as they seek to complete the task.

Hawai'i Pacific Health asked frontline staff to help identify EHR areas that should be changed, using a nominations process. Nominations are submitted through a dedicated intranet email site, and the inbox is monitored by a small team. Nominations are sorted for either immediate action or evaluation and action by subject area workgroups. The staff member who made the nomination receives a “thank you” acknowledgment and then a follow-up email about the outcome of the suggestion.

Since the program began in October 2017, more than 350 nominations have been received from clinicians of all types. Nurses and physicians have submitted the bulk of the topics, but pharmacists, therapists and others who use the EHR have participated.

Skills/Competencies:

- Critical thinking and analysis
- Knowledge of electronic health record system
- IT support to identify technical improvements

“This is a very simple program. To be successful, it needs staff to think about how they use the EHR as they provide clinical care. It requires the staff member to submit the idea via a simple formatted email, although some ideas have come in through a phone call or interaction with members of our EHR optimization team.”

Proof of Concept

There has been very positive response to this program across the clinical staff. The chief quality officer announced the program in managers and directors meetings at each of HPH's four hospitals and leadership endorsed it. There was initially a lot of sheepish laughter about a program called "Getting Rid of Stupid Stuff", but then enthusiastic support as it was presented. As nominations have come in and been addressed, HPH has received a lot of appreciation for being willing to listen and make changes.

Several nominations for stupid stuff beyond the EHR documentation topics have been received. Across the organization, there is a recognition that clinicians have changed the way they think about clinical protocols, and are willing to stop and consider current practices. "Our CEO takes every opportunity to encourage us to keep working to identify and eliminate stupid stuff, and almost 18 months after we started it is clearly part of our approach to doing business," said Melinda Ashton.

The positive reaction to HPH's Perspective column in the Nov. 8, 2018 issue of the *New England Journal of Medicine* suggests that this approach has trust-building value. HPH has been approached by a number of organizations and heard from CMOs, CIOs and others around the country that there is something unique here. Their willingness to label well-intended, required work as stupid has seemingly struck a nerve.

Replicability/Scalability

This trust practice is very simple to implement; no fancy tools are needed. A dedicated email inbox and a few knowledgeable staff members can get a program started.

Some important components for success, however, include:

- Executive sponsorship and willingness to publicly acknowledge that stupid things may exist in the organization they lead
- IT support and participation, even if they don't lead
- Ability to efficiently evaluate nominations from multiple perspectives so that implemented changes are not themselves viewed as stupid
- Effective prioritization so that additional work can be scheduled

For more information, contact Dr. Melinda Ashton at melinda.ashton@hawaiiipacifichealth.org

WINNER PATIENT-CENTERED DESIGN

Practice Name: UnityPoint Health Prairie Parkway LGBTQ Clinic

Author: Kyle Christason, MD, Medical Director, UnityPoint Accountable Care and Family Medicine Physician

Organization: UnityPoint Health

Practice Category: Patient-Centered Design

Relational Type: Trust between patient and organization

Description of Trust Practice

The Prairie Parkway LGBTQ Clinic occurs two evenings per month at one of UnityPoint Health's established Family Medicine clinics in Cedar Falls, Iowa. The clinic is staffed by providers and staff who are all full-time employees of other UnityPoint clinics across the Waterloo region, along with a physician who is employed at a regional Federally Qualified Health Center. The clinic provides primary care and routine exams, vaccinations, routine cancer screening, contraceptive management, sexually transmitted infection testing and treatment, pre-exposure prophylaxis (PrEP), hormone therapy, post-surgical care following gender affirming procedures, and on-site lab testing and radiology. Unity Point Health is a network of hospitals, clinics and home care services in 14 locations throughout Iowa, Illinois and Wisconsin.

Clinic workflow is designed to avoid potential missteps, particularly where healthcare has historically missed opportunities to create a positive experience for LGBTQ people. There is a dedicated phone line and email, managed by only two people who are trained to query the patient on pronouns and a preferred name. This small yet critical step helps affirm patients who identify as transgender or gender-fluid. All providers and staff attended Safe Zone training, a sensitivity and bias-awareness course for providers, nurses, pharmacists, medical assistants, patient service representatives, lab techs, radiology techs and leadership. This was fundamental to creating a common understanding of the clinic's mission, to equip staff with the correct skills and language, and to create a mutually accountable culture.

Each clinic starts with a staff huddle and centering reflection, a poem, video, a passage from a book or just a simple inspiring quote. The staff use the time to reaffirm their common purpose, mutual support and accountability, focusing on one or two topics per clinic day (e.g. encouraging every patient to get the flu shot). At the close of the day, they share "joy bombs" and "pain spots" (rapid-cycle process improvement). This intentional recognition by staff and providers of the power of their work, as well as what they can improve on, creates a powerful and positive clinic culture.

Skills/Competencies

- Patient-experience mindset
- Openness
- Mutual support and accountability
- Team-based care concepts

"There is special focus given to the interactions and communication among all team members in the practice. The success of the care experience in our clinic is dependent on everyone's willingness to function in a coordinated and efficient way with each person fully invested in their role on the team."

Proof of Concept

Qualitatively, the clinic has countless anecdotes about patients' positive experiences; statements like "this clinic saved my life" are common. A patient satisfaction survey is provided to every patient, and patients are asked to share one thing they liked about the visit and one thing that could be improved. Most respond that nothing could be improved, although a few have asked for the clinic to be open for more hours.

Patients express how much it means to have someone within health care make it safe for them to live authentically, and often state that they have started to care about themselves again. This means accessing care appropriately, addressing preventive care and effectively managing chronic disease.

Quantitatively, the patient experience is measured on a numerical scale of 1–5, with survey questions regarding courtesy of the receptionist, nursing staff and care provider, and the clinic environment as a safe place. With a greater than 60% survey return rate, each of these domains has an almost perfect score of 4.9. The clinic served 156 patients in its first year (2018), of which 51 were new to UnityPoint Health.

