Developing a Trust Research Agenda

May 19, 2021

Meeting Report

Introduction

As our health care system continues to rebuild from the COVID-19 crisis and confront the ongoing threats of structural racism and inequality, trust has emerged as a vital issue to explore in efforts to improve the nation's health and well-being.[1] The foundation of any successful relationship, trust is key to ensuring positive health care interactions for both patients and clinicians. Building trust, not only between patients and their clinicians and health care system, but also between the public as a whole and the broader health care system, will be crucial to improving health care outcomes, increasing patient satisfaction, and ensuring the well-being of health care professionals. This process will require additional investment, interest, and leadership in the area of trust research to ensure that health systems' and health professionals' actions and behaviors to promote trust are evidence based.

Through the *Building Trust* initiative, the ABIM Foundation aims to elevate the importance of trust as an essential organizing principle to guide improvements in health care. As a part of the initiative, the ABIM Foundation and AcademyHealth convened approximately 70 researchers, clinicians, patients, and funders on May 19, 2021, to begin developing a trust research agenda. The meeting focused on understanding the state of trust research and existing gaps in the literature; identifying opportunities for trust research and building a research agenda; and beginning to establish a research community devoted to advancing trust research. The meeting agenda is included in Appendix 2, and the participant list is included in Appendix 3.

State of the Field

To orient participants to the current state of trust research, Jodyn Platt, Ph.D., University of Michigan and Lauren Taylor, Ph.D., The Hastings Center, presented preliminary findings from their recent literature review on trust. They explained the framework for their review, shared their findings, and offered initial thoughts on the gaps and issues identified in light of the goal of informing a research agenda.

Literature Review Findings

Defining trust as "a willingness to be vulnerable to another for a given set of tasks" (Mark Hall), the review covered literature published on trust in health and health care between 1970 and 2020. To assess the breadth of research, the literature was organized according to (1) the entities in the trust relationship being examined; 2) special topics such as health equity and misinformation and trust in science; (3) the quantity of research within different trust relationships; and (4) whether trust is the input or outcome. The literature review confirmed that the preponderance of research on trust in

health care focuses on the patient-clinician relationship, and that investigations into the nature of trust in other health care relationships, such as clinician-clinician, patient-organization, or clinician-organization are under-developed. In addition, while commentaries about trust are common in the health care literature, more rigorous investigations, including developing robust theoretical frameworks, mixed methods research, or intervention studies are significant opportunities for groundbreaking research.

Dr. Platt and Dr. Taylor noted a number of additional gaps in the literature:

- Although there is a great deal of research on patient trust in clinicians, there is a lack of consensus about the best measures of trust regarding the doctor-patient relationship. Scales on mistrust are more robust. Additionally, **research on patient trust in clinicians far outpaces research on clinician trust in patients.**

- **The literature on clinician trust in other clinicians is relatively small**, and most of this research focuses on competence as a key determinant of trust. So, there are opportunities for greater exploration into how trust evolves between clinicians.

- **Research on patient or clinician trust in organizations and systems is also limited**. In this area, financial interests may be a determining factor, potentially affecting the level of trust that patients have in health systems and organizations. It was also noted that there is a lack of clarity around definitions for systems versus organizations, making it difficult to compare across studies.

- In exploring issues of health equity, there is a need to challenge narratives on trust and distrust. Most of the existing research in this area focuses on Black/African American populations and their experiences of discrimination and racism eroding trust, **while there is little research that addresses how health care actors can build trust**. Additionally, greater attention needs to be paid to examining trust issues for other racial minorities and marginalized groups, such as the LGBTQI+ community.

- An area for robust growth is research on actions and practices that build trust. Most of the existing quantitative research focuses on the outcomes of trust (e.g., health, behaviors, satisfaction), but **there is considerably less research on the inputs of trust (e.g., social, individual, behavioral) and how to build trust.**

In closing, Dr. Platt and Dr. Taylor made a number of recommendations to strengthen the trust research base. First, they suggested that researchers consider a range of linear and non-linear theoretical frameworks to guide future research, noting the dynamic and cyclical nature of trust relationships. Examining signals made by

the trustee or trustor that elicit trust or mistrust was described. Next, they emphasized the opportunity and need for interventional studies, in particular those that employ randomized and longitudinal approaches. Finally, they provided cross-cutting guidance, suggesting researchers be as specific as possible when defining the trust relationship.

