



DRAFT: Building Patient Trust in the Collection, Use, and Sharing of Social Determinants of Health Data

Executive Summary

Quality of life, health, and healthcare outcomes are impacted by factors beyond the care a person receives from their healthcare providers. Those non-medical factors, including food insecurity, housing status, and transportation needs, are often referred to as the social determinants of health (SDOH). When SDOH data is collected, used, and shared, care teams can gain insight into a person's full medical and non-medical story, allowing them to improve an individual's overall health and wellbeing.

Yet, individuals may be unwilling or less eager to share their non-medical information. This information is deeply personal and can be difficult to discuss. Sharing these experiences often comes with stigma, self-judgment, shame, or fear of blame or retribution. Individuals may have had negative consequences from sharing this information in the past. They may question why SDOH data is collected or how it is used and shared. Or they may not trust the healthcare system or their care teams.

Without this information, care teams cannot get a full picture of the patient. This can lead to less optimal outcomes, higher risk of readmission, and overall higher healthcare costs.

Improving trust has been a core principle of the AHIMA effort, Data for Better Health®, which seeks to increase awareness of how collecting, using, and sharing SDOH data can improve individual and community health outcomes. This white paper weaves together the knowledge, research, and insights gathered by the AHIMA team since this effort launched in 2023.

It begins with an overview of SDOH, explores definitions of trust, and examines key aspects of existing trust frameworks. The paper proposes a nine-step **AHIMA Framework for Building Patient Trust** that can be used to build trust between patients, care teams, and health information professionals who operationalize and maximize our ability to collect, use, and share SDOH data.

AHIMA remains committed to learning and sharing best practices. We invite you to submit your comments on this paper and the AHIMA Framework for Building Patient Trust. Your feedback will be used as AHIMA evolves this framework to support health information professionals, care teams, patients, thought leaders, policymakers, and the public in this work. Please submit your comments by **Friday, January 16, 2026**.



Introduction

Only 20 percent of our health is related to access to care and quality healthcare services. The remaining 80 percent is determined by factors — including an individual's physical environment; socioeconomic factors like education or job status; or health behaviors such as diet and exercise.ⁱ

These conditions in the environments where people are born, live, learn, work, play, worship, and age are referred to as social determinants of health (SDOH). The term SDOH is often used synonymously with other terms such as social drivers of health, upstream drivers of health, or societal factors that influence health.

A growing body of evidence suggests SDOH plays a substantial role in determining health and healthcare outcomes. When this information is appropriately collected, used, and securely shared, the entire care team gains insight into what makes up a person's full medical and non-medical story, allowing them to collaborate on improving an individual's overall health and wellbeing.

The cornerstone to successfully leveraging SDOH data to improve health outcomes is trust. Individuals must feel comfortable sharing this information with their care teams. They must trust that the information will be appropriately collected, used, and securely shared. They must trust that their care team will not judge them, shame or blame them, or seek retribution.

If they do not, they may not share their non-medical information. Care teams will then not get a full picture of the patient. The data will be incomplete, inaccurate, or not collected at all, which can lead to less optimal outcomes, higher risk of readmission, and overall higher healthcare costs.

Put simply, we cannot improve health outcomes without addressing SDOH; and we cannot address SDOH without building trust between patients and care teams.

Patient Trust

The concept of trust has been defined in many ways. There has been significant work done to define this term in a leadership context. For example, the leading definition from Charles Feltman defines trust as choosing to risk making something you value vulnerable to another person's actions.ⁱⁱ



Alternatively, David Maister describes trust as a feeling that provides the foundation for strong relationships, and which must be earned, not given.ⁱⁱⁱ And Brené Brown indicates that when we trust, we are braving the connection with someone.^{iv}

In healthcare, patient trust can be defined as a collection of expectations that patients have of their care teams or a feeling of reassurance or confidence patients have in their care team.^v While trust is an integral part of every relationship we have, trust between patients and their care teams is the foundation of stable, effective, and sustainable healthcare.^{vi} It is fundamental to safety, dignity, and overall health and wellbeing.