Replicability/Scalability

This clinic practice provides not only a replicable model for LGBTQ care, but a framework for any clinical practice. The key practice elements – compassion, multi-disciplinary teamwork, robust huddles, story-telling and person-centered care – can be reproduced in any care setting. What sets this practice apart is the intention that every person brings to their work. There is a depth of thought and consideration given to every interaction, decision and connection. The providers and staff, who are members of other clinic teams, have been able to transfer the mindset and care approach they've developed in this practice to their "home" clinics.

An additional (and unforeseen) benefit has resulted for providers, who regularly report that the LGBTQ Clinic is the favorite part of their work. They feel more connected, more effective, and more influential in their service to this patient population, and that has brought an unexpected level of joy back in to their professional life.

Following the model developed in Cedar Falls, the Des Moines region opened an LGBTQ Clinic on April 9, 2019. There has been interest in opening LGBTQ clinics in additional UnityPoint Health regions. UnityPoint Health recognizes the need for this type of care experience in all of its markets, particularly more isolated, rural regions where patients currently travel significant distances to seek culturally competent care. Full-scale replication of this practice is being explored across the organization.

For more information, contact Rachel Dahlen at rachel.dahlen@unitypoint.org

Practice Name: The Comprehensive Care Physician (CCP) Program

Author: David Meltzer, MD, Chief Section of Hospital Medicine, Director/Founder, Comprehensive Care Physician (CCP) Program

Organization: University of Chicago Medicine (UCM)

Practice Category: Multi-Stakeholder Collaboration

Relational Type: Trust between patient and physician

Description of Trust Practice:

The Comprehensive Care Physician (CCP) Program addresses the problem of fragmented care among frequently hospitalized patients by providing these with a physician who cares for them both in hospital and clinic. To have a sufficient number of hospitalized patients each day while having an ambulatory panel of patients that is small enough to manage despite hospital duties, CCPs restrict the size of their patient panel and focus on those at increased risk of hospitalization. This focus on providing both inpatient and outpatient care enables CCPs to improve care by leveraging the knowledge, trust, communication and interpersonal relationship between doctor and patient that can develop with sustained inpatient and outpatient engagement. The CCP program is comprised of five CCP physicians and a small team of two nurses, one licensed social worker, and one clinic coordinator. The work of the CCP clinical team is highly integrated as they are co-located and participate in daily multidisciplinary rounds to discuss particular complex patient cases and coordinate efforts. The CCP program serves Medicare beneficiaries at increased risk of hospitalization, primarily individuals who have been hospitalized at least once in the past year. Such patients are only 10 percent of Medicare beneficiaries, but account for over half of Medicare spending. The UCM CCP program serves a medically complex and socioeconomically disadvantaged population.

Skills/Competencies:

- Inpatient and outpatient primary care clinical skills
- Interdisciplinary care skills
- Understanding of complex social needs
- Ability to work well on an interdisciplinary team

“The CCP clinical team relies on a set of skills to develop and sustain trust between one another. Given the leanness of the team, it is important that the CCP physicians, nurses, social workers and clinic coordinator work effectively with one another.”

Proof of Concept:

The CCP program has been evaluated since 2012 through a Center for Medicare and Medicaid Innovation-funded randomized controlled trial in which 2,000 eligible patients were randomly assigned to either CCP or to standard care with care from different physicians in the hospital and clinic. Statistically, patient satisfaction with their physician has increased from the 20th to the 95th percentile nationally, self-rated mental health has improved, and hospitalizations have decreased 15–20 percent, preventing one hospitalization for every four persons enrolled for a year. Patients were surveyed at randomization and every three months by telephone to assess patient experience with their primary physician, satisfaction, health outcomes and hospitalization rate. The response rates in the follow-up surveys for both arms were 89 percent for the 12-month follow-up calls and 82 percent for the 24-month follow-up calls. In unadjusted analyses over two years, 84.3 percent of patients randomized to CCP reported usually or always trusting their physician, compared to 81.7 percent of those randomized to standard care. At two years, these differences remained similar, at 85.7 percent for CCP compared to 83.3 percent for those randomized to standard care. The one-year model shows a significant odds ratio comparing CCP to SC of always trusting the physician as 1.38 (95% CI [1.01, 1.88]) and the two-year estimate was 1.37 (95% CI [1.04, 1.81], both significant at $p < 0.05$).

Replicability/Scalability

CCP takes a lean approach to care coordination that reorganizes responsibilities to reduce care discontinuities rather than hiring additional clinicians to manage care. It has been adapted for a private practice-based community hospital setting with UCM's affiliated Ingalls Hospital, and UCM is working with several Chicago hospitals to explore how a network of CCP and similar models might improve the care of frequently utilizing patients. Vanderbilt and Kaiser Permanente's Mid-Atlantic Region are also implementing versions of CCP. Internationally, National University Singapore has implemented a version of CCP and the U.K. National Health Service and Manipal University in India are exploring versions of CCP.

UCM has also launched a complementary practice called the “rounder model,” under which the physician see patients in the hospital for part of each day but does not maintain a panel of ambulatory patients. Instead, rounders partner with a set of ambulatory providers to care for those providers' patients whenever they are hospitalized, creating sustained relationships with those patients and providers that should improve outcomes. The rounder model is simpler to implement, which may make it a useful first step to implementing a full-scale CCP model. In addition, UCM operates a CMS-funded learning collaborative with 15 health care systems that provides opportunities to discuss complex cases and CCP implementation issues.