Participant Discussion

In reaction to the presentation, attendees provided their own thoughts on the current state of trust research and gaps in the literature:

- Echoing the findings in the literature review, attendees underscored the need to place a greater emphasis on exploring clinician trust in patients as well as caregivers.

- A point of particular interest for many attendees was the difference between *trust* and *trustworthiness*[2]. Participants noted that patients, especially those from marginalized communities, may rightfully distrust health care entities, and therefore the impetus should perhaps be placed on organizations making themselves trustworthy and fixing unjust systems. As one participant noted:

  "it would be misguided to try to increase individual patient trust in entities - particularly systems - that are historically/currently exploitative, abusive, or indifferent. … the orientation of a research and intervention agenda should be to fix those systems, not encourage patients to increase their trust."

  – Kellan Baker

- Attendees consistently mentioned the need for researchers to take a more nuanced and dynamic perspective when examining trust issues, considering the multifaceted and reciprocal nature of trust in relationships.

- Participants also suggested leveraging and building on trust research from other disciplines, such as psychology, social and racial justice, African American studies, as well as related literature on patient and community engagement.

- The importance of focusing on equity and recognizing the role of power in this work was also raised, with an emphasis on prioritizing trust research among historically marginalized populations, including racial and ethnic groups, the LGBTQI+ community, and disabled individuals.

Developing a Research Agenda

The remainder of the meeting was devoted to identifying and developing research topics/questions that would further the trust agenda. Attendees discussed a host of potential research topics/questions in small groups, and each group identified approximately two research questions for further consideration by the broader group. The topics/questions put forth by each small group were compiled into an overall list of 26 potential topics/questions. Attendees then voted on their top three choices via an online prioritization process. The 10 research questions/topics receiving the most votes were selected for further development in a subsequent set of small groups. Attendees were able to select the research topic/question they wanted to focus on by joining the relevant small group. An overview of the top 10 research topics/questions, edited for clarity and brevity, is provided below, followed by highlights from the subsequent small group discussions further developing each research question/topic.

Overview of Top 10 Research Topics/Questions by Level of Trust

The list of top 10 research topics/questions is grouped according to level of trust—organizational, clinician, and patient and community. Although there is some overlap across the three levels and goals of the proposed research questions, the topics/questions have been categorized to indicate potential levels of focus for advancing trust efforts. The rank order has been retained within these categories. Highlights from each group's discussion are included in Appendix 1.

Advancing Trust at the Organizational Level

1. What can organizations do to address influential structural determinants of distrust, such as partisanship and politicization, structural racism, and systems of privilege in order to improve trust with patients and within their systems?

2. How can trust be defined and measured at an organizational level, e.g., between patients and organization, community and organization, employees and organization, and clinicians and organization?

3. Perform an analysis of positive deviance to identify fundamental drivers of optimal trust within organizations that have diverse populations, studying signals at different levels, e.g., patient-clinician, system-clinician, and system-community.[3]

4. What are the policies, partnerships, and practices that constitute trustworthiness of organizations?

a. What is the impact of new organizations in new communities? Mergers? Workforce-community concordance? Patient-clinician concordance? Pipeline of trainees?

5. When organizational policies and values prevent clinicians from providing the care they think they should provide, how does that affect their trust in organizations?

a. What are the downstream effects of the loss of organizational trust on patient and clinician outcomes?

Advancing Trust at the Clinician Level

6. Why is trust in nurses consistently high vs "noisy" (or inconsistent) trust estimates in physicians--why the disparate scores and consistency? (correlate: why is trust in nurses more global and trust in physicians more personal?)

7. One of the drivers of patient trust is the perception that the doctor cares about them. How does a clinician convey that they care about a patient?

a. What are the things they do or don't do? What are the behaviors, language, attributes?

b. What makes patients trust their clinician more, and what would diminish or threaten that trust?

c. What underlies trust? Where is the locus of trust, mistrust, confidence?

8. What is the level of trust clinicians have in patients and their caregivers, and what interventions might most meaningfully increase that trust?

