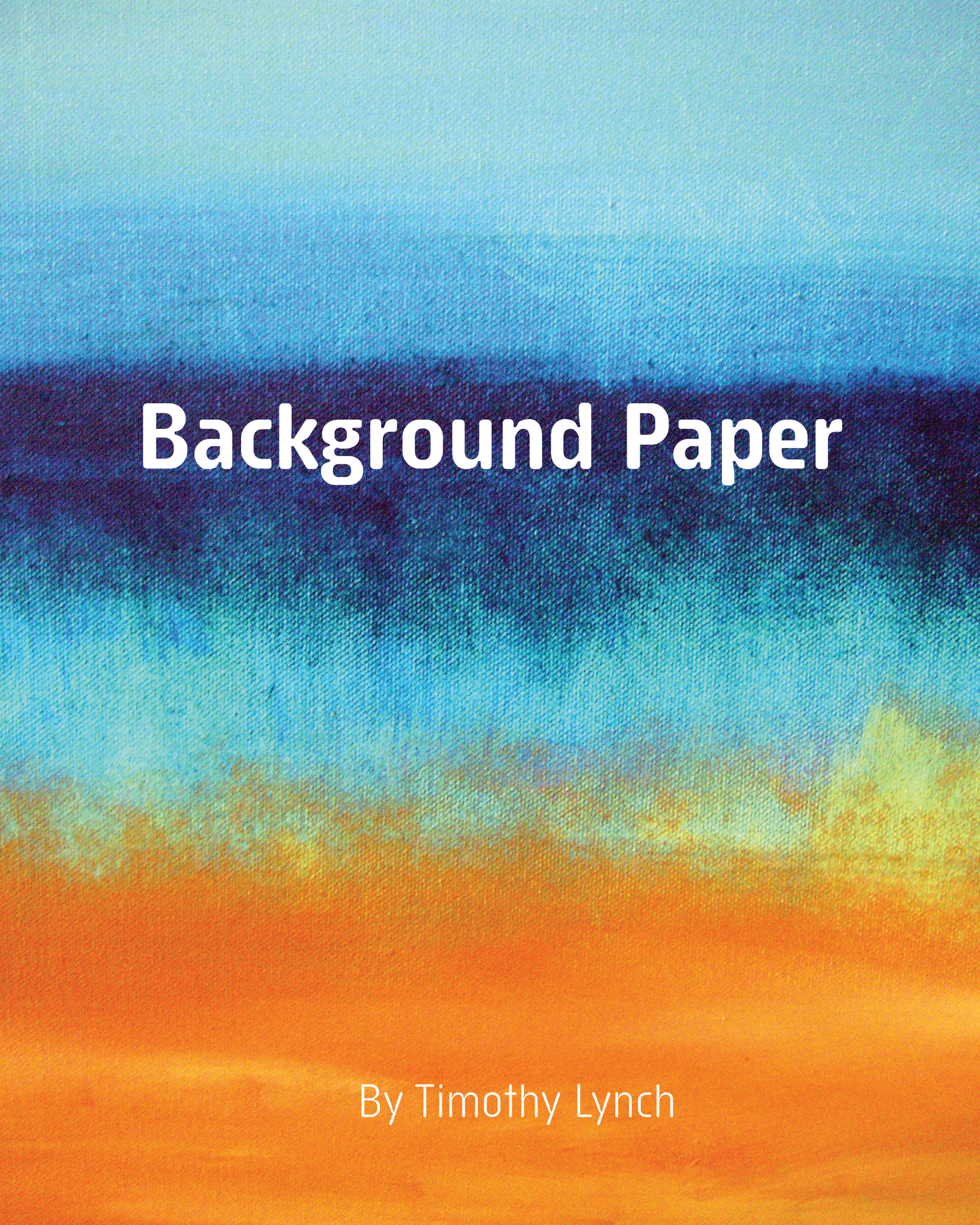

# Background Paper

By Timothy Lynch

With this year's Forum, the ABIM Foundation continues a conversation that began last year about trust in health care. During the 2018 Forum, participants explored trust in a variety of contexts in the health care system, such as between patients and physicians/clinical teams, between clinicians and their own organizations, and among organizations working in the health care field. Discussions that began at that Forum have since led to a broader consideration of trust in the health care world, including through a series of 11 articles written by Forum participants that have been or soon will be published in *JAMA*. Last year's Forum also influenced the ABIM Foundation's thinking about how it might improve trust in health care, beginning with its creation of the Trust Practice Challenge, the winners of which will be presenting at this year's event.