For more information, contact Dr. David Meltzer at dmeltzer@medicine.bsd.uchicago.edu

Practice Name: Immediate Radiology Results Delivery

MERITORIOUS

Author: Jennifer L. Kemp, MD, FACR, Vice President Diversified Radiology

Organization: Diversified Radiology and Rose Medical Center

Practice Category: Patient-Centered Design

Relational Type: Trust between patient and physician

Description of Trust Practice

Through the Immediate Results Delivery Program, radiologists at Diversified Radiology in conjunction with technologists at Rose Medical Center in Denver, CO, report their findings directly to outpatients immediately following their CT and ultrasound imaging exams. When a technologist encounters a patient who seems particularly anxious or who expresses concern about waiting to receive his/her imaging results, the technologist will ask the patient whether he/she would like to speak with the radiologist. If the patient agrees, the technologist reaches out to the radiologist by either text messaging or phone. The radiologist then reads the study and calls the technologist back, typically within 5–10 minutes. If the patient is located in the same department as the radiologist, they will meet face to face to discuss results. If the patient is located at another imaging center, the technologist puts the patient on the phone to discuss the results with the radiologist. In serious cases, the radiologist contacts the patient's referring physician to ensure he/she knows what the radiologist discussed with the patient. More information can be found in this case study from the American College of Radiology.

Skills/Competencies

- Empathy
- Communication
- Coordination

“Traditionally, radiologists do not deliver imaging results directly to patients. This practice helps engage patients more fully in their care because they receive the results from the imaging experts, who can best explain the findings and answer their questions. The practice starts with empathy on the part of the technologist, recognizing when a particular patient would benefit from talking with the radiologist. The practice also relies on strong communication and coordination skills on the part of the radiologists, who must deliver the results in a clear and understandable manner while keeping referring providers informed about the conversations they have had with patients about significant findings.”

Proof of Concept

This practice builds trust with referring providers because the radiologists keep the clinicians informed about any significant results they discuss with patients. As Richard Abrams, MD, says, “The only way this works is if there's trust between the patient, the physician and the radiologist. Collaboration is critical to ensure that none is overstepping their skills and bounds.” It also builds trust with patients by allowing them to speak with the person who interpreted their imaging studies. About 90 percent of patients who are given the opportunity to speak with the radiologists take it, according to this [case study](#).

Replicability/Scalability

This practice can be easily reproduced at other radiology groups and hospital settings. Each patient consultation takes just a few minutes, making it possible for radiologists to include immediate results delivery into their existing workflow with minimal disruption.

For more information, contact Dr. Jennifer Kemp at jkemp@divrad.com

Practice Name: OpenNotes

Author: John Santa, MD, MPH, Director of Dissemination; Leonor Fernandez, MD, Vulnerable Populations and Health Equity

Organization: Beth Israel Deaconess Medical Center

Practice Category: Patient-Centered Design

Relational Type: Trust between patient and physician

Description of Trust Practice:

The practice of OpenNotes is technically simple, but represents a consequential change in the culture of medical practice. Clinicians invite their patients to read what they have written about them, offering ready access to their medical records and making their care transparent. While individual clinicians have long shared paper copies of their notes with patients and their authorized care partners, such practice has not been widespread. Moreover, while HIPAA more than 20 years ago afforded patients the right to review their notes, only rarely did patients do so. Many did not realize such notes exist (as is still the case today) and when they tried to access their notes they often encountered many hurdles. Today, electronic records can enable instantaneous sharing via patient portals and apps. Clinical notes differ from other types of information in the record. They document interactions and conversations patients have with their doctors, nurses or other health care professionals and usually include details, assessments and plans regarding perhaps the most important information regarding a given patient's condition and treatment plan. Notes can tell "the story" of a person's health care, connecting many disparate elements scattered through their records. Easy access to ambulatory notes brings patients substantial benefits that well outweigh any risks for both patients and clinicians

Skills/Competencies:

- Technological competence
- Culture
- Patient involvement and responsiveness
- Promotion

"Beyond being an effective way for clinicians to reinforce and enhance the information they share in a visit, the invitation to such communication and transparency increases mutual trust: patient trust in clinicians and the trust of clinicians in their patients."

Proof of Concept

Growing research indicates that a large majority of patients who have read notes and participate in interviews, focus groups and surveys report very positively about their experience with this practice. Many of the benefits cited appear based on the following: open note transparency helps reinforce and model mutual trust, respect and clarity. Patients report that they recall and understand their health conditions better, feel more in control of their health, adhere better to medication usage, have better communication with clinicians and care partners and have increased trust in their doctors. They also report better awareness of next steps and increased ability to find and report potential errors in their record. Strikingly, African Americans and other ethnic minority respondents, as well as respondents with less than high school education, are more likely to report improved trust in their clinicians and in their health care organizations than white patients or those with higher incomes.

Replicability/Scalability

OpenNotes is technologically simple to implement and unlike many other innovations in healthcare it does not require new staff, major changes in clinical practice, or disruptions in workflow, making it easily scalable and reproducible in other organizations. Most of the large electronic medical record vendors support the practice by making certain functionalities available; however, most of the smaller vendors do not. The U.S. Department of Health and Human Services' Office of the National Coordinator for Health Information Technology has recently proposed criteria for interoperability related to the 21st Century Cures Act that will require notes be included in information easily available in patient portals and via Fast Healthcare Interoperability Resources application programming interfaces (APIs). Failure to do so could possibly be reported as "information blocking" and result in penalties.

For more information, contact Dr. John Santa at santa1177@comcast.net

Practice Name: Rough, Rapid, Right

MERITORIOUS

Authors: Karl Koenig, Joseph M. Abell Arthroplasty and Value-Based Health Care

Fellowship Director, [Department of Surgery and Perioperative Care](#), Associate Professor, [Department of Surgery and Perioperative Care](#), Medical Director, Musculoskeletal Institute, [UT Health Austin](#); Lucas Artusi, Assistant Professor of Medicine, Dell Medical School, Assistant Professor of Practice, School of Design and Creative Technology, Systems Designer, Design Institute for Health

Organizations: Musculoskeletal Institute, UT Health Austin; Department of Surgery and Perioperative Care, Dell Medical School; Design Institute for Health, Dell Medical School & The College of Fine Arts at the University of Texas at Austin; Practice Category: Patient-Centered Design; Relational Type: Trust among team members

Description of Trust Practice

The Design Institute for Health—a partnership between the Dell Medical School and the College of Fine Arts at the University of Texas at Austin—employs a team of designers who leverage both systems thinking and the human-centered design process to drive innovation in health and healthcare.