Advancing Trust at the Patient and Community Level

9. What are longitudinal trends in trust at the population level, and what factors affect change in trust?

10. What are the frames (e.g., patients, communities, institutions, or policies) for advancing trust that would have the biggest impact on health equity?

a. How can we center the community and their needs?

Key Considerations Across Research Topics/Questions

A broad range of considerations emerged from the small group discussions in which attendees further developed the top 10 research topics/questions. Each small group had the opportunity to explore the following aspects for a given research topic/question: study settings, populations of focus, data and measures, methods,

partners, and funders. It should be noted that attendees may not have fully covered each of these considerations in their discussions. Additionally, for research topics/questions that aimed to improve trust through an intervention, attendees also had the opportunity to discuss the proposed interventions and outcomes. Key themes from the small group discussions are summarized below.

Study Settings. Attendees proposed a variety of study settings depending on their research topic/question of interest, ranging from clinics, private practices, patient-centered medical homes, and home care to hospitals, health systems, and graduate medical education to population-based studies and community-based research. One group specifically emphasized the importance of focusing on the community and equity in this work.

Populations of Focus. A wide variety of study populations was proposed, with an emphasis on groups that have historically experienced lower levels of trust, including racial and ethnic minorities; low-income populations; LGBTQI+ patients; and people with disabilities or mental illnesses. Other potential populations included patients with chronic conditions, as well as those who avoid the health system altogether because of a lack of trust. The idea of starting with and focusing on the community was also raised. At the clinician level, the following groups were proposed: physicians, nurses, physician assistants, nurse practitioners, other staff, white clinicians, clinicians of color, primary care, specialty care, and those with different gender identities.

Data and Measures. Attendees engaged in rich discussions about the kinds of data and measures that would be needed to address trust. Many started with the importance of first defining and then exploring measurement of the key concepts of trust and trustworthiness. Attendees also emphasized the importance of starting with patients and the community in defining trust and developing measures. The need to include measures of racism was also raised to ensure grounding in this frame. The use of positive deviance as an approach was explored, including the use of existing surveys, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey and safety culture surveys, to identify areas in health systems that already exhibit high levels of trust. Attendees also noted the need for a variety of trust-related measures, including measures of trust in individual physicians, physician trust in patients, relationship measures, institutional trust measures, and patient-reported outcomes, among others.

Methods. The importance of using both quantitative and qualitative methods was highlighted across many of the proposed study areas. Specifically, attendees noted the value of surveys to understand general perceptions, and interviews or focus groups to better understand patient experiences or health professional perspectives. Longitudinal studies would allow for more robust research on trust.

Other proposed methods included participant observation; audio- or video-recorded interactions; ethnographic research; appreciative inquiry; artificial intelligence to discover positive deviants; and text analysis for trust/respect, for example in the news media or chart notes. The use of process mapping/systems science was also proposed to understand potential barriers to trust, such as requiring clinicians to log in to their computers upon entering an exam room, taking focus away from the patient. Another suggestion specifically emphasized:

> **"engaging patients/families early, often, and intensively in every phase of the research."**
> *– Notes from working group*

Partners. Attendees suggested a variety of potential partners, including organizational leadership, clinicians, and staff; professional societies; patients and families; multistakeholder advisory groups; community organizations; and government agencies. The ABIM Foundation and the Institute for Healthcare Improvement were named as potential partners. Attendees also highlighted the importance of including perspectives from other sectors outside of health care whose work is also affected by trust, for example, public health, social justice, and citizen science with a focus on public understanding of science.[4] One group suggested partners:

> **"that could help [with] having the necessary conversations about historical and structural racism and equity issues."**
> *– Notes from working group*

Funders. Attendees indicated a range of funders to approach, including those interested in health equity, quality improvement, complex care, patient-centered care, public health, justice, and environmental health, among others.

Interventions (if applicable). Research topics/questions that addressed interventions included a focus on motivational interviewing as a counseling approach, user-centered design, and building a culture among clinicians and staff that is trusting of patients.

Outcomes (if applicable). While the main outcome for studies that included an intervention was increasing patient trust, other potential outcomes for patients included improved adherence, follow-up, preventive care, quality of life, self-rated health, and clinical out-comes. At the clinician level, increased trust towards patients and families was also highlighted as an outcome.