Patients who trust their care teams report fewer symptoms, higher satisfaction with treatment and better health-related quality of life.^{vii} Trust is also associated with improved patient satisfaction, better continuity of care, more beneficial health behaviors, adherence to treatment, better quality care, and patient safety scores.^{viii}

When trust does not exist patients and care teams may feel afraid, annoyed, frustrated, or resentful towards each other. Patients also may engage in strategies to protect themselves such as not engaging with the healthcare system, skipping needed care or screenings, or selecting not to share medical and non-medical information with their providers or care teams.

The Decline of Patient Trust in Healthcare

Confidence in the healthcare system is at an all-time low. According to a 2025 Gallup survey, confidence in health institutions is at 32 percent, nearly a 50 percent drop since 1975 when it was 80 percent.^{ix}

Surveys have been conducted to gain insights into the reasons for this decline. For example, the COVID-19 pandemic has been associated with a decrease in trust. A study, published in JAMA revealed that trust in physicians and hospitals decreased from 71.5% in April 2020 to 40.1% in January 2024.^x And this decline in trust applies to non-medical information. A 2021 survey conducted by the Pew Charitable Trusts found that 48 percent of respondents felt comfortable with their non-medical information being shared among their care teams.^{xi}

“Trust is about keeping promises, making people feel heard, and not judging them.”

Tara Montgomery, founder and principle of Civic Health Partners
2023 AHIMA Data for Better Health Leadership Summit
Keynote Speaker

“Journal of AHIMA” article — *Shared Vision and Purpose from the Top Drive SDOH Initiatives* — available [here](#). Last accessed Sept. 13, 2025.

A report from AMF Media Group and the Medical Group Management Association identified the influence of insurers, pharmaceutical companies, and the government as major contributors to declining trust.^{xii} Other surveys have found that feelings of distrust are higher in marginalized communities.^{xiii}

Research from the Institute for Health Improvement and the American Board of Internal Medicine Foundation found three core reasons behind the lack of trust between providers and communities:

1. Misgivings from personal and/or historical experience;
2. Misdoubts about motivation and/or decision-making; and
3. Misalignment in values.^{xiv}

In addition, misinformation on the internet and social media is accelerating the rate at which trust is eroding. Many people wonder who to trust with regard to community health statistics, prevention strategies, and treatment.^{xv}

Despite these challenges, AHIMA believes there is an opportunity to build trust across the healthcare system as care teams seek to address SDOH.

Common Elements in Existing Trust Frameworks

Today, many frameworks have been developed to build trust between individuals, communities, and organizations. Some come from outside healthcare while others address challenges and opportunities in the healthcare environment. See **Appendix A** and **Appendix B** for descriptions of leading trust frameworks.

While each framework offers a unique perspective, there are common elements among them that care teams can utilize to build trust with patients. These elements include:

- **Care.** Care involves showing genuine interest in others' well-being, their goals, and circumstances. This includes showing you have that person's best interest in mind when making decisions and taking actions related to their care and treatment. When care is expressed, trust is fostered through a sense of intimacy and togetherness.
- **Communication.** Effective communication starts with listening – hearing and understanding what patients are communicating through words, writing, or body language. For care teams, it also means providing context, transparency, minimizing confusion, sharing intentions, and ensuring patients have the information they need to



make decisions. Communication builds trust by reducing friction caused by uncertainty.

- **Affirmation.** Affirmation builds on communication. It involves not only listening, but paying attention to patients lived experiences and connecting them with care team members that have shared lived experiences.^{xvi} This includes providers that share the same race, ethnicity or culture, speak the same language, or live in the same neighborhoods.
- **Competence.** This is a belief that someone is capable and skilled enough to deliver on their promises and perform their responsibilities effectively. As a care team, it means having the ability to take good care of patients, deliver positive health outcomes, maintain the security of health information, and more.
- **Reliability.** Keeping commitments, or being reliable, builds a strong foundation for trust. When care teams do what they say they will do, and are consistent in performing such actions, they create a sense of predictability, safety, and security that strengthens trust over time.
- **Boundaries.** Respecting patients' limits also builds trust. There are boundaries that must be considered in every healthcare interaction. For example, care teams should assess what information is needed for treatment and ask questions that align with that assessment. They may also allow patients the opportunity to opt-out or decline to answer questions.
- **Privacy.** Trust is built when sensitive information – medical or non-medical – is kept confidential. This means the information is protected, secure, handled with discretion, and only shared when appropriate.