The human-centered design process has several phases that allow designers to identify latent user needs; understand the context of users' lives, their challenges and capabilities, and the workarounds they've devised; and quickly devise, develop, test and iterate potential solutions for those needs. The two cycles—one for problem/opportunity identification, another for solution generation—follow a rhythm of divergent and convergent thinking.

User research takes the form of in-depth, qualitative, contextual interviews and observations, in addition to immersive experiences during which designers attempt to navigate the same situations as their users in order to develop increased understanding of their mental models for how they engage with their health and healthcare. Once the design team has collected that information, they spend many hours conducting synthesis activities, uncovering hidden patterns in user needs, mapping user journeys, and understanding the systems that underpin these activities.

The cycle for solution generation begins with idea generation—or ideation—most commonly through brainstorming; this phase results in a large volume of ideas in a short span of time. Designers then build and test a subset of those ideas. At this early stage, building means creating products (physical or digital), services, environments, systems and communications tools at a very low level of resolution (rough), in a short span of time (rapid), to gain new insights about both the specific need being addressed and about the users more generally (right).

By working in this way, the Design Institute reduces the cost of innovation in dollars, time, and other resources and to create a sense of shared ownership and trust among members of the organization by involving clinical, operations and other personnel as early as possible in idea development. The subtle bonus is that by “failing” without spending large amounts of money or time, when an idea doesn’t pan out quite as expected—an common occurrence when pushing innovation in complex systems—the organization becomes more tolerant of the inherent messiness that comes with trying to create transformative change in healthcare.

Skills/Competencies

- Ability to design graphic, product, service and environmental solutions
- Stellar listening and observation
- Change management
- Systems thinking

“The team often builds paper prototypes of digital applications, constructs products using common hardware store materials, or mocks up physical environments and services by using foam-core boards to build out a space and having designers play different roles—patient, provider, administrator, etc.—to make the experience feel real. They then test their products with users, not just to gain an understanding of that particular solution’s effectiveness, but also to learn more about the users.”

Proof of Concept

Dell Medical School providers are seeing a similar volume of patients compared to clinics following a transactional, fee-for-service model. Early outcomes measures suggest patient outcomes are comparable to if not better than existing clinical models. Many of the patients are historically under- or uninsured, and not only are their satisfaction scores high, but they frequently express how “nice” the clinics feel and how different they are from what they are accustomed to, the latter being a critical outcome given the history of racial, economic, and health disparities faced by Central Texans. Providers trust in the model because they participated in its development. They were not dropped into a new space and forced to learn it; they collaborated in its creation.

Replicability/Scalability

The human-centered design process is widely known and understood: much has been written about it, there are many organizations teaching it, and there are many resources available to facilitate its implementation. Having a team of dedicated designers working with a high degree of autonomy and access is a critical component in a learning health system driving toward innovation, but is comparatively cheap compared to the return on investment in outcomes for patients as well as the experience for those getting and receiving care alike.

For more information, visit designinhealth.org

Practice Name: Shared Decision Making for Elective Surgery Decisions

Author: Karen Sepucha, Associate Professor

Organization: Massachusetts General Hospital/Partners Healthcare System

Practice Category: Patient-Centered Design

Relational Type: Trust between patient and physician

MERITORIOUS

Description of Trust Practice

Since 2005, Massachusetts General Hospital has had a program to promote shared decision-making (SDM) in primary care, focused on clinician training and distribution of patient decision aids. In 2012, its orthopedic group, prompted by the SDM program, began a new project to promote the use of patient decision aids for elective surgery decisions in orthopedics. They integrated four decision aids into routine care (treatment choices for hip osteoarthritis, knee osteoarthritis, herniated disc and spinal stenosis). Clinicians and staff have the ability to “order” decision aids for patients through the electronic medical record. The order is documented in the chart and the patient receive the decision aid online if enrolled in the hospital’s web portal. Patients who were not part of the portal were sent a copy of the decision aid (booklet and DVD) to their home. There are different workflows to get the decision aids to patients, through referral to a specialist, from staff pre-specialist visit, and from the specialist after the visit. Flexibility in getting the decision aids to patients was necessary to adapt to different clinical situations and was a key driver of the sustained success of the project. The project involved training clinicians and staff in the ordering process, familiarizing them with the content of the decision aids, and standardizing the messaging to patients about the tools.

Skills/Competencies

- Communication skills
 - Inviting the patient to participate in the conversation
 - Eliciting patient goals
- Presenting options
- Communicating probabilities

“Some of the core skills required of patients to engage in shared decision making include health literacy, numeracy, and comfort asking questions, sharing preferences and disagreeing with a clinician’s recommendation. Studies find that decisions aids improve patient knowledge, reduce decisional conflict and help patients clarify their treatment preferences.”

Proof of Concept

Massachusetts General surveyed about 650 patients, half before the implementation and half after the implementation, to examine the impact of the implementation of patient decision aids in orthopedics. Patients completed a survey one week after the visit with the specialist (regardless of whether they received a decision aid). The survey included questions to assess knowledge, treatment preference, shared decision making and the quality of communication with the specialist. Overall, patients reported more shared decision making ($p=0.009$) and better communication ($p=0.02$) with the specialist after the decision aid implementation. Patients who reported reviewing the entire decision aid also had higher shared decision making scores than those who did not ($p=0.002$). Finally, patients who reviewed the decision aid had significantly higher knowledge scores than those who did not ($p<0.001$). Although trust was not measured directly, the data provide evidence of a stronger patient-physician relationship and by extension more trust.