Conclusion and Next Steps

As highlighted throughout the course of the day, a key area of focus for advancing trust research lies at the organizational level. Although individual relationships between clinicians and patients remains an important area of study, greater emphasis should be placed on examining trust at a systems level with a focus on structural interventions. Such a focus is especially timely and critical, as many health care organizations are rebuilding from COVID-19 and must also address the persistent issues of structural racism and discrimination. As the past year has so clearly demonstrated, the foundation of trust in health care does not exist for many communities, and because the conditions in which people are born and live impact their trust overall, structural approaches to building trust are paramount.

The overall health care system and health care organizations must be designed to support and engender trust. Health care organizations play a substantial role not only in care delivery, but in establishing the overall health care context and culture. Indeed, health care organizations have the capacity and influence to affect change, drawing on their direct connections to patients, with the potential for large-scale impact. A focus on research at the organizational level would also allow for other levels to be addressed, including patients and the community, as well as clinicians. Research on trust, even if conducted at the level of a health care organization, must center the needs of patients and communities, and include a focus on equity.

Building on the themes that emerged from the meeting, the ABIM Foundation and AcademyHealth will continue to lay the groundwork for advancing research on trust. We will explore the current landscape for trust research and funding through a review of the HSRProj (Health Services Research Projects in Progress) database to review trust research that is currently underway. This will be complemented by key informant interviews with leaders from public and private funding agencies to gain a better understanding of their funding priorities as they relate to trust and trust-related research. We will also promote the trust research agenda more broadly and focus on building a research community around trust.

Appendix 1: Top 10 Research Topics/Questions – Highlights from Small Group Discussions

Advancing Trust at the Organizational Level

1. **What can organizations do to address influential structural determinants of distrust, such as partisanship and politicization, structural racism, and systems of privilege in order to improve trust with patients and within their systems?**

Group one proposed exploring societal and structural determinants with the purpose of improving trust more concretely within health care organizations. While clinician-patient factors were certainly noted as relevant, the group highlighted the value of organizational outreach to communities, ensuring that the heterogeneity and intersectionality of different subpopulations is considered. Potential research methods included a mixed methods approach, as well as ethnographic research. The challenges of addressing overlapping factors, such as individual and system level factors, was raised. The group also recommended drawing on other relevant literature from such areas as cultural humility or literature on racism to inform this work.

2. **How can trust be defined and measured at an organizational level, e.g., between patients and organization, community and organization, employees and organization, and clinicians and organization?**

Group two focused on defining and measuring trust. They proposed a study in a clinical setting within a larger health care organization. Given that trust is a relatively underdeveloped research area, the group suggested a mixed methods approach, starting with qualitative work to better understand how people think about trust. This information would then be used to develop and test operational measures. Group one also highlighted the importance of understanding how history, social issues, and structural aspects of equity affect trust, and noted the importance of including partners that could bring these issues to the fore. In terms of funding, it was noted that the health care organization at the center of the study may be interested in funding this work.

3. **Perform an analysis of positive deviance to identify fundamental drivers of optimal trust within organizations that have diverse populations, studying signals at different levels, e.g., patient-clinician, system-clinician, and system-community.**

Group three discussed the need to first identify what represents positive deviance and those who may be performing better on trust-related measures, and then exploring what can be learned from any existing trust-enhancing activities. The research question could be explored in a specific clinical area, such as emergency department settings across health care organizations, or

across departments within one health care organization, for example, to understand which service units have higher scores on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) or safety culture surveys. While this study would be descriptive in nature, it could serve as a bridge to interventional studies to further determine how to build trust.

4. **What are the policies, partnerships, and practices that constitute trustworthiness of organizations?**

   a. **What is the impact of new organizations in new communities? Mergers? Workforce-community concordance? Patient-clinician concordance? Pipeline of trainees?**

   Group four focused on trustworthiness and exploring what makes a health care organization worthy of trust. The group proposed that health care organizations conduct a self-examination of their inequities in practice (e.g., related to trust) by looking at a variety of indicators. The findings from this work could then be shared with stakeholders, including patients and the community, with the goal of working with them to explore how best to address the issues that were identified. This small group also discussed the potential for building trust between health care organizations and their communities through greater workforce concordance. Health care organizations could partner with communities, particularly high schools and colleges, as a way to develop a pipeline of health care workers that are part of the community.