The Foundation has decided to focus on trust through the Forum and its other programmatic work for a variety of reasons, all of which fall under the umbrella of professionalism as it is defined in the "Physician Charter on Medical Professionalism." The Charter stresses the importance of patient welfare and patient autonomy, which can be exercised only in the context of trusting relationships.[1] Indeed, the Charter says that professionalism is the basis of medicine's contract with society, and states: "Essential to this contract is public trust in physicians, which depends on the integrity of both individual physicians and the whole profession."

During the 2019 Forum, participants will explore potential strategies and tactics that innovators have employed to improve trust at various levels of the health care system, and consider the conditions that need to be in place to enable promising practices to thrive and spread. We hope that the conversations that take place over the Forum's three days inspire participants to adopt promising innovations and develop their own new approaches to building trust.

To aid in these explorations, this paper will review developments that have taken place in the trust sphere since last summer's meeting, describe a sample of trust innovations, and provide a short overview of diffusion principles in health care that could aid meeting participants in their thinking about how they might best implement some of the ideas generated during our time together. In addition, we recommend that you review the background paper from the 2018 Forum, which describes what we know about the status of trust in the health care system, and why trust matters. You could also review an article that Foundation staff published in *Academic Medicine* earlier this year that explains the Foundation's interest in launching a trust initiative at this time.

## WHAT'S NEW IN TRUST

The ABIM Foundation has worked since last year's Forum to develop its trust agenda, in combination with partners. First, the Foundation coordinated with the working groups created at the 2018 Forum, which developed and submitted 11 papers about trust to *JAMA*. The journal has published all of these papers, which address the following topics:

- "A Framework for Increasing Trust Between Patients and the Organizations That Care for Them" by Thomas H. Lee, MD, MSc, Elizabeth A. McGlynn, PhD, and Dana Gelb Safran, ScD
- "Building Trust Between Physicians, Hospitals and Payers: A Renewed Opportunity for Transforming US Health Care" by Lewis G. Sandy, MD, Hoangmai H. Pham, MD, MPH, and Sharon Levine, MD
- "Physicians' Trust in One Another" by Richard M. Frankel, PhD, Virginia P. Tilden, PhD, and Anthony Suchman, MD, MA

1 ABIM Foundation, American College of Physicians, European Federation of Internal Medicine. The physician charter [Pamphlet]. Philadelphia:2002. Available from: http://abimfoundation.org/what-we-do/physician-charter.

- "From Distrust to Building Trust in Clinician-Organization Relationships" by Mary Jane Kornacki, MS, Dave A. Chokshi, MD, MSc, and Jack Silversin, DMD, DrPH
- "Trust Between Teachers and Learners" by David Sklar, MD and Graham T. McMahon, MD, MMSc
- "Building Trust Between the Government and Clinicians: Person to Person and Organization to Organization" by Peter V. Lee, JD, Donald Berwick, MD, and Christine A. Sinsky, MD
- "Trust Between Health Care and Community Organizations" by Soma Stout, MD, MS, Lisa A. Simpson, MB, BCh, MPH, and Prabhjot Singh, MD, PhD
- "Building Trust in Health Systems to Eliminate Health Disparities" by Donald E. Wesson, MD, MBA, Catherine R. Lucey, MD, and Lisa A. Cooper, MD, MPH
- "Why Physicians Should Trust in Patients" by Rachel Grob, PhD, Gwen Darien, BA, and David Meyers, MD
- "Why Bolstering Trust in Journalism Could Help Strengthen Trust in Medicine" by Vineet M. Arora, MD, MAPP, David Rousseau, MPH, and Gary Schwitzer
- "Promoting Trust Between Patients and Physicians in the Era of Artificial Intelligence" by Shantanu Nundy, MD, MBA, Tara Montgomery, and Robert M. Wachter, MD

The Foundation also sought to learn more about how those in the field are seeking to build trust by launching the Trust Practice Challenge. The Challenge asked people who work in or interact with the health care system to share specific approaches that have shown promise in improving trust between clinicians and patients, among clinicians, between clinicians and health systems/hospitals, and in other contexts. Nearly 70 entries were submitted, and the ABIM Foundation staff and expert judges reviewed them to select eight winners, who will present at the Forum.