AHIMA Framework for Building Patient Trust

AHIMA's nine-step framework applies common elements of existing trust frameworks to build trust between patients, care teams, and the health information professionals who operationalize and maximize the collection, use, and sharing of SDOH data.

1. **Cultivate a culture and environment that supports trust.** This can be done by building a safe environment for patients to share their lived circumstances. To effectively do so, it may require making trust a strategic priority like at Banner Health, where its 10-year strategic plan includes fostering trust through the entire system.^{xvii} It



may also require gaining a deeper understanding of why patients and communities distrust healthcare organizations and care teams. It may also require making changes to ensure patients have a safe environment to share their non-medical needs.

Potential Strategies to Implement:

- Make building trust an organizational strategic priority that can guide employees through daily interactions and critical decision-making. Ensure care teams know there is a shared vision and purpose from leadership.
- Create shared values around trust and encourage teams working together to integrate those values by providing guidance and strategy at the organization level and facilitation of dialogue among teams.
- Understand what causes trust and distrust for patients.
- Acknowledge past breaches of trust at the community and individual level. To regain trust, embrace humility, voice responsibility, and when appropriate, apologize for past harm in a genuine and authentic way.
- Understand that care teams cannot undo all breaches of trust, but they can strive for understanding, demonstrate empathy, and persist in other trust-building behaviors.
- Provide information to patients so they are informed of the care they receive and are empowered to decide what role they want in their own care decisions.
- Create a safe space – both physical and psychological – where patients and care teams have permission to be honest, ask for help, and share struggles without fear of blame or retribution.
- Prioritize continuous learning and improvement.

2. **Adopt consistent, transparent communication.** Communicating how SDOH data is collected, shared, and used in a consistent, transparent way will help increase patients' willingness to share non-medical information. This can be done in several ways. For example, Nationwide Children's Hospital in Columbus created a script to use when screening patients and families for SDOH.^{xviii} Inova Health also developed a video for patients to help inform how SDOH data is used to support patients' health and wellbeing.^{xix}

Potential Strategies to Implement:

- Provide a clear explanation of SDOH screening, including what SDOH are, how they impact health, and why screening questions are being asked.
- Communicate clearly, in plain language, how this information may be used.



- Consistent with organizational policies, obtain consent from patients that they are comfortable with this information being shared (e.g., with care teams, community-based organizations, etc.) and acknowledge that patients can withdraw their consent at any time if they no longer wish to share this information.
- Create policies as to who will and will not have access to the information and in what circumstances such data may be used to tailor treatment plans or make referrals to resources, when available.
- Acknowledge that patients have taken time and risk by providing personal information and share the organization's policies and procedures to ensure their SDOH data is kept private, confidential, and secure.
- Specify that all patients are being asked these questions.
- Respect patient agency by asking permission to conduct the screening, stating explicitly that patients are not required to participate and providing the opportunity to decline or stop the screening process at any time.
- Note that the screening process does not in and of itself constitute an application for resources, nor will connection to resources always be possible.
- Ensure that when questions are asked and patients respond, patients will receive a response from the care team.
- Ask patients to prioritize identified needs. Begin matching referrals to resources and services to those areas patients identify as most important, when possible.
- Ask open-ended questions, listen, and summarize what the patient has said to ensure understanding.
- Allow for discussion and the co-creation of next steps as a partnership between the care team and patient.

Building Trust in the Absence of Data Segmentation

In an ideal world, to foster trust, when a patient requests their non-medical or other sensitive information not be shared with another provider or entity, the care team would have the ability to segment this data within the health IT system at a granular level. Unfortunately, lack of technical solutions to allow for segmentation remains a persistent challenge. Data segmentation solutions are not widespread among health IT system vendors or cost prohibitive. Work is ongoing by organizations such as the [Shift Collaborative](#) to create a “privacy-safe interoperability infrastructure” by leveraging fast healthcare interoperability resource (FHIR) and standards-based data segmentation, security labeling, consent management, and terminology value sets.