5. **When organizational policies and values prevent clinicians from providing the care they think they should provide, how does that affect their trust in organizations?**

   a. **What are the downstream effects of the loss of organizational trust on patient and clinician outcomes?**

   Group five focused on the desire of clinicians to provide the best possible care to their communities and their patients within the context of structural barriers that may not always facilitate that kind of care. The group proposed a mixed methods approach that would involve clinicians, staff, and patients, as well as those setting policy, such as health care executives or the health system board of directors. The study would start with participant observation or focus group work with clinicians and staff to identify underlying issues. This information would then be used to develop and field surveys, such as clinician questionnaires on burnout. The research would be focused on identifying interventions for how health care systems can provide a better workplace that fosters trust and teamwork, ultimately leading to better health care outcomes for patients and communities.

Advancing Trust at the Clinician Level

6. **Why is trust in nurses consistently high vs "noisy" (or inconsistent) trust estimates in physicians--why the disparate scores and consistency? (correlate: why is trust in nurses more global and trust in physicians more personal?)**

Group six proposed a two-by-two research design examining how patients may have differing levels of trust in nurses versus physicians, and how the level of trust may also vary between a patient's personal experience with their own doctors or nurses versus their perspectives on doctors or nurses more generally. The inclusion of nurse practitioners was suggested as a particular focused comparison because their scope may resemble that of physicians, yet they are still labeled as nurses, who are generally more trusted than physicians. The study methods would include a set of closed-ended questions to ascertain the kinds of attributes for which patients may trust either party, such as a correct diagnosis or having the patient's best interests at heart. Open-ended questions could then be used to ask patients to reflect on their experiences. The study design was noted to have broad applicability across settings, for example inpatient versus outpatient, community health center versus non-salaried, etc.

7. **One of the drivers of patient trust is the perception that the doctor cares about them. How does a clinician convey that they care about a patient?**

   a. **What are the things they do or don't do? What are the behaviors, language, attributes?**

   b. **What makes patients trust their clinician more, and what would diminish or threaten that trust?**

   c. **What underlies trust? Where is the locus of trust, mistrust, confidence?**

   Group seven focused on how doctors convey that they care about their patients. The group proposed a multi-site study across many types of settings, including ambulatory, inpatient, home care, and specialties. Individuals from outside of health care would also be recruited to capture those who may elect not to seek care. The importance of ensuring diverse perspectives and representation from more marginalized populations who may be less likely to be treated in a caring manner was also emphasized. Qualitative methods were proposed, such as patient interviews, focus groups with patients, and recorded interactions with health professionals. The group also discussed the importance of considering systemic barriers. The potential for developing a measure for a culture of respect was proposed as a way to identify areas where interventions may be needed to ensure patients are treated with more care.

8. **What is the level of trust clinicians have in patients and their caregivers, and what interventions might most meaningfully increase that trust?**

Noting that clinician trust in patients remains an understudied area with only one key existing measure, group eight proposed a multi-disciplinary approach with deep patient and family engagement to explore clinician trust in patients and caregivers. The study would include a needs assessment phase, followed by a series of interventions informed by implementation science and rapid evaluation, with the goal of developing a measure to assess clinicians' trust in patients. The importance of examining various types and levels of clinicians and administrative staff was emphasized. The group also acknowledged the importance of looking at the role of concordance across race and other attributes, such as gender identity.

Advancing Trust at the Patient and Community Level

9. **What are longitudinal trends in trust at the population level, and what factors affect change in trust?**

Group nine proposed a national, population-based trust study to assess patients' trust in clinicians and institutions over time. The study would include oversampling to capture underrepresented populations and would follow individuals longitudinally for a period of at least five years, although the study could go on for much longer, potentially spanning generations, similar to the Framingham Study. Using surveys, as well as interviews and focus groups, the study would capture people's experiences of trust in the overall health system, e.g., interactions with clinicians, the emergency room, insurance companies, etc. The information collected could be temporally linked to secular events, such as a crime or a catastrophe, to assess how such events may impact trust. Given the broad relevance of trust issues, the study could involve multiple sectors, such as public health and law enforcement.

