DATA FOR BETTER HEALTH®

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 well-being.

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 (HI) professionals who play an essential role in our ability to collect, use, and share SDOH data.

We encourage you to use this white paper in combination with the other resources found on the Data for Better Health® website.

Introduction

Only 20 percent of our health is related to access to care and quality healthcare services. The remaining 80 percent is determined by other 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 play 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 well-being.

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 author Charles Feltman defines trust as choosing to risk making something you value vulnerable to another person's actions.[ii]

Alternatively, David Maister, former Harvard Business school professor and author, describes trust as a feeling that provides the foundation for strong relationships, and which must be earned, not given.[iii] And author and researcher 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 well-being.

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 toward 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 insight into the reasons for this decline. For example, the COVID-19 pandemic has been associated with a decrease in trust. A study, published in the Journal of the American Medical Association (JAMA) revealed that trust in physicians and hospitals decreased from 71.5 percent in April 2020 to 40.1 percent in January 2024.[x] This decline in trust is also seen when talking about the collection, sharing, and use of non-medical information. A 2021 survey conducted by the Pew Charitable Trusts found that only 48 percent of respondents felt comfortable with their non-medical information being shared among their care teams.[xi]

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]

> **"Trust is about keeping promises, making people feel heard, and not judging them."**
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> **Tara Montgomery**, founder and principal 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.

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. Doubts 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

Many frameworks have been developed to build trust among 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 understanding 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 who have shared lived experiences.[xvi] This includes providers who 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 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 & Confidentiality.** 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.

What role do HI professionals play?

Patients do not often see HI professionals; however, these professionals ensure that sensitive health stories remain accurate, accessible, protected, and complete at all times. They play a role that is essential in the collection, use, and sharing of SDOH data. While many aspects of that role are reflected in the AHIMA Framework for Building Patient Trust, HI professionals' work is reflected in many resources released by AHIMA.

AHIMA Framework for Building Patient Trust

AHIMA's nine-step framework applies common elements of existing trust frameworks to build trust among patients, care teams, and the HI 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 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.
- Work with patient advocates and community-based organizations to understand key drivers of trust for patients.
- 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 related to building trust.
- Engaging patients and care teams in the creation and design of SDOH screening tools, workflows, and policies.

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 them about how SDOH data is used to support patients' health and well-being.[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. As a result, 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. Leveraging such an infrastructure in the long-term would empower patients to direct at a more granular level when and to whom certain data elements may be shared, including SDOH data.

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. For example, Sinai Urban Health Institute in Chicago deploys community health workers to physically meet asthma care patients in their homes. Care team members also live in the same neighborhoods and share the same culture as the children, adults, and caregivers they visit.[xx] Learning about your patients also includes understanding their digital readiness and offering a variety of methods for screening that meet patients where they are on the digital continuum.

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 (including American Sign Language for deaf patients), 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.
- Evaluate how often SDOH data is collected from patients (e.g., every six months, once a year).
- 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 that 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 equally as important as their clinical needs.
- Cultivate a dedicated care team that trusts each other's 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. For instance, MetroHealth in Cleveland sends educational materials through its patient portal when someone screens positive for stress, physical inactivity, or social isolation.[xxi] 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.[xxii]

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.
- Implement a process by which patients are notified when a connection to a resource is made.
- Follow up with patients to verify the connection was successful and their needs were met.

6. Develop policies and procedures related to SDOH data collection, use, privacy, security, data quality, and governance. It will be critical for HI 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 adheres to national standards where they exist (e.g., ICD-10-CM, United States Core Data for Interoperability and Health Level Seven® FHIR® standards). This includes adoption of Gravity Project consensus-driven terminology and data exchange standards on SDOH. Adoption and implementation of such standards make the process more efficient for patients and care team members and allows SDOH data to be retrieved more easily when needed.
- Implement clearly defined ethical standards that are transparent and consistent for how SDOH data will be used and secured within your organization as well as who will have access to it outside of the organization.
- 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 modeling 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.[xxiii] 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 SDOH 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.[xxiv]

However, the use of AI tools in this context is not without risk. Individuals already report low trust in their healthcare system to use AI responsibly.[xxv] 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.[xxvi] 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 could 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.
- Assess the need for a data sharing agreement with third parties in certain circumstances.
- 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. It is important to measure the success of specific efforts and programs related to SDOH data. To do so requires measuring trustworthiness and developing standards of accountability when trust is breached.

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.
- Establish formal breach response protocols, including disclosure, remediation, and patient notification when patient trust is at risk.
- Test SDOH 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 their non-medical information.

Give patients the time needed to complete screening and make decisions.
- Remember that trust can fluctuate, even when gained, it may be lost at any time. Organizations and care teams must keep learning, adapting, and responding.

Getting Started

Healthcare providers and the HI 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.

About the American Health Information Management Association (AHIMA®)

AHIMA is more than an association–we are a force for change in healthcare. We are the visionary architect at the center of health information equipping over 100,000 members and credential holders to uphold the highest professional standards through education and certification. We believe every patient deserves the best possible health care, and that starts with accurate, secure data. We represent the extraordinary individuals who work tirelessly to keep us all safe. Visit https://www.ahima.org to learn more.

About Nyoo Health

Nyoo Health partners with hospitals and healthcare organizations to advance women's health – assessing strengths, uncovering gaps, and working with existing teams and resources to create a strategy that uniquely matches organizations and patients and communities they serve. Visit https://www.nyoohealth.com/ to learn more.

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Appendix A: Existing Trust Frameworks

Trust Framework	Description
Four Drivers of Trust From The Thin Book of Trust: An Essential Primer for Building Trust at Work	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.
The Trust Equation From The Trusted Advisor	This equation, attributed to David Maister, includes three numerators of 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.
4C Model of Trust	Credited to Warren Bennis, this model consists of Competency, Congruity, Constancy, and Credibility. Each is essential for building trust in relationships.
BRAVING, the Seven Pillars of Trust	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.
The Trifecta of 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	Description
American Association of Medical Colleges Center for Health Justice Principles of Trustworthiness Toolkit	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 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	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.
America's Essential Hospital's Practical Steps Towards Patient Trust	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 Trust Model	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.
Four Pillars of Ethics in Healthcare	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 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.
Institute for Healthcare Improvement, Framework for Rebuilding and Strengthening Trust	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.

Trust Framework	Description
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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