The Foundation has also continued to explore the topic of misinformation in medicine. In January 2019, the Foundation convened a group of health care leaders, patient advocates, journalists and foundation executives to propose and discuss potential responses to the misinformation problem. Since then, measles outbreaks around the country have demonstrated the continuing salience of this issue and the resistance to expert opinion among a segment of the public, which has made it difficult to persuade people about vaccine safety. In response to this reappearance of a disease that had been proclaimed eliminated from the United States in 2000, several major social media platforms announced steps to combat misinformation about vaccines. For example, Facebook said that all health care articles appearing on Facebook would be eligible for fact-checking, and articles deemed false would rank lower in users' feeds than articles deemed to be accurate.[2] YouTube, owned by Google, said it would improve enforcement of its policy against ads running on anti-vaccine videos, depriving anti-vaccination activists of a source of revenue.[3] Congressional committees in the House and Senate held hearings on vaccines earlier this year, including a focus on how misinformation spreads. *NEJM* has also accepted a paper by Richard Baron, MD, the President and CEO of ABIM and the ABIM Foundation, and Adam Berinsky, PhD, the Mitsui Professor of Political Science at MIT and last year's Kimball Lecturer, entitled "Mistrust in Science Threatens the Physician-Patient Relationship."

2 Belluz J. Pinterest, Facebook, and YouTube are cracking down on fake vaccine news[Internet]. Vox; 2019 Mar 1 [cited 2019 May 15]. Available from: https://www.vox.com/2019/3/1/18244384/measles-outbreak-vaccine-washington

3 Ingram D. YouTube pulls ads from anti-vaccination videos after questions about enforcement [Internet]. NBC News; 2019 Feb 22 [cited 2019 May 15]. Available from: https://www.nbcnews.com/tech/internet/youtube-pulls-ads-anti-vaccination-videos-after-questions-about-enforcement-n974851

The Foundation is now considering the need for research on the gaps that currently exist in our understanding of the prevalence and impact of medical misinformation, and on promising approaches to addressing the problem. This is a component of a larger effort the Foundation is pursuing to prioritize important areas for trust-related research in health care.

## PRACTICAL APPROACHES TO BUILDING TRUST

As noted above, much of the discussion at this year's Forum will be devoted to practical approaches to building trust. Our Kimball Lecturer, Toyin Ajayi, MD, will offer some [such] approaches of her own. Dr. Ajayi is the Co-Founder and Chief Health Officer of Cityblock Health, a health and social services company focused on building healthier communities through a digitally enabled, integrated model that provides medical, behavioral health and social service delivery for underserved urban populations.

Dr. Ajayi argues that trust is critically important to a well-functioning and just health care system. "At the heart of ensuring that everyone—especially the most vulnerable—receives the care, support and services they need to live healthier lives, is trust," she told an audience at a 2018 NCQA event.[4] However, she notes that trust is often understandably lacking among patients from vulnerable populations, whose communities have been victimized by unethical experiments such as the Tuskegee syphilis study and who are the most affected by exorbitant prices for critical medications like insulin.

Dr. Ajayi cites the "transformative power of longitudinal trusted relationships as a fundamental attribute of successful models to improve care for people with complex needs."[5] Put another way, she has said "a more trustworthy system must start with people." She calls for fostering and sustaining trusted relationships between patients and at least one member of the care team, suggesting that this relationship need not—and probably should not—be with a physician. Indeed, she has suggested that non-clinicians are often best positioned to maintain these trusting relationships. Following from this idea, the community health workers that Cityblock employs to do outreach to patients and community members quite intentionally do not have health backgrounds.

She has noted that the growth of team-based care carries a potential downside: that no one on the team feels personally invested in each patient. "We don't want to silo things on care teams so that there's no one losing sleep over the patient," she has said. "Never undermine the dose-dependent power of a meaningful, trusted relationship. Every person should have an ally on their care team that they can trust, that they can ask for advice in a fragmented system."