Replicability/Scalability

Efforts to scale this practice across Partners Healthcare system and its network of more than eight hospitals and 300 primary care practices have begun. The decision aid ordering process has been built into a new electronic medical record system, and they are working with orthopedic and neurosurgery groups across the main Partners' hospitals to raise awareness of SDM and decision aids and to design workflows to increase their use in academic and community settings. In addition, they are looking directly at the link between decision aid use and trust, specifically whether prescribing the decision aids before hip and knee arthroplasty and spine surgery increases trust in the surgeon and reduces regret about the decision to undergo the procedure, thereby lowering malpractice risk. The project includes development and validation of a trust survey to use as an outcome measure and a survey of patients six months after the procedures who did and did not receive a decision aid.

For more information, please visit www.mghdecisionsciences.org or contact Karen Sepucha at ksepucha@mgh.harvard.edu

PATIENT-CENTERED DESIGN

Practice Name: The Buprenorphine Team (B-Team)

MERITORIOUS

Authors: Richard Bottner, PA-C, Director, Support Hospital Opioid Use Treatment (SHOUT)

Texas and Director, B-Team; and Nicholaus Christian, MD, Internal Medicine Resident and Research Lead, B-Team

Organization: Dell Medical School, University of Texas at Austin

Practice Category: Patient-Centered Design

Relational Type: Trust between patient and physician

Description of Trust Practice

The Buprenorphine Team (B-Team) is an inter-professional and multidisciplinary service at an urban academic medical center that seeks to improve care for patients with opioid use disorder (OUD) through medical intervention and institution-wide education. The B-Team can be consulted by any member of the care team, including the nurse, social worker, resident or attending physician, for hospitalized patients who also have OUD. A trained physician and/or advanced practice provider from the B-Team meets with the patient to obtain a detailed history and discuss education about OUD and possible treatment options, using patient-centered language and behavior, to develop a trusting relationship. The B-Team teaches other health care providers about these techniques and leads a number of activities specifically aimed at reducing stigma and raising awareness about OUD. When patients want buprenorphine therapy, the B-Team obtains consent and works side by side with the care team to initiate treatment, via a protocol developed by pharmacists, prescribers and nurses. While induction therapy typically lasts 48 hours, the B-Team follows patients during the remainder of their hospitalization, which may be up to six weeks. During this time, the team provides psycho-spiritual support, facilitates changes in medication therapy and answers questions from the care team related to OUD and its treatment. The B-Team also provides robust care coordination with the intake coordinator (a licensed professional counselor) at designated outpatient partner clinics. At discharge, the B-Team clinician prescribes bridge therapy with buprenorphine until the arranged outpatient follow-up appointment, which is typically within three days of discharge.

Skills/Competencies

- Professionalism, patient-centered care, interpersonal/communication skills, systems-based practice, medical knowledge and practice-based learning and improvement*
- Interprofessional collaboration
- Empathy and listening
- Collaborative counseling

“Interpersonal and communication skills are important to maintain open dialogues and promote the exchange of information. These skills are paramount in team-based healthcare. Systems-based practice requires providers to coordinate patient care across the care continuum, appreciate cost effectiveness, advocate for quality, and work in interprofessional teams. The team promotes patient-centered and recovery-based language throughout the institution and develops relationships with appropriate outpatient clinics.”

*Six core competencies of the American College of Graduate Medical Education

Proof of Concept

From mid-September 2018 through early February 2019, the B-Team received 43 consultations for patients with presumed OUD, reflecting adoption of patient-centered care principles for patient with this disorder throughout the institution. All patients referred to the B-Team received patient-centered education about OUD, multiple print resources and an offer to start treatment or direct referral to an outpatient treatment program. Of these patients, 42% (N=18) were eligible for buprenorphine therapy during hospitalization. Of those who started therapy, almost all received a warm handoff to the outpatient clinic (N=17). One week after discharge, 47% of patients engaged in their follow-up appointment. Thirty-five percent of patients took part in their one-month appointment, and 18% were still engaged in therapy at three months. There are a number of ongoing quality improvement processes that should further improve outcomes. For example, the team reduced the eligibility criteria for patients seeking treatment, which created barriers to recovery. As of January 2019 patients need only to be at least 18 years old and diagnosed with OUD to receive services.

Replicability/Scalability

The B-Team is the only service of its kind in Texas and one of only few wrap-around services for patients with OUD admitted to hospitals in the nation. Often hospitals rely on robust addiction medicine services, which cannot be replicated in most institutions since many lack formal addiction medicine programs. The B-Team represents a model by which healthcare teams already engaged in hospital care can meet the need of this patient population. This work is reproducible with effective multidisciplinary care, understanding of the regulatory environment, and development of stakeholder partnerships. To scale this work, Dell Medical School has launched the Support Hospital Opioid Use Treatment (SHOUT) Texas program, establishing a center of excellence and thought leadership for the hospital-based treatment of OUD throughout the state. Goals include the creation of toolkits, webinars, evidence-based and state-specific guidelines, grand rounds presentation and coaching.

For more information, contact Richard Bottner at richard.bottner@austin.utexas.edu

TRANSPARENCY

On Guard for Influence

Research shows that it is human nature to be influenced by individuals and groups with whom we have relationships, and that bedrock attributes of trust include transparency, accountability and integrity. The American Board of Internal Medicine has developed detailed policies and tools to help keep competing interests at bay when it comes to decision-making by its more than 350 volunteer governance members. **p. 70**

WINNER TRANSPARENCY

Practice Name: Trust in Transparency and Public Reporting

Author: Christopher Queram, President and CEO

Organization: Wisconsin Collaborative for Healthcare Quality

Practice Category: Transparency

Relational Type: Trust between clinician and organization

Description of Trust Practice

The Wisconsin Collaborative for Healthcare Quality (WCHQ) is a voluntary consortium formed in 2004 by nine health system leaders, in partnership with the business community, who believed data collection, transparency and collaboration had the power to transform practice and improve the quality of patient care. WCHQ members, which have grown to nearly 40 provider and dental organizations, agree not to compete on quality, owing to a shared belief that every patient should receive the same high-quality, safe care, regardless of where they may reside in the state. Members share and use data to fulfill accountability to consumers (the public) and to catalyze performance improvement. Today, WCHQ's membership represents more than 65 percent of the primary care physicians practicing in Wisconsin, along with thousands of nurses, quality improvement specialists and others in administrative and support roles. They deliver care to more than 94 percent of the state's Medicare beneficiaries.