10. **What are the frames (e.g., patients, communities, institutions, or policies) for advancing trust that would have the biggest impact on health equity?**

   a. **How can we center the community and their needs?**

   Group ten emphasized the importance of equitable partnerships and equitable funding as a starting point for trust work and research. They noted that defining trust should occur at the community level, by asking communities what their idea of trust is and how they think it can be achieved. At the same time, the group cautioned against putting the onus on communities to solve problems that have been imposed on them. The group also discussed the role of broader societal issues, such as how the political climate can influence trust. For example, they cited how vaccine hesitancy may have more to do with distrust in government policies, whereas health care organizations may be held accountable for vaccination numbers.

Appendix 2: Meeting Agenda

Aims

1. Review a literature review of articles about trust to be aware of the state of research and identify gaps.

2. Identify opportunities for research related to trust and build a research agenda based on topics of interest to the researchers in the room.

3. Begin to establish a research community devoted to advancing research on trust.

Trust Research Agenda Meeting

May 19, 2021 from 10:30 AM-4:00 PM ET

AGENDA

10:30-10:40   Welcome
Speakers: Rich Baron, Lisa Simpson and
Daniel Wolfson

10:40-10:50   Impromptu Networking
Moderator: Daniel Wolfson
Goal: Identify area of interest in trust and share article about trust (optional)

10:50-11:30   Review of Literature on Trust/Q&A
Moderator: Daniel Wolfson
Presenters: Jodyn Platt, University of Michigan and Lauren Taylor, Hastings Center
Goals: Provide a framework and results of review of the literature on trust & offer initial thoughts on gaps and issues identified

11:30-12:20   Small Groups and Large Group Discussion
Moderator: Lisa Simpson
Goal: Identify research topics/questions

12:20-12:30   Summary of the Morning and Plan for Second Session
Speakers: Lisa Simpson and Daniel Wolfson

Adjourn   12:30-1:30

1:30-2:05   Prioritize Research Questions and Opportunities
Moderator: Lisa Simpson
Goal: Discuss and rank opportunities for research in trust

2:05-2:15   Break

2:15-3:00   Research Question/Topic Development
Moderator: Lisa Simpson

3:00-3:55   Group Discussion of Prioritized Topics
Moderator: Daniel Wolfson
Each group presents one research question

3:55-4:00   Summary of Meeting and Next Steps
Speakers: Daniel Wolfson and Lisa Simpson

Appendix 3: Meeting Attendees

Mercy Adetoye
Fellow Physician - University of Michigan

Phillip Alberti
Founding Director, AAMC Center for Health Justice - Association of American Medical Colleges

David Atkins
Director, Health Services Research and Development - Department of Veterans Affairs

Kellan Baker
Centennial Scholar - Johns Hopkins Bloomberg School of Public Health

Richard Baron
President and CEO - American Board of Internal Medicine and The ABIM Foundation

Mary Catherine Beach
Professor - Johns Hopkins University

Ramona Benkert
Interim Dean and Professor - Wayne State University

Laura Bogart
Senior Behavioral Scientist - RAND Corporation

Clarence Braddock III
Professor of Medicine and Vice Dean for Education - David Geffen School of Medicine at UCLA

Kate Carmody
Program Associate - The ABIM Foundation

Marshall Chin
Richard Parrillo Family Professor of Healthcare Ethics - University of Chicago

Bonnie Cluxton
Vice President - AcademyHealth

David Coleman
John Wade Professor and Chair, Department of Medicine; Physician in Chief - Boston Medical Center

Patricia Conolly
Physician

Deidra Crews
Professor of Medicine - Johns Hopkins University School of Medicine

Paul Crits-Christoph
Professor - Perelman School of Medicine, University of Pennsylvania

Gwen Darien
Executive Vice President, Patient Advocacy and Engagement - National Patient Advocate Foundation/Patient Advocate Foundation

Joyce Dubow
Consumer/Patient Advocate

Maura Dugan
Research Assistant - AcademyHealth

Susan Edgman-Levitan
Executive Director - The John D. Stoeckle Center for Primary Care Innovation; Co-chair MGB Patient Experience Leaders - MGH Stoeckle Center for Primary Care Innovation