### Trust Practice Challenge

Cityblock is an important player in a growing field of health care organizations and clinicians focusing on building trust as a means to improve care. The sophistication of these efforts became clear from the responses the Foundation received to its Trust Practice Challenge. These responses described a broad range of initiatives to build trust that addressed themes such as transparency, value, patient-centered design, knowing one's patients, conversations, leadership and combating misinformation.

4 Ajayi T. Quality Talks 2018. NCQA; 2018 Nov 13. Available from: https://www.ncqa.org/videos/toyin-ajayi-md-quality-talks-2018/

5 Ajayi T. WTFix 2018: Toyin Ajayi. What's the Fix. 2018 May 21 [cited 2019 May 15]. Available from: https://www.youtube.com/watch?v=gZvQKCwxlW0

The number of intriguing entries significantly exceeded the number of stories we could share at the Forum. A compendium that includes two dozen meritorious practices is included with the Forum materials. Taken as a whole, the pool of practices we learned about through the Challenge provides excellent fuel for thought for the Foundation as it considers how it might support the development of trust in health care. Among other things, the entries demonstrated the importance of the duration and continuity of patient-physician relationships and of physicians knowing their patients; of leaders who focus on the quality of interactions, culture and feedback; of patients who are engaged in their care; and of systems that enable time and space for reflection.

A few of the Challenge entries are described in the following pages; these stories include both Challenge winners and practices that are included in the compendium.

## Communication/Knowing Your Patient: University of Chicago Medicine

Some patients at University of Chicago Medicine receive a comic when they check in for their appointments. The comic seeks to address the well-noted (and trust-eroding) trend that has accompanied the rise of Electronic Health Records (EHRs): patients feeling that their physicians are focused more on their computer screens than on them. The comic is called "Computers in the Clinic: YOUR ROLE!" and uses an 'ABC' mnemonic device:

- **A:** Ask to See the Screen: This portion of the comic encourages patients to let their clinicians know they are feeling left out of the conversation and to ask to see the computer screen.
- **B:** Become Involved: Patients are encouraged to review their records, ask questions, and point out any errors.
- **C:** Call for Attention: This section urges patients to speak up and ask for their physician's undivided attention if they have a sensitive topic to discuss.

Lolita Alkureishi, MD, Associate Professor and Clerkship Director in Pediatrics, envisioned the comic after leading a successful set of interventions to teach clinicians how to balance their use of the EHR system with patient care. "We realized we hadn't talked to patients," Dr. Alkureishi said.[6] Her team worked with a graphic artist (who is also a nurse at Northwestern University) to develop two versions of the comic: one to hang in providers' workplaces and one to hand out to patients.

Patients viewed the comic very favorably. Nearly three-quarters of pediatric parents (72 percent) and adult patients (70 percent) reported that the comic effectively encouraged them to become more involved with the EHR during their visits. Two-thirds of adult patients and 57 percent of pediatric parents said their provider was less distracted by the computer and more focused on them. African-American and Hispanic patients were more likely than white patients to report having asked clinicians to see the screen and to have been more involved in their office visits.

Dr. Alkureishi said she was struck by some of the comments patients made during follow-up interviews, including:

- "The comic was great because I didn't know it was my right to look at the computer."
- "I wasn't sure you could ask questions."
- "For someone who's bashful or reserved, the comic is very helpful."

"The bottom line is patients trusting their provider," she said. "By their asking questions, they're not a 'trouble patient' or an instigator; instead, we're inviting them to do it and giving them that authority. Trust is really what we're getting at when we're talking about the impact on the doctor-patient relationship."

6 Lynch Timothy (Senior Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with Alkureishi Lolita (Associate Professor in the Section of Academic Pediatrics, University of Chicago, Chicago, IL). 2019 Apr 3.

## Patient-Centered Design: Design Institute for Health at UT Austin Dell Medical School

Another Trust Practice Challenge entrant offered a novel approach to building trust within teams and improving the patient experience. The Design Institute for Health at UT Austin's Dell Medical School leads a co-creation process that brings together clinical staff and designers to create physical spaces and services intended to enhance the care experience for clinicians and patients. Lucas Artusi, MS, an Assistant Professor and systems designer, is part of a team of about 15 people, including commercial designers, engineers, an anthropologist, a medical illustrator and a linguist. “We’re a little strange as far as academic medicine goes because none of us are academics and none of us are physicians,” Mr. Artusi said.[7] The spaces they’ve created, the first of which opened in 2017, have departed from typical clinical design in ways such as eliminating waiting rooms and creating shared provider working spaces for interdisciplinary care teams.