3. **Know your patients and meet them where they are.** Learn about your patients, from basic information to their individual healthcare preferences and meet them where they are to build trust. At Oak Street Health, the care team integrates birthday reminders into the electronic health record (EHR). If a patient is at its center, staff members sing, present a signed card, or hold up a birthday banner in the patient's honor.^{xx} Sinai Urban Health Institute in Chicago deploys community health workers to asthma care patients' homes. Care team members also live in the same neighborhoods and share the same culture as the children, adults, and caregivers they visit.^{xxi}

Potential Strategies to Implement:

- Know your patients as individuals by learning their names, preferences, and healthcare needs.
- Adapt to patients' individual needs, including their own language, traditions, values, and preferences, by offering screening questions in different languages, providing translation services, virtual options, or religious accommodations.
- Offer different methods for screening, including verbal, written, in-person, electronic, or a combination. Limit settings in which questions are asked, so patients are not asked to provide this information in multiple settings.
- Ensure the care team members having these conversations understand or share patients lived experiences.
- Allow patients to ask questions and help them get answers to their questions.
- Ask patients about their strengths, interests, and assets. Balancing SDOH screening questions with what patients find meaningful, allows care teams to convey respect, promote self-efficacy, and empower patients.

4. **Train teams to support a culture of trust.** Care teams must understand it is a privilege to be in a conversation with a patient who is vulnerable. By acknowledging this, they can help build a culture that allows patients to share freely.

Potential Strategies to Implement:

- Foster a culture that supports holistic care where a patient's social needs are seen as equally as important as their clinical needs.
- Account for the stigma associated with SDOH.
- Cultivate a dedicated care team that trusts their skills and competencies by embracing a culture that supports individual's strengths and provides dedicated



resources (e.g., training, funding, and time) to advance efforts to collect, use, and share SDOH data.

- Train care team members on how to ask sensitive questions with a patient-centered approach that includes empathy and respect.
- Avoid making assumptions about patients.
- Train staff on trauma and its psychological, emotional, and behavioral effects, as well as support for self-care and secondary trauma prevention.
- Facilitate role-playing scenarios to help staff feel more comfortable and confident.
- Create an FAQ document to address the team's frequently asked questions.

- 5. Ensure resources are available to individuals who report SDOH needs.** When a patient identifies a need, organizations should have a clear, easy-to-use system for connecting them with relevant community resources. This can range from a resource flyer to a closed-loop connection. MetroHealth in Cleveland sends educational materials through its patient portal when someone screens positive for stress, physical inactivity, or social isolation.^{xxii} Sharp Healthcare in San Diego partners with United Way 211 and San Diego's Community Information Exchange (CIE). Together, a network of partners uses a shared language, resource database, and technology platform to create a single care plan for the individuals they serve.^{xxiii}

Potential Strategies to Implement:

- Determine what resources are available in the community.
- Analyze SDOH and population health data to understand which types of referrals are most common for patients in the community.
- Develop partnerships with community-based organizations (CBOs) and others to offer resources to patients with identified SDOH needs, prioritizing those referrals that are most common.
- Design clear, easy-to-use systems for connecting patients with relevant community resources – this can include a resource flyer, a warm-handoff to a resource provider, scheduling an appointment for a patient to meet a resource provider, or a closed-loop connection that ensures patients receive needed resources.
- Ensure that care teams are trained on these referral systems and understand how to use them to provide resources to patients.
- Follow up with the patient to see if the connection to the resource was successful and if their needs were met.

- 6. Develop policies and procedures related to SDOH data use, privacy, security, data quality, and governance.** It will be critical for health information professionals and



compliance teams to develop policies and procedures that keep SDOH data safe and secure.