Richard Frankel
Professor of Medicine and Geriatrics - Indiana University School of Medicine

Lynne Garner
President – The Donaghue Foundation

Marianne Green
Vice Dean for Medical Education - Northwestern Medical Group

Jessica Greene
Professor & Luciano Chair of Health Care Policy - Baruch College, City University of New York

Derek M. Griffith
Co-Founder and Co-Director - Racial Justice Institute; Professor, Health Systems Administration - Georgetown University

Rachel Grob
Director of National Initiatives, Senior Scientist, Clinical Professor - University of Wisconsin Madison

Reshma Gupta
Executive Medical Director of Value and Population Care - University of California Health

Mark Hall
Professor of Law & Public Health - Wake Forest University

Leora Horwitz
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Holly Humphrey
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Kedar Mate
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Deputy Director - Agency for Healthcare Research and Quality

Sarah Millender
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Tara Montgomery
Founder/Principal - Civic Health Partners

Paige Nong
PhD Student – University of Michigan School of Public Health

Jacquelynn Orr
Program Officer, Research Evaluation Learning – Robert Wood Johnson Foundation

Sachiko Ozawa
Associate Professor - University of North Carolina

Susan Perez
Associate Professor - California State University, Sacramento

Robert Phillips
Executive Director, The Center for Professionalism & Value in Health Care - American Board of Family Medicine

Jodyn Platt
Assistant Professor of Learning Health Sciences - University of Michigan Medical School

Chris Queram
Interim President & CEO - National Quality Forum

Kelly Rand
Program Officer - The ABIM Foundation

David Reuben
Chief, Division of Geriatrics - David Geffen School of Medicine at UCLA

Cynda Rushton
Anne & George Bunting Professor of Clinical Ethics & Professor of Nursing - Johns Hopkins University Berman Institute of Bioethics & School of Nursing

Anita Samarth
CEO & Co-Founder - Clinovations Government + Health

David Schleifer
Director Research - Public Agenda

Mark Schlessinger
Professor of Health Policy - Yale School of Public Health

Eric Schneider
Senior Vice President for Policy and Research - Commonwealth Fund

Karen Sepucha
Associate Professor - Harvard Medical School

Neel Shah
Director, Deliver Decisions Initiative - Harvard Medical School

Leigh Simmons
Medical Director, Health Decision Sciences Center - Mass General Hospital

Lisa Simpson
President and CEO - AcademyHealth

Christine Sinsky
Vice President, Joy in Medicine - American Medical Association

Mildred Solomon
President – the Hastings Center; Professor of Global Health and Social Medicine – Harvard Medical School

Brian Southwell
Senior Director, Science in the Public Sphere Program, Center for Communication Science - RTI International

Darlene Tad-y
Physician - Colorado Hospital Association

Lauren Taylor
Post-Doctoral Fellow - NYU Grossman School of Medicine and The Hastings Center

Leslie Tucker
Consultant - The ABIM Foundation

Antonia Villarruel
Professor and Margaret Bond Simon Dean of Nursing - University of Pennsylvania School of Nursing

Daniel Wolfson
Executive Vice President and COO - The ABIM Foundation

Acknowledgement

Endnotes

1. Structural racism (or structural racialization) is racial bias across institutions and society. It describes the cumulative and compounding effects of an array of factors that systematically privilege white people and disadvantage people of color. (https://unityfirst.com/2019/the-language-of-inclusion/)

2. Trustworthiness is defined as being worthy of confidence (Merriam Webster).

3. "Positive Deviance (PD) refers to a behavioral and social change approach which is premised on the observation that in any context, certain individuals confronting similar challenges, constraints, and resource deprivations to their peers, will nonetheless employ uncommon but successful behaviors or strategies which enable them to find better solutions. Through the study of these individuals– subjects referred to as 'positive deviants' - the PD approach suggests that innovative solutions to such challenges may be identified and refined from their outlying behavior." (https://www.betterevaluation.org/en/plan/approach/positive_deviance)

4. "In citizen science, the public participates voluntarily in the scientific process, addressing real-world problems in ways that may include formulating research questions, conducting scientific experiments, collecting and analyzing data, interpreting results, making new discoveries, developing technologies and applications, and solving complex problems." (https://www.citizen-science.gov/#)