The design team conducts ethnographic research to inform its concepts, spending time with clinicians and patients, interviewing them and observing how they work and use space. “We watch people flow through a clinic, often in conjunction with interviewing them,” Mr. Artusi said. “We’ll ask if people ever had trouble with a particular [design element], and they will say no. When we watch them work, though, we see inefficiencies and struggles that they’ve learned to work through. People are smart and figure out workarounds to bad design, but it’s a clear sign that we can do better.”

When it comes time to use the research findings to create concrete plans for a clinic, the team uses cheap and temporary materials to build a “mock up” version of a clinic. Clinicians are there to make suggestions and the design team moves the walls, furniture and other elements around based on their insights; concepts are also tested with patients. Part of the appeal of this process is that it allows “failure” to happen quickly and inexpensively. It also builds trust within teams by soliciting a wide range of opinions.

“We run a scenario to see how the design feels for clinical colleagues and patients and their loved ones,” Mr. Artusi said. “Bringing people along for the ride, as participants and co-creators, engenders a lot of trust. You’re not building it for somebody; you’re building it with somebody.”

Mr. Artusi said that reaction from patients and clinicians has been positive. Dell serves a heavily low-income population, with anywhere from 30 to 90 percent of the patients its various clinics serve carrying public insurance. Patients frequently express how “nice” the clinics feel and how different they are than what they are accustomed to, which Mr. Artusi calls a “critical outcome given the history of racial, economic and health disparities faced by Central Texans.”

## Conversations and Support: Amicus Consulting

Amicus Consulting, led by Jack Silversin, DMD, DrPH and Mary Jane Kornacki, MS, works frequently with health systems that are seeking to strengthen challenging relationships. Their work often involves creating “compacts” between health care organizations and their physicians, which make explicit what each party can expect from the other. “There often has to be some pre-work if feelings are running high or people don’t trust one another,” Ms. Kornacki said.[8] As part of their compact process, and in other consulting work, Amicus sometimes uses two practices that are specifically targeted at building trust.

7 Lynch Timothy (Senior Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with Artusi Lucas (Assistant Professor and Systems Designer, The Design Institute for Health, Dell Medical School, Austin TX). 2019 Apr 4

8 Lynch Timothy (Senior Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with Kornacki M and Silversin J (Founding Partners, Amicus Consulting, Cambridge, MA). 2019 Apr 5

The first is called perceptions sharing, a structured activity led by a neutral facilitator. In it, two groups of people that are dealing with trust issues or otherwise need to work better together—such as physicians and managers, or departments—use an established format to record and exchange written comments that describe their perceptions of the other and why they hold those views. Each group records (a) how they see their own strengths, contributions and shortcomings; (b) how they see the other group's strengths, contributions and shortcomings; and (c) how they think the other group would describe them. The written impressions are exchanged, each group reads the other's comments, and the group members discuss their reactions together. According to Ms. Kornacki, the activity offers participants insights into how they contribute to unhelpful dynamics, and how their behavior leads to distrust or harms a relationship. Dr. Silversin stressed that the perceptions exercise does not actually build trust, but rather helps create an environment where trust-building is possible.

"The idea is to get people to accept and hear how they're perceived and why," Ms. Kornacki said. "Then there can be an opportunity to say 'We hadn't thought about that,' and in a structured way try to understand what they could do differently to create a more productive relationship." Ms. Kornacki and Dr. Silversin described work they did to facilitate a compact at a system after the departure of an executive who did not have the trust of key stakeholders. Silversin said the perceptions sharing exercise offered the "first time of genuine exchange between administrators and doctors." "Some behaviors changed immediately," Dr. Silversin said. "The exercise addressed practical stuff right away and gave everyone energy to go on and do the real work." Dr. Silversin said that the success of the exercise depends upon the "curiosity of senior executives." "If an administrator says 'I'm here because I want to understand, and is genuinely curious, there's a real chance at a breakthrough," he said. Typically a facilitator—either an external consultant or a skilled and trusted internal staff person—is needed to lead these discussions, as having a 'safe space' to air and process perceptions is essential.