Potential Strategies to Implement:

- Integrate SDOH data into the EHR in a standardized, structured way that not only makes the process more efficient for patients and care team members but easier to retrieve when needed.
- Implement clearly defined ethical standards that are transparent and consistent for how SDOH data will be used and secured, including who will have access to it within and outside of the organization if shared with a CBO.
- Make sure that all necessary care team members have access to the information needed for decision-making so they can proceed accordingly.
- Adopt “break the glass” procedures that allow authorized personnel to bypass standard security controls to access critical systems or sensitive information during a system failure, major incident, or true emergency.
- Develop robust data governance policies, including clear consent management strategies, secure health IT systems, and the use of “minimum necessary” as defined by the Health Insurance Portability and Accountability Act (HIPAA) when sharing data for purposes other than treatment, payment, and/or healthcare operations.
- Work with the HIM department including coding and CDI teams to ensure SDOH data collected within the organization is documented in the medical record and coded correctly.
- Develop policies and procedures that safeguard against the use of SDOH data for discriminatory practices, such as denying or limiting healthcare services.
- Prior to deployment, test algorithms used for predictive modelling and analytics using real-world SDOH data to avoid bias.



Leveraging AI tools to Collect, Share, and Use SDOH Data

Prior studies indicate that providers may feel uncomfortable when asking patients about their non-medical needs. This may be because they are not comfortable with asking such questions or believe patients would be offended. **(endnote:**

<https://pmc.ncbi.nlm.nih.gov/articles/PMC11528312/>) In other instances, providers cite lack of time due to understaffing or other clinical needs as a barrier to collecting and discussing a patient's non-medical needs with them. AI tools offer the potential to alleviate these barriers. AI agents could be trained and deployed to administer screening questionnaires and collect this information from patients with empathy and respect.

Large language models (LLMs) could also be used to improve the capture of SDOH data in clinical documentation. At Mass General, investigators have demonstrated that LLMs can be trained to automatically extract SDOH data from providers' notes, improving their ability to identify patients that need community resources. Their findings show that such models could identify 93.8 percent of patients with non-medical needs whereas ICD-10-CM diagnostic Z codes indicating at least one non-medical need showed up in only 2 percent of cases. **(endnote:**

<https://www.massgeneralbrigham.org/en/about/newsroom/articles/generative-artificial-intelligence-models-effectively-highlight-social-determinants-of-health-in-doctors-notes>, <https://www.nature.com/articles/s41746-023-00970-0#Sec2>)

However, the use of AI tools in this context is not without risk. Improperly trained tools or tools that rely on poor quality data can lead to or perpetuate bias which can further erode trust. Training data that is not representative or applicable to the environment in which the tool is used can lead to poor outcomes or incorrect clinical decision-making further hindering trust. Additionally, lack of interoperability and standardized terminologies and definitions related to SDOH data can limit the implementation and use of AI tools.

(endnote: <https://pmc.ncbi.nlm.nih.gov/articles/PMC10829781/#sec5>). Additional work is needed to ensure AI tools deployed to improve the collection, sharing, and use of SDOH do not further erode patient trust. This includes improved data governance policies and procedures, transparent information about how AI tools perform and ingest data in the real-world environment, appropriate protections to ensure the confidentiality, privacy, and security of such information, and the upskilling of the healthcare workforce to ensure such tools are properly deployed and used.



- 7. Establish clear policies on data sharing with third parties.** Develop policies and procedures that address SDOH data use, privacy, security, data quality, and governance with external organizations such as CBOs or government-related entities.

Potential Strategies to Implement:

- The internal implementation tactics listed in #6 above apply here and should be adapted to protect SDOH data that is shared with third parties.
- Develop a shared-understanding framework for data privacy that extends beyond what is traditionally considered protected health information (PHI) to account for the fact that non-medical organizations may use different terminologies and standards when protecting, using, and sharing SDOH data.
- Define data sharing rules. Have clear, written policies on who has access to the data and for what purpose.
- Establish a standard for the “minimum necessary” information to be shared with CBOs.
- Make clear that SDOH data must be used and shared in accordance with all applicable state and federal laws and should not be used for discriminatory practices, denial of healthcare services, or unfair marketing practices.
- Design a closed-loop referral or consider using existing community referral resource databases that facilitate a closed-loop connection, such as [Findhelp](#), [The Neighborhood Navigator](#), [Helpline Center](#), [United Way 211](#), and [UniteUs](#).

