Lesson 1: Introduction to The Three Drivers of Trust for COVID-19 Vaccine Uptake

Description: In this lesson, we will introduce the three drivers of trust: empathy, logic, and authenticity. We will discuss what we need to do to build trust on our teams and organizations, particularly when forms of inequity are present. We will discuss ways to address the historical and present-day impact of racism and other inequities experienced by staff who identify as Black, Indigenous or People of Color. We will explore how to design and execute a strategy to build trust at scale – for all levels of staff, on all shifts, and across departments, even when facing staffing challenges. Learners will engage champions and share leadership to build trust person-by-person in long-term care facilities. We will explore how to get the most out of the course and summarize how the methods support learners to build trust in real time to improve staff COVID-19 vaccine uptake, staff wellbeing and resident safety.

Learning Objectives:
At the end of this lesson, learners will be able to:

- Describe how to make the most of the course to build trust on teams and across the organization to increase vaccine uptake in improve other safety and infection control efforts
- Explore why trust (and a culture of trust) matters in long-term care facilities
- Define trust and recognize the three drivers of trust: empathy, logic and authenticity
- Explore barriers to trust such as resistance to change, structural inequities and histories of broken trust
- Assess personal readiness to build trust
- Identify long-term system-level strategies to support trust in the context of vaccine uptake
- Identify, recruit and train trust-building champions to improve COVID-19 vaccine uptake in long-term care facilities
- Share leadership and design a strategy to build trust person-by-person across our organizations for vaccine uptake

Faculty: Kate Hilton, JD, MTS; Courtney Bishnoi, Jerald Cosey

Story from a Long-Term Care Facility:

- A long-term care leader and staff highlight a long-term care facility's successful approach to high levels of vaccine uptake

Practice exercise & reflection: Assess your empathy, logic, authenticity, and readiness to build trust. Set an aim and measure to track your progress as you apply the methods in the course. If participating in the course with a partner or team, work on this exercise together.

Key Takeaways:

- People trust you when they think that they believe that you care about them (empathy), when they have faith in your judgment and competence (logic), and when they think they are interacting with the real you (authenticity)
- Trust building is an ongoing series of conversations, not a one-time event; it takes time, patience and persistence; it can be lost if not repeatedly nurtured
- Trust does not involve persuading, convincing, cajoling, or pressuring people

- Barriers to trust include people's psychological resistance to change, existing inequities and histories of broken trust, and burnout
- Differences in race, age, culture, income-level, staff role, and other traits impact people's ability to trust one another
- Building a culture of trust and safety will help you retain and recruit staff and address burnout
- Systemic racism impacts trust building: leaders must understand the historical and present-day impact of racism among those who identify as Black, Indigenous, or People of Color, many of whom often experience discrimination at work and while accessing and using health care, and how that impacts their willingness to trust the COVID-19 vaccine
- Leaders should show up ready to respect and be present to people's experiences of disparities and power dynamics; ask their permission to discuss it; acknowledge the bias of one's lived experience; and recognize that many people are not used to and may be uncomfortable with having conversations about race and inequity
- Leadership means taking responsibility to enable others to achieve a shared purpose in the face of uncertainty
- Servant leaders share power, put others first, and help people develop
- Leaders should conduct an emotional inventory to check their own mindset and readiness to build trust
- Trust building champions and/or vaccine ambassadors communicate with empathy, logic and authenticity; they meet people where they are with curiosity and without judgment
- COVID-19 vaccine and booster uptake can be achieved at scale by recruiting vaccine ambassadors who build trust person-by-person, and on all shifts, through an intentional and distributed relational strategy
- Credit and celebrate vaccine ambassadors (and others) for their contributions to your facility's vaccine uptake
- Building trust for vaccine uptake in long-term care facilities can also include system-level strategies such as paid-time off for vaccination and booster recovery, engaging employee unions and training staff about trauma-informed care

Readings:

- Hilton K, Anderson A. IHI Psychology of Change Framework to Advance and Sustain Improvement. Boston, Massachusetts: Institute for Healthcare Improvement; 2018. http://www.ihi.org/resources/Pages/IHIWhitePapers/IHI-Psychology-of-Change-Framework.aspx
- Centers for Disease Control and Prevention. U.S. Department of Health and Human Services. *COVID-19 Vaccination Field Guide: 12 Strategies for your Community*. https://www.cdc.gov/vaccines/covid-19/downloads/vaccination-strategies.pdf
- Agency for Healthcare and Research Quality (AHRQ). Invest in Trust: A Guide for Building COVID-19 Vaccine Trust and Increasing Vaccination Rates Among CNA's. *https://www.ahrq.gov/sites/default/files/wysiwyg/nursing-home/materials/invest-in-trust-guide.pdf*

Additional Resources:

- AAMC Principles of Trustworthiness: https://www.aamchealthjustice.org/media/271/download?attachment

- We Are Greater Than Covid. The Conversation: Between Us, About Us. https://www.greaterthancovid.org/theconversation/toolkit
- Preferred terms for select groups and populations: https://www.cdc.gov/healthcommunication/Preferred_Terms.html
- Wyatt R, Alderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2016. http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx
- American Medical Association & American Association for Medical Colleges. Advancing Health Equity: A Guide to Language, Narrative and Concepts. https://www.ama-assn.org/system/files/ama-aamc-equity-guide.pdf
- The State of Trustworthiness, AAMC Center for Health Justice, 2021. https://www.aamchealthjustice.org/resources/state-trust

Lesson 1, Lecture 1: Introduction (4 min) (Courtney)

No Slide- Video Only
Hi, I'm Courtney Bishnoi, Vice President of Quality and Programs at the American Health Care Association and National Center of Assisted Living. Thank you for joining us, and welcome to Building Trust: A Strategy to Improve Vaccine Uptake, Patient Safety and Staff Wellbeing in Long-Term Care.

SLIDE 1
The purpose of this course to help long term care leaders, both formal and informal, understand their strengths and opportunities when it comes to trust building, learn and develop trust-building skills, and build a strategy to increase trust across their organization. To do this, we brought in experts in principles of trust, as well as an advisory group of long-term care leaders and trade associations to share their experience with trust and distrust in long term care. Two of those experts, Kate Hilton, a behavioral health scientist with the institute for healthcare improvement, and Jerald Cosey, a long-term care leader, will be serving as faculty throughout this course.

There are many structural issues and challenges that impact trust across long-term care organizations, and not all of them are within our control. Our reimbursement rates, workforce shortages, regulatory pressures and changing guidance all impact our ability to build trust with staff. Also, our own trust with the health care system and even burnout can make it hard to build trust. However, rather than allow these incredible challenges to limit us, we want to expand on what's within our sphere of influence as leaders and use these tools to help build a better culture of trust and safety in our organizations. We believe that leaders who take this course and apply the principles explained within will be able to meet these challenges.

SLIDE 3
In this course, we will define the core elements of trust, identify how you can assess the presence of trust in your organization, discuss the impact of experienced inequities, suggest some approaches and techniques you can practice, and provide some strategies you can use to effectively build trust throughout your organizations.

SLIDE 4
Each lesson will feature a set of short video lectures that explain core trust building concepts, demonstrate practices, and provide strategies for applying them in your organization. Each lesson will also feature a leader or staff member in long term care sharing a story about how they applied the practices to improve vaccine uptake or other outcomes. We also provide practice exercises to help you practice the concepts taught and self-reflect and additional resources for a more in-depth exploration of the subject.

SLIDE 5
We used two foundational resources for the development of this program. The first is the Institute for Healthcare Improvement's *Conversation Guide to Improve COVID-19 Vaccine Uptake*, which is authored by our very own Kate Hilton. The second is a TED talk by Harvard professor Frances Frei on how to build and rebuild trust. Frei has dedicated her life's work to researching and understanding what trust is and the conditions that create it, and we have built this course on her research.

If you have not done so, please review these two resources before continuing the course.

SLIDE 6

Finally, we strongly encourage you to take this course with a colleague to practice with and provide you with feedback and help you get the most out of this course.

No Slide- Video Only
Next up, you will hear from Jerald talking about why trust in long term care is so important. Thank you again for joining us, and I hope you enjoy this course.

Lesson 1, Lecture 2: Why Trust? (10 min) (Jerald)

No Slide- Video Only
Hi, my name is Jerald Cosey. I am currently the Operational Leadership Development Director for American Senior Communities and support the development of leaders in over 90 skilled nursing and assisted living communities in Indiana and Kentucky. I have operated Skilled Nursing Communities for the past eight years. As a volunteer, I started in senior healthcare, visiting two gentlemen for five years, focused on minimizing isolation amongst our revered elders. A health crisis, multiple surgeries, and hospital stays opened my eyes to the nobility of serving others. I wanted to serve others the way healthcare professionals had served me. I left an 18-year sales career to do something special, just like all of you. There is nothing more honorable than placing the needs of someone else before your very own. My role with this training is to provide you with an operational leader's perspective on why trust in nursing homes is important to pay attention to and continually develop.

SLIDE 8
2020 and 2021 were tough years for our country and for our profession. We faced a pandemic that disproportionally impacted our residents, our staff and our families. We experienced a social injustice movement sparked by the tragic deaths of several young African Americans and people of color. We saw political divisions increase to levels unseen in recent memory. We saw several natural disasters unfold across the country; tornadoes in the Midwest, wildfires out west, hurricanes along our coastal states and flooding in nearly every state. People outside of our industry may not understand that when tough times occur in our world, they directly impact our personal lives with our responsibilities at home and our professional lives with our obligations at work as care professionals serving human beings. We don't have "snow days"; we only have "Go days." These events have affected all of us, personally and professionally, and in different ways depending on your age, gender and race.