The second intervention is a "Trust Busters" card sorting activity. Facilitators distribute decks of cards (produced by Amicus) that represent common behaviors or practices that can reduce trust in a work environment, such as "inconsistent messages" or "great performance not appreciated." Participants, working individually or in pairs, sort through the deck and decide which cards most accurately represent issues salient to their work environment. They then "vote" for the "trust busting" practices that are most relevant to their workplace by placing sticky notes on a poster of all "trust busters." (Wild cards enable participants to bring up trust issues not included in the deck.) This process allows some anonymity and produces a visual ranking of what most undermines trust, which in turn becomes the basis for a discussion of what needs to change to repair trust. Some "trust busters" can be addressed locally while others might need to be escalated up the hierarchy. When done across multiple departments or teams, this creates a summary of pressing trust issues for leaders to understand and address.

Ms. Kornacki said that this activity typically is used at the frontline or middle management level, as opposed to the perceptions sharing exercise, which usually involves senior management. Also unlike the perceptions sharing exercise, an outside facilitator is unnecessary; for example, a human resources representative can lead an exercise with the cards. Kornacki said the cards offer a way to make people comfortable enough to discuss trust. "People aren't going to say they don't trust their leaders," Ms. Kornacki said. "You have to have some way in. The cards are both kind of fun and safe."

"What builds trust is authenticity, being honest and being humble," Ms. Kornacki said. "These exercises offer a way into what can be challenging conversations. As human beings, we're wired to avoid things that make us uncomfortable." She said these devices help people clear the air, take responsibility for their own past behavior, and understand how others see the world.

## Value: Geisinger Health System

In an era of increased consolidation, trust between patients and the systems where they seek care has become a salient issue. Geisinger Health System offers an example of a system that has taken a bold step to increase public trust. Its "Refund Promise" program provides patients with a refund of any co-pays and deductibles they paid if the system does not meet their expectations of "caring" in their interactions. For example, Geisinger will provide refunds for poor communication, treatment delays, a lack of hospitality or excessive wait times. (Geisinger does not offer refunds for disagreements with clinical staff about diagnoses, therapeutic decisions or medical testing.) Refunds can happen based on patient requests, but system employees are also authorized to offer them if they observe "care failures."

The Refund Promise arose from a larger Geisinger effort focused on improving the patient experience. Through the initiative, called Proven Experience, Geisinger 'hard-wired' a set of practices that were measurable and were shown to have enhanced patients' experience of care, such as nurses rounding on patients every hour. David Feinberg, MD, then Geisinger's CEO, expanded upon the commitment to patient experience by announcing in 2015 that patients should get their money back if they had a poor experience.

"The reaction [within Geisinger] ranged from enthusiasm to a great deal of skepticism," said Greg F. Burke, MD, the system's Chief Patient Experience Officer. Dr. Burke said that leaders from various parts of the system had understandable concerns about financial and legal ramifications of the concept, but came together to implement it under a tight timeline. "Dr. Feinberg looked at the larger picture and said 'How can we not do this now?'" Dr. Burke said. "I was always comfortable promoting it; it's just the right thing to do. Putting financial risk in the picture is the trust-builder."[9]

Although Geisinger doesn't feature the Refund Promise in its marketing and advertising efforts, the idea spread through the system's patient-facing app, word of mouth and attention from local media. Dr. Burke said that the system receives about 50–70 refund requests monthly, and the foregone revenue in the first few years of the program amounted to about $1 million. Typically, Geisinger honors patient refund requests without disputing patients' perceptions of the care they received. "The amount of trust a patient puts into a medical organization is extraordinary," Dr. Burke said. "We don't want to feel like we're not trusting them when they report their experience."

Dr. Burke said that he thinks the Refund Promise has increased the public's trust in Geisinger. "Patients are surprised that we do it and say they never would have expected this from a health care organization," he said. He suggested that diminishing public trust in the health care system in recent decades is largely attributable to skepticism about financial motivations and conflicts, and "any attempt to say we're willing to take a financial risk and trust you" helps counteract that skepticism.