WCHQ was an industry pioneer in producing valid and reliable comparative measures of physician performance for an entire population of patients, irrespective of payment source. Achieving this goal required direct access to data residing within the billing and clinical systems of the provider organizations. Through an iterative series of trust-building conversations, WCHQ members agreed to voluntarily submit patient-level billing and clinical data to create the first true population-based measure of diabetes process and control in 2004.

WCHQ has steadily built on this foundation of trust by creating a robust data warehouse that stores granular information on more than 500 million patient encounters. The WCHQ measure portfolio currently consists of more than 40 ambulatory quality measures at both the health system and practice-site levels. WCHQ members also use the data for internal improvement and can evaluate performance down to the level of the individual clinician. WCHQ convenes and facilitates collaborative learning sessions that focus on sharing best practices. The combination of transparent public reporting and sharing best practices epitomizes an environment of reciprocal trust. Members trust that WCHQ will be a faithful and diligent steward of their data and that, in return, WCHQ will generate valid and reliable measure results that are used in the spirit of public accountability, collaboration and improvement.

Skills/Competencies

- Inclusive governance
- Relational management
- Consensus building on core values

“WCHQ adheres to nine core values (www.wchq.org/about/values.php) that are essential to building consensus and driving improvement in pursuit of our mission to improve the health and affordability of health care across Wisconsin and beyond. First among the nine is Trust, defined as the avoidance of ‘using performance data for market advantage or purposes other than the advancement of WCHQ’s mission.’ The remaining eight values reinforce, amplify and advance this foundational precept through commitments to Participation, Inclusiveness, Shared Responsibility, Openness, Adaptive Self-governance, Intellectual Output and Transparency.”

Proof of Concept

Wisconsin was one of the first states in the country to publicly report clinical data related to quality when WCHQ released a diabetes process and control (hemoglobin A1C and cholesterol) measure for six physician organizations in October 2004. WCHQ has grown to an organization that now has 35 members and a diverse measurement portfolio with over 40 measures.

Publicly reporting quality results requires trust, especially given that there is always a top and a bottom performer, even in a state with exceptional quality. WCHQ members recognize that improvement will result from the sharing of best practices once top-performing organizations can be identified through public reporting and benchmarking. WCHQ’s model brings health care leaders together to create a forum for discussions centered on public reporting, quality improvement and per capita cost, and appropriateness of care.

Evidence suggests that WCHQ has contributed to Wisconsin’s serial ranking as one of the top performing states in the country on meta-measures of health care quality. Some of the evidence is observational, as a review of the longitudinal data on the WCHQ web site shows steady and sustained improvement across the measure portfolio. WCHQ’s experiences have contributed to the evidence base through several qualitative and quantitative studies published over the last decade.¹⁻³

Replicability/Scalability

The WCHQ governance model and value streams can be replicated in any practice setting and geographic region that combines vision, foresight and will to pursue a multi-stakeholder, collaborative approach to systems change. As one concrete example, WCHQ has expanded its measurement and improvement work to dentistry, welcoming four dental practices to its membership in 2018. Their vision is to advocate for an integrated model of oral and systemic health, while leading dental providers down the now familiar path of initiating data collection, generating measures for benchmarking, facilitating improvement, and reporting publicly. The WCHQ model has spread outside Wisconsin “organically” by virtue of mergers involving health care systems based in other states as well as members that serve patients across the borders with Illinois, Iowa, Michigan and Minnesota. WCHQ is seeking to expand beyond adjoining states by pursuing franchise partnerships. WCHQ’s data repository can accept data from anywhere in the country and its intellectual property could be licensed to and adopted by a willing partner in another state.

For more information, visit www.wchq.org

- 1 Greer, AL. *Embracing Accountability: Physician Leadership, Public Reporting, and Teamwork in the Wisconsin Collaborative for Healthcare Quality*. The Commonwealth Fund, 2008.
- 2 Smith MA, Wright A, Queram C, and Lamb GC. Public reporting helped drive quality improvement in outpatient diabetes care among Wisconsin physician groups. *Health Affairs (Milwood)*. 2012; 31(3): 570-77
- 3 Lamb GC, Smith MA, Weeks WB, and Queram C. Publicly reported quality-of-care measures influenced Wisconsin physician groups to improve. *Health Affairs (Milwood)*. 2013; 32(3): 536-543.

Practice Name: Universal Disclosure of Relationships: Enhancing Trust by Understanding Competing Relationships*

Author: Lorna Lynn, MD, Vice President, Medical Education Research

Organization: American Board of Internal Medicine

Practice Category: Conflict of interest

Relational Type: Trust in science and evidence

Description of Trust Practice

The American Board of Internal Medicine (ABIM) relies on the contributions of over 350 volunteer governance members on more than 50 boards and committees. Most of these members are physicians who are certified in internal medicine and/or one or more of its subspecialties. Many of these members are also sought out by other organizations, including health care-related industries (especially pharmaceutical companies and medical device makers), medical specialty societies and patient advocacy groups. These collaborations can benefit the members themselves, other organizations, and the public, which benefits from advances in health care products, technology and delivery. However, these relationships also introduce the risk of industry influence. ABIM understands that even the appearance of potential industry influence on its products or policies jeopardizes the profession's and the public's trust in its certification programs.

ABIM has developed detailed policies and tools to help assure that any competing interests do not affect decision-making by governance members. These tools begin with detailed universal disclosure about any relationships that a governance member has (or has had within the prior 12 months) with any health care-related company, medical specialty society, or patient advocacy group. This detailed disclosure process is the bedrock for ABIM's other tools for addressing competing interests: open discussion among members about each other's relationships and potential impact on the group's work; prohibition of high-risk activities; and developing management plans for individuals and groups when needed. ABIM knows that the relationships its governance members have with ABIM have similar potential to represent competing interests, and therefore asks members to disclose their relationship with ABIM in all public speaking and in their disclosures for publications.