- 8. Measure success.** What is measured matters, and it is important to not only measure the success of specific efforts and programs related to SDOH data but to also measure trustworthiness.

Potential Strategies to Implement:

- Create dashboards to track and aggregate SDOH needs of patients served and referrals made to external organizations.
- Obtain timely feedback from patients about the processes and procedures used to collect, use, and share SDOH data. This can be done on an individual basis or in small groups as well as electronically, in-person or via phone.
- Assess whether the organization’s performance is in line with patients’ expectations and what gaps may exist for improvement.
- Test screening processes and procedures with patients and care team members before standardizing an approach.
- Develop a process to regularly assess the impact of SDOH programs and their correlation to better health outcomes.



- Incorporate a standard process to track referral outcomes and adjust as needed to improve efficiency and effectiveness.
- Measure trustworthiness – this can be done by evaluating whether care teams and patients have successful conversations about SDOH, whether referrals are made, whether patients come back for follow-up, and more.

9. Acknowledge that building trust takes time. Trust is not simply given; it must be earned over time.

Potential Strategies to Implement:

- Acknowledge that you cannot do everything on the first patient encounter. It may take several visits for a patient to share non-medical information.
- Understand what causes trust and distrust for patients; acknowledge past breaches of trust; demonstrate empathy and understanding.
- Become comfortable with the time it may take to build trust and accept if patients do not want to provide SDOH information.
- Follow the lead of patients and community members who are marginalized and most mistrustful of the organization.
- Recognize that patients have taken the time and risk of sharing personal information. Give patients the time needed to complete screening and make decisions.
- Remember that trust is an evolution – and even when gained, it may be revoked at any time. Organizations and care teams must keep learning, adapting, and responding.

Getting Started

Healthcare providers and the health information professionals that manage SDOH data will not be able to collect, use, and share it without building trust with patients. Building trust starts by asking questions. Here are some that can help organizations get started:

- How does collecting, using, and sharing SDOH data align with our organization's mission and values?
- How can we identify and acknowledge past breaches of trust? What must we do to demonstrate responsibility and empathy to rebuild trust?
- Do our teams have the training and resources needed to ask the right questions and act on the information provided?



- What policies, procedures, and security protocols do we have in place to protect SDOH data? How are we protecting SDOH data? Are we communicating this clearly to patients?
- How do we vet and build relationships with community-based partners to ensure they are trustworthy and effective?
- How do we build policies, procedures, and security protocols to enable closed-loop referrals with CBOs?
- How do we obtain patient feedback on their experience with SDOH screening and follow-up?

Conclusion

Building the trust necessary to collect, use, and share SDOH data is a challenging and complex undertaking. It requires uncomfortable conversations, changes to workflows and processes, and workforce training. Leadership commitment from individuals, departments, and organizations, willingness to engage in change management, as well as partnerships with CBOs, is crucial.

Earning trust takes time, maybe years. Even once relationships are built, the work must continue to avoid losing trust in the future. Incremental changes, including the steps set forth above, will make a difference.

Through Data for Better Health®, AHIMA will continue to learn and share best practices with those working to build this trust.

Data for Better Health®

AHIMA® launched Data for Better Health® to increase awareness of how collecting, using, and sharing SDOH data can improve individual and community health and healthcare outcomes. Through this effort, AHIMA provides tools, resources, and education to HI professionals, thought leaders, policymakers, and the public that support a better understanding of the importance of SDOH data and how it can be used to improve peoples' health and quality of life. Visit www.dataforbetterhealth.com to learn more.



Appendix A: Existing Trust Frameworks

Trust Framework

Four Drivers of Trust

From *The Thin Book of Trust: An Essential Primer for Building Trust at Work*

The Trust Equation

From *The Trusted Advisor*

4C Model of Trust

BRAVING, the Seven Pillars of Trust

The Trifecta of Trust

Description

Designed by Charles Feltman, this framework has four assessment domains that can be used to assess an individual's trustworthiness. These include sincerity, reliability, competence, and care. This equation, attributed to David Maister, includes three numerators credibility (does this person know what they are talking about?), reliability (do they deliver on their commitments?), and intimacy (do they make me feel safe and secure?). When they increase, trust increases. The denominator is self-orientation (do they have my best interests at heart?). When this is reduced, trust also increases.