Dr. Burke also said that Geisinger sees the Refund Promise as an investment because the refund requests can expose negative elements in the system's customer service. This gives the system the opportunity to fix problems that are diminishing patients' views of it. "The biggest gain has been what we've learned about what our patients experience," Dr. Burke said.

9 Lynch Timothy (Senior Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with Burke G (Chief Patient Experience Officer, Geisinger Health System, Danville, PA). 2019 Mar 26

## Medical Misinformation: Journalist's Resource

As noted above, the persistence of false information about topics such as vaccine safety can have a profound impact on public health. Moreover, the credibility of physicians derives largely from their expertise in medical knowledge; if patients begin to question the legitimacy of that knowledge, it could have profound consequences for the physician-patient relationship.

Carmen Nobel and her colleagues at *Journalist's Resource* (*JR*) are attempting to help solve this problem by facilitating more accurate reporting about research topics, including health and science issues. Journalist's Resource, a project of the Harvard Kennedy School's Shorenstein Center on Media, Politics and Public Policy, is an open-access website that practicing journalists can use to understand public policy and health-related research. *JR*'s goal since its founding in 2010 has been for journalists who are reporting on policy topics to ask: "What does the research say about this?" *JR* aims to help journalists distinguish between high- and low-quality research, and provides tools that are designed to help them report on complicated or commonly misunderstood policy topics, like proposals for a 'single-payer' health care system.

Specifically, *JR* publishes overviews of the state of research on particular topics (e.g., successful interventions to address childhood asthma); journalistic accounts about noteworthy individual studies; and "tip sheets" about issues in research (e.g., how to understand margin of error). More than 50,000 people subscribe to its weekly e-mail newsletter, a similar number follow *JR* on Twitter, and its site receives about 2 million visitors per year. Everything *JR* creates is freely available for media outlets to publish.

Ms. Nobel, the Program Director at *JR*, said that the main challenge to accurate reporting is that newsrooms are understaffed. "In smaller communities, beat reporting has disappeared," she said. "Reporters covering health today are covering politics or some other issue tomorrow. They don't have time to develop a good background for what they're covering. Without a knowledge base, it's easy to fall into 'one side says this and the other says that,' as if there are two sides to every story."[10] Too often, she said, reporters don't explore what the research says about an issue, and thus fail to inform their audience when a question like vaccine safety is actually well-settled.

"There's a connection between how people report on anything and public trust," Ms. Nobel said. "People are getting their information from the media, and if they don't trust what they see in the media, they're not going to trust that information. Our hope is that the more accurate and nuanced reporting is, the more trustworthy it will be."

# SPREADING TRUST PRACTICES

During the Forum, participants will consider how we can spread practical approaches like these to building trust. Although successful diffusion is atypical in any sector, with the vast majority of innovations failing to take hold,[11] observers of the health care system have noted that the "dynamics that govern the adoption of innovations [in health] are unusually complex."[12] Indeed, the health sector is famous for its resistance to innovation, as shown in the commonly cited statistic that it takes 17 years for new research to be widely implemented.[13]

10 Lynch Timothy (Senior Director of Foundation Programs, ABIM Foundation, Philadelphia, PA). Interview with Nobel C (Program Director, Journalist's Resource, Cambridge, MA). 2019 Mar 20

11 Dearing JW, Cox JG. Diffusion Of Innovations Theory, Principles, And Practice. Health Aff (Millwood). 2018 Feb;37(2):83-190.

12 Shrank WH, Keyser D. Diffusion of Innovations in Health Care – Obtaining Evidence to Move Faster [Internet]. Health Affairs (blog); 2017 May 16 [cited 2019 May 15]. Retrieved from: https://www.healthaffairs.org/do/10.1377/hblog20170516.060078/full/

13 Institute of Medicine. Crossing the Quality Chasm: A New Health System for the 21st Century. National Academy Press; Washington (DC); 2001. 360 p.