Skills/Competencies

- Transparency
- Recognizing that individuals are often unable to make judgments about what relationships present conflicts

“Most people are confident that their own decision-making is free from any external influence, even while research shows that it is human nature to be influenced by individuals and groups with whom we have relationships.”

*Not eligible to be a winner of the Challenge

Proof of Concept

ABIM boards and exam committees are required to have two members who either have no financial relationships with industry or are at extremely low risk of bringing industry influence. While some groups initially struggled to identify members without financial relationships, this requirement has led to consideration of candidates from a wider array of practice settings, thus increasing the diversity of the governance groups and more authentically representing the broader internal medicine community.

ABIM is in the planning stages for a structured qualitative and quantitative evaluation of the effects of its process that will focus on whether members feel confident that they have the information they need to identify any potential unintended bias in the decisions made or products developed by the board or committee on which they serve. Anecdotally, many members have said that they understand the reason for requiring such information, and appreciate the opportunity to provide the context and detail that helps their colleagues and the public understand the benefits that collaboration between physicians and industry can produce.

Scalability

Disclosure of relationships to identify conflicts of interest is required in a variety of settings, such as for authors, lecturers, researchers and members of committees developing clinical guidelines. While the general process of disclosure is common, specifics vary considerably. ABIM's process could certainly be adapted by other groups to fit their needs. The biggest challenge for many groups would be moving to a process in which individuals provide detailed information about all of their professional relationships, so that the multiple connections many of them will have are known, and any unintended bias can be recognized.

For more information, contact Dr. Lorna Lynn at llynn@abim.org

VALUE/AFFORDABILITY

A Reckoning with Lapsed Care

Skyrocketing costs have touched most every health care system in some fashion, placing strains on physicians and other clinical providers and putting patients at risk for financial harm. Geisinger Health has taken a novel approach to trust by addressing value and affordability with its Refund Promise. **p. 75**

Practice Name: Fostering Trust Through Culture Change

Author: Reshma Gupta, Interim Chief Value Officer

Organization: University of California, Los Angeles (UCLA) –Olive View Medical Center

Practice Category: Value/Affordability

Relational Type: Trust between clinician and organization

MERITORIOUS

Description of Trust Practice

Health systems facing pressures to reduce healthcare costs risk losing trust among care teams. These teams often are asked to see more patients, build revenue, and cut costs without messaging around preserving quality or individualized patient experiences. This loss of trust in turn can reduced care team engagement and success of improvement interventions.

Both presumed and experienced trust are foundational to improve value and affordability in health and health care. Building trust, therefore, will require understanding the culture underlying mistrust, re-envisioning how we provide messaging and training to our care teams and keeping patients central. Culture is defined as a system of shared assumptions, values, beliefs and norms within an environment; it has a powerful role in shaping clinician practice patterns. The culture within medicine currently contributes to the overuse of resources, and a culture for improvement is correlated with clinical outcomes. The High Value Care Culture Survey (HVCCS) offers a method to measure and identify targets for improvement in the culture. It measures the culture of value-based decision-making among front-line clinicians to identify target areas for improvement. The survey includes four domains: leadership and health system messaging, data transparency and access, comfort with cost conversations and blame-free environment.

Care teams may respond best to putting the cost of care in the context of patient stories revealing financial harms, with a focus on patient outcomes over costs, volume of services or profits alone. They may also benefit from additional training to deliver more affordable evidence-based, personalized care to patients and to have cost-conversations with patients.

UCLA's practice focuses on identifying targets for mistrust and the culture of high value care. UCLA aimed to develop a multi-specialty learning community to create a space for open discussion, train, and provide resources for value improvement efforts. They selected a value officer in each division in the department of medicine to lead these efforts who meet monthly for formal training in value improvement and work together to discuss methods to improve culture. They completed the HVCCS to identify areas of opportunity to build culture and trust, and now work together to improve these opportunities and the infrastructure to support greater health care value. Patient stories are central to individual and group initiatives. The officers partake in one-to-one coaching on initiatives, taking into account patient-specific factors and needs, especially among their vulnerable safety-net population.

Skills/Competencies

- Learning to apply the HVCC survey and steps to build a culture of high value
- Building comfort in holding open department-wide discussions about trust and culture
- Communication and person-centered messaging

“This practice is taking place within the department of medicine including over 15 divisions as well as multiple disciplines. The department has financially supported a Chief Value Officer, programmer, analyst and program manager to lead the overall program.”

Proof of Concept

The HVCCS and interviews with care team members revealed that they hoped for increased visibility and support by leadership to increase healthcare value with a person-centered approach. Since the program’s inception in October 2018, follow-up interviews with members have already demonstrated increased engagement by value officers, faculty, and staff. Previously front-line clinicians and staff from two divisions expressed interest in leading improvement initiatives, and now that number is 15.

Replicability/Scalability

It is feasible to measure culture and trust among front-line care teams and can identify tangible methods to target improvement. Once targets are identified, tools and trainings can be deployed, including cost conversation modules, patient stories, and evidence-based practice guidelines. Finally, developing a community of learners can facilitate open communication and aligned culture change to combat mistrust.

For more information, contact Dr. Reshma Gupta at R44gupta@ucla.edu

Practice Name: Refund Promise

Author: Greg Burke, MD, Chief Patient Experience Officer

Organization: Geisinger Health

Practice Category: Value/Affordability

Relational Type: Trust between patient and organization

Description of Trust Practice

Geisinger's refund promise states in simple terms that if patients' expectation of "caring" in their interaction with the health system is not met, they are entitled to a refund of direct financial obligations related to their care. This includes co-pays, deductibles and co-insurance. It does not include out of pocket expenses for travel or lost wages. Examples can include communication failures, treatment delays, hospitality gaps or excessive wait times. The patient is the judge of the failure and is assured that his or her perceptions are not in question. Patient disagreements with the clinical staff on diagnoses, therapeutic decisions or medical testing are not included, and the promise is not retroactive to the date it was promulgated by the system CEO.