Credited to Warren Bennis, this model consists of **C**ompetency, **C**ongruity, **C**onstancy, and **C**redibility. Each is essential for building trust in relationships.

Created by Brené Brown, this roadmap includes seven elements: **B**oundaries, **R**eliability, **A**ccountability, **V**ault, **I**ntegrity, **N**onjudgment, **G**enerosity. This framework allows individuals and groups to build stronger, more resilient relationships based on trust.

Developed by Zenger Folkman, The Trifecta of Trust highlights three behaviors that can account for the vast difference in the impact of individuals with high levels of trust and those not trusted at all. They include expertise/good judgment, demonstrating consistency, and building relationships. By mastering this trust trifecta, leaders increase effectiveness and happiness, both in business and in life.



Appendix B: Existing Healthcare Trust Frameworks

Trust Framework

[American Association of Medical Colleges
Center for Health Justice Principles of
Trustworthiness Toolkit](#)

[The American Board of Internal Medicine
\(ABIM\) Foundation Dimensions of Trust](#)

Also see the ABIM Foundation's initiative, [Building Trust](#) for research and trust practices being used by over 50 organizations across the country

[America's Essential Hospital's Practical
Steps Towards Patient Trust](#)

[The ASC-DOC Trust Model](#)

[Four Pillars of Ethics in Healthcare](#)

Description

The Principles of Trustworthiness Toolkit is a structured, community-driven framework and offers tools that organizations of any kind can use to become more trustworthy partners.

The Dimensions of Trust will help healthcare organizations make trust a central strategy. These dimensions include competency, caring, communication, and comfort. They suggest that trust is built on a clinician's medical expertise, ability to show empathy, communicate clearly, ensure patient comfort, and be transparent about the financial aspects of care.

The Practical Steps Towards Patient Trust sets forth four overarching recommendations for building an environment that facilitates patient trust. These include building an organizational culture, focusing on person-centered care, cultivating a physical environment, and engaging the community at large.

The ASC-DOC model is designed to build trust in real-time patient interactions. It stands for **A**uthenticity, **S**afety, **C**onsistency, **D**ependability, **O**wnership, and **C**ompetence. This framework is highly patient-centered, encouraging providers to pay close attention to patient cues and engage in a mutual, reciprocal process of building trust. While not a dedicated trust framework, the four pillars of ethics – autonomy, beneficence, non-maleficence, and justice – serve as a foundational ethical framework for building trust. By respecting a patient's right



[Institute for Healthcare Improvement,
Framework for Rebuilding and Strengthening
Trust](#)

to make their own decisions (autonomy), acting in their best interest (beneficence), doing no harm (non-maleficence), and treating all patients equitably (justice), providers can establish a strong ethical basis for a trusting relationship.

The Framework for Rebuilding and Strengthening Trust identifies key drivers of mistrust in healthcare. In addition, it offers a blueprint for how to build and strengthen trust where it has been broken or previously did not exist. This includes 1) acknowledging past breaches of trust; 2) redressing and closing trust gaps in the present; and 3) building systems to strengthen trust for the future.

[Patient-Centered Communication Model](#)

While there are many versions of this model, the version linked was featured in the American Family Physician Journal.

The Patient-Centered Communication Model focuses on communication as the primary driver of trust. It highlights the importance of active listening, empathetic responses, and shared decision-making. The framework stresses that effective communication makes patients feel heard, respected, and valued.

[Oregon Primary Care Association Principles
of Patient-Centered Approaches to Social
Needs Screening](#)

Oregon Primary Care Association developed this approach, called Empathic Inquiry, to assist their teams in screening for social needs. It draws on the concepts and skills of motivational interviewing and trauma-informed care.

ⁱ County Health Rankings and Roadmaps, Model of Health. Available [here](#). Last accessed Oct. 2, 2025.