Many are familiar with the Diffusion of Innovation Theory that E.M. Rogers developed and popularized in the 1960s. A less-familiar example from his work, however, illustrates a point of particular relevance to our discussions at the Forum: *that trust may itself be a factor in whether and how innovations spread*. Rogers writes about a Peruvian village that rejected a public health campaign to introduce the boiling of water to avoid disease. He attributes the campaign's failure to the inability of the health worker who led the campaign to gain the villagers' trust.[14]

This story is not the only suggestion that trust-building practices may spread more quickly in trustworthy environments. Author Stephen M.R. Covey argues that the absence of trust causes friction that serves as a "trust tax" inhibiting the adoption of innovations and indeed taking a toll on "all activity—in every relationship, in every interaction, in every communication, in every decision."[15] Conversely, "high trust is like the leaven in bread" and materially improves innovation.

For Rogers, perceptions of an innovation are the most important predictor of whether and how quickly it will spread.[14] He proposed five main factors that shape those perceptions:

- Relative advantage: Here, the issue is how much of an improvement the innovation provides over the status quo. Rogers suggests that individuals are more likely to adopt an innovation if they are able to gain knowledge about its expected consequences, thereby reducing uncertainty.
- Compatibility: This factor is concerned with whether the innovation is consistent with an organization's or individual's values, experiences and needs. Don Berwick, MD, in applying Rogers' thinking to the health care setting, noted that improvements in care processes will only take hold if they "resonate with currently felt needs and belief systems." For example, he argued that obstetricians will not display interest in new methods of reducing cesarean delivery rates if they believe current rates are acceptable or are needed to avoid malpractice litigation.[16]
- Complexity: Simple innovations generally spread more quickly than complicated ones. Relatedly, innovations that can be simplified as they are applied in new settings will be more likely to succeed. To illustrate this point, Dr. Berwick cited Intermountain Health Care's successful implementation of a clinical guideline to reduce the rate of pressure sores. Clinicians there chose just two care changes from the broad menu of options that were included in the 30-page guideline book: calculating a decubitus ulcer risk score using the Braden Scale and turning patients every two hours. With this simplified intervention, the system achieved an 80 percent reduction.
- Trialability: Innovations that can be pilot tested or experimented with in advance of a full institutional commitment will spread more effectively.
- Observability: Innovations are more likely to spread if those who are slower to adopt innovations (e.g., people in the 'early majority' or 'late majority') have the opportunity to see innovators and early adopters try it.

14 Rogers EM. Diffusion of Innovations. 4th ed. New York, NY: Free Press; 1995. 579 p.

15 Covey SMR, The Speed of Trust. New York, NY: Free Press; 2006. 384 p.

16 Berwick DM. Disseminating innovations in health care. JAMA. 2003 Apr 16;289(15): 1969-75.

Tom Bodenheimer, MD, reviewed the literature on spread within and beyond health care, and examples of health care institutions that had embraced innovation, for a 2007 report for the California Health Care Foundation. With echoes of Rogers' work, he recommended that innovations should:

- Fit the culture and values of the majority of potential adopters;
- Deliver improvements in measured performance for several groups of patients in several sites;
- Be actively promoted by top leadership, with sites within the organization enabled to customize implementation;
- Be framed to make them "sticky" for the majority of people in the organization, i.e., speak to the concerns of those who are neither innovators nor early adopters;
- Make day-to-day work easier for potential adopters;
- Be supported by a financial business case for the organization adopting it.[17]

In recent years, we have seen a more focused effort to foster the spread of innovations in clinical medicine. For example, the National Institutes of Health created the National Center for Advancing Translational Sciences in 2012 with the goal of delivering new treatments and cures to patients faster. The Agency for Healthcare Research and Quality, the Department of Veterans Affairs, the Patient-Centered Outcomes Research Institute, and the Center for Medicare and Medicaid Innovation are also focused on promoting diffusion.[12] Spreading non-clinical interventions, however, has been less of a focus.

## CONCLUSION

This year's Forum participants will hear about concrete steps that others have taken to build trust in a variety of health care relationships and have the opportunity both to consider how they might help spread those concepts and to develop ideas of their own. We hope the examples outlined here and the discussion of diffusion in health care help inform your participation in the Forum and your post-Forum activities.

17 Bodenheimer T. The Science of Spread: How Innovations in Care Become the Norm [internet]. California Health Care Foundation. 2007 Sep [cited 2019 May 15]. Retrieved from: https://www.chcf.org/publication/the-science-of-spread-how-innovations-in-care-become-the-norm/