Employees are empowered when observing "care" failures to offer the refund or forgive any outstanding bill. However, patients are free to contact the system by any method to request a refund. This is done most frequently through patient advocates, but can also be managed by operations leaders. Difficult cases can be referred to the "patient experience" leadership team to adjudicate. The bias should favor the patient; the guiding principle is that since patients have trusted the health system with their own health and safety, the system must trust their reports of "care" failures. Ultimately, the system benefits from the trust exemplified by the promise, and also learns valuable lessons to improve the process of caring for patients and families.

Skills/Competencies

- Open-mindedness
- Advocacy for patients and families
- Listening, empathic communication and humility
- Being accountable for service and quality

"The refund promise is a new concept in health care. Therefore, healthcare leaders and operational managers most remain open minded about the process and remain singular advocates for 'making it right' for patients and families."

Proof of Concept

In health care, the level of trust handed over to a health system, and in particular to an individual clinician, is staggering – sometimes no less than life or death. Therefore, it is a moral imperative that if health care fails in caring for patients in the terms already discussed, their financial burden should be removed with no questions asked.

As it says on Geisinger's phone app – "You put your trust in us and so we put our trust in you."

Replicability/Scalability


The refund promise is fundamentally straightforward and has been applied to all areas of clinical care: inpatient, outpatient, urgent care, etc. There are few rules or paper trails; refund decisions are left to front-line leaders, managers and patient advocates. It simply requires the courage to make the promise and stand by its guiding principles, which are based on integrity, humility and trust. The patient experience team has learned from tracking complaints where efforts are required to improve satisfaction. The pay-out has been relatively small, compared to the overall budget. From an operational standpoint, the gains in patient loyalty and the promotion of a positive institutional reputation are hard to quantify, but well worth the investment.

For more information, contact Greg Burke at gburke@geisinger.edu

Index of Winners and Meritorious Practices from Trust Practice Challenge

Communications/Knowing Your Patients

The following entries focused on interpersonal communication with patients in their practices for building and nurturing trust.

-  • **Graphic Medicine to Empower Patients to Trust Physicians Using Electronic Health Records**, University of Chicago Medicine **p. 10**
- **Choosing Wisely**, ABIM Foundation, **p. 12**
- **Communication and Resolution Program (CRP) Certification Program**, University of Washington **p. 14**
- **Proper Name Pronunciation**, GreenField Health **p. 16**

Conversations/Support

The following entries focused on supportive conversations and systems in their practices for building and nurturing trust.

-  • **Relational Leadership Institute**, Oregon Health & Science University **p. 18**
-  • **Voices of Duke Health Listening Booth and Podcast**, Duke University School of Medicine, Department of Medicine **p. 20**
- **3rd Conversation**, X4 Health and 3rd Conversation **p. 22**
- **AOTA Communities of Practice**, American Occupational Therapy Association **p. 24**
- **Open Honest Questions**, Center for Courage & Renewal and 100 Million Healthier Lives **p. 26**
- **Peer Support**, Brigham and Women's Hospital **p. 28**
- **Respect for People**, Virginia Mason Medical Center **p. 29**
- **Third-Year Student Professionalism Essay Assignment**, Indiana University School of Medicine **p. 31**
- **Trust-Busters Card Sorting Activity**, Amicus Inc. **p. 33**

Leadership

The following entries focused on leadership skills in their practices for building and nurturing trust.

-  • **Colleges Advisory Program**, Johns Hopkins School of Medicine **p. 35**
-  • **The Leader Index**, Mayo Clinic **p. 37**
- **Narrative Leadership**, Primary Care Progress **p. 39**
- **Personal and Professional Development (PPD)**, Massachusetts General Hospital **p. 41**

Misinformation

The following entries focused on misinformation in their practices for building and nurturing trust.

- **Journalist's Resource**, Harvard Kennedy School's Shorenstein Center on Media, Politics and Public Policy **p. 44**
- **Untangling the ALS X-Files**, ALS Untangled **p. 46**
- **Vaccine Education Center**, The Children's Hospital of Philadelphia **p. 48**


Patient-Centered Design

The following entries focused on patient-centered design in their practices for building and nurturing trust.

-  **Getting Rid of Stupid Stuff**, Hawai'i Pacific Health **p. 51**
-  **Prairie Parkway LGBTQ Clinic**, UnityPoint Health **p. 53**
- **Comprehensive Care Physician (CCP) Program**, University of Chicago Medicine **p. 55**
- **Immediate Radiology Results Delivery**, Diversified Radiology and Rose Medical Center **p. 57**
- **OpenNotes**, Beth Israel Deaconess Medical Center **p. 59**
- **Rough, Rapid, Right**, Muskuloskeletal Institute, UT Health Austin; Department of Surgery and Perioperative Care, Dell Medical School; Design Institute for Health, Dell Medical School & The College of Fine Arts at the University of Texas at Austin **p. 61**
- **Shared Decision Making for Elective Surgery Decisions**, Massachusetts General Hospital/Partners Healthcare System **p. 63**
- **The Buprenorphine Team (B-Team)**, Dell Medical School, University of Texas at Austin **p. 65**

Transparency

The following entries focused on transparency as in their practices for building and nurturing trust.

-  **Trust in Transparency and Public Reporting**, Wisconsin Collaborative for Healthcare Quality **p. 68**
- **Universal Disclosure of Relationships: Enhancing Trust by Understanding Competing Relationships**, American Board of Internal Medicine **p. 70**

Value/Affordability

The following entries focused on value and affordability in their practices for building and nurturing trust.

- **Fostering Trust Through Culture Change**, UCLA –Olive View Medical Center **p. 73**
- **Refund Promise**, Geisinger Health **p. 75**

 Ribbon indicates Top Tier designation by judges



ABIM Foundation
510 Walnut Street, Suite 1700
Philadelphia, PA 19106