ⁱⁱ Charles Feltman, *The Thin Book of Trust: An Essential Primer for Building Trust at Work*. Highlights available [here](#). Last accessed Sept. 11, 2025.

ⁱⁱⁱ David Maister, *The Trusted Advisor*. Summary available [here](#). Last accessed Sept. 11, 2025.

^{iv} Brené Brown, *BRAVING, the Seven Pillars of Trust*. Available [here](#). Last accessed Sept. 13, 2025.

^v BMJ Open, *A Study of the Nature and Level of Trust Between Patients and Healthcare Providers, Its Dimensions and Determinants: A Scoping Review Protocol*. Available [here](#). Last accessed Sept. 13, 2025.



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- ^{vi} MedEDPublish, *Toward Understanding and Building Trust for Practicing and Emerging Healthcare Professionals: The ASC-DOC Trust Model*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{vii} MedEDPublish, *Toward Understanding and Building Trust for Practicing and Emerging Healthcare Professionals: The ASC-DOC Trust Model*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{viii} F1000 Research, *The “House of Trust.” A Framework for Quality Healthcare and Leadership*. Available <https://pmc.ncbi.nlm.nih.gov/articles/PMC11179047/>. Last accessed Sept. 13, 2025. Banner Health, *Banner Health Among Nation’s Most Trustworthy and Innovative Companies*. Available [here](#). Last accessed Sept. 8, 2025.
- ^{ix} Gallup, *Confidence in Institutions*. Available: [here](#). Last accessed Sept. 8, 2025.
- ^x JAMA Network Open, *Trust in Physicians and Hospitals During the COVID-19 Pandemic in a 50-State Survey of US Adults*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{xi} Pew, *Most Americans Want to Share and Access More Digital Health Data*. Available at: [here](#). Last accessed on Oct. 2, 2025.
- ^{xii} MedCity News, *Americans’ Trust in the Healthcare System Is Plummeting. How Can It Be Repaired?* Available [here](#). Last accessed Sept. 15, 2025.
- ^{xiii} Fortune, *People Are Much Less Likely to Trust the Medical System if They Are From an Ethnic Minority, Have Disabilities, or Identify as LGBTQ+, According to a First-of-its-kind Study by Sanofi*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{xiv} Institute of Healthcare Improvement, *Quality at the Speed of Trust*. Available [here](#). Last accessed Sept. 8, 2025.
- ^{xv} MedEDPublish, *Toward Understanding and Building Trust for Practicing and Emerging Healthcare Professionals: The ASC-DOC Trust Model*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{xvi} Harvard Undergraduate Health Policy Review, *Combatting Maternal Mortality through Trustworthiness and Advocacy: A Conversation with Dr. Neel Shah*. Available [here](#). Last accessed Sept. 14, 2025.
- ^{xvii} University of Arizona College of Medicine, *Fostering Trust in Health Care Through Collaboration*. Available [here](#). Last accessed Sept. 8, 2025.
- ^{xviii} Children’s Hospital Association and Nyoo Health, *Screening for Social Drivers of Health: Children’s Hospitals Respond*. Available [here](#). Last accessed Sept. 15, 2025.
- ^{xix} Inova Health, *Social Drivers of Health Video*. Available [here](#). Last accessed Sept. 15, 2025.
- ^{xx} Institute for Health Improvement Blog, *Building Trust in Health Care: A Patient’s Experience Holds Key Lessons*. Available [here](#). Last accessed Sept. 8, 2025.
- ^{xxi} Sinai Chicago, *Asthma CarePartners Program (Current Phase)*. Available [here](#). Last accessed Sept. 9, 2025. The American Hospital Association, *The Value Initiative Members in Action, Sinai Health System – Chicago Community Health Workers Help Asthma Patients Thrive*. Available [here](#). Last accessed Sept. 9, 2025.
- ^{xxii} Journal of AHIMA, *How Health Information Professionals Can Help Their Organization Leverage SDOH Data*. Available [here](#). Last accessed Sept. 13, 2025.
- ^{xxiii} Sharp Health News, *Sharp Partners with 2-1-1 San Diego to Help Those in Need*. Available [here](#). Last accessed Sept. 15, 2025.