And yet, we continue to come to work every day. We put a smile on our faces, despite the challenges we are experiencing, and care for our residents with all we have. To serve in our space requires a great deal of emotional energy. But we are senior healthcare professionals; we persevere, help people, and overcome challenges. I couldn't be prouder to serve alongside each of you.

SLIDE 9
Pick up any newspaper and you will find evidence of crumbling trust: gun safety, climate change, mask confrontations at the grocery store. And that’s if you trust the newspaper you’re reading.

Gallup has been polling Americans for the past 40 years about their trust in leaders in all areas such as media, government, religion, schools, and business. Their most recent results from 2021 in the left graph show that trust in leaders has fallen to historical lows. They have even documented an erosion in trust in our churches, as depicted in the right graph.

SLIDE 10
Recent data from Pew Research, another polling organization, also shows significant differences in trust by your race, how old you are, how far you got in school and how much you make.

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And so, perhaps not surprisingly: we trust one another less and less. We question who to believe in and what to believe – not only at work, but also in our families and in ourselves.

This context surrounding trust matters, and it can creep into even the strongest organizations. As leaders of long-term care facilities, we are seeing the impact: from historically high rates of burnout and resignations among staff who have given so much during this pandemic, to staff who do not trust the safety or efficacy of COVID-19 boosters. The pandemic has traumatized our staff, and trust has been broken. I am still recovering from the trauma as an operational leader, being fully transparent. At times, I didn't feel like the world understood our contributions as an industry, especially early in the pandemic. The hospital healthcare professionals were celebrated as heroes. But often, I felt villainized as a long-term care professional by the media and at times by some family members of those we served. I would think, don't they see our honor? From the safety of their homes, don't they see our contribution? My trust was broken.

The problem is: we rely on trust. Without trust, our collective enterprise falls apart. It is the reason staff are willing to follow new clinical guidelines when we update our Policies & Procedures; it is the reason leaders delegate important tasks to staff to ensure resident safety; it is the reason colleagues ask one another to cover a shift or help with their resident; and most importantly, it is the reason that residents live in our facilities. We rely on commitments that are built on the trust that we will all do what we say we will do.

Make no mistake, in most of our long-term care facilities, we have done just that. Our leaders and staff have come together in ways we never imagined. When my facility had its first positive COVID case, April 4th, 2020, on a Saturday morning, my DNS, Shirley, called me with an urgent but calm tone: "Jerald, the test came back positive." I remember driving into work. Even though the streets were empty, our parking lot was full. When others sheltered in place, our staff showed up to be there for our elders who we love and cherish. We showed up to serve alongside each other. I will never forget watching the teamwork unfold. All of our departmental professionals showed up from housekeeping to nursing to therapy. Our DNS masterfully managed the bed board as we made room moves. I will never forget my Business Office Manager and Activities Director making room moves. Social Services, MDS, and Housekeeping Leaders doing deep cleans. Maintenance Director and Culinary Manager separating hallways with plastic tarps. Our marketing, sales, myself, making phone calls to all families. Every department within the community, represented by professionals at every level committed to serving.

This story is not my story; it represents all our stories. Staff have made all kinds of sacrifices to support our residents during an exhausting and emotionally draining time. Our care providers showed up when we needed them most, and it’s taken its toll. But tough times can't destroy us as leaders; it galvanizes us as one senior living industry.

SLIDE 11
Here is the good news! Research has shown that when staff trust their managers, many of the issues we are struggling with right now get better. Staff who report trust in their managers report less stress, more energy, higher productivity, experience fewer sick days, feel more engaged and satisfied with their lives and report less burn out.

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There is more good news, too: trust hasn’t disappeared; it’s shifted. While we’ve seen a decrease in people’s trust in institutions and their leaders, our trust has gone up in social

networks, and in those who earn our trust – at any level of an organization. We also know how to build trust.

That's where this course comes in. We going to learn methods to build and rebuild trust, and we are going to try them out together. We're going to use them to build a culture of trust and safety to retain and recruit staff, increase vaccination and booster rates, and deliver high quality care to residents in long term care facilities. Building trust with employees, colleagues, community partners and residents has never been more important than it is now.

Thank you again for being here and for everything you do to serve our staff and residents. I am excited to take this journey with you.

Lesson 1, Lecture 3: What is Trust? (8 min) (Kate)

No Slide- Video Only
Hi, my name is Kate Hilton, and I've worked with leaders in healthcare on the human-side of change throughout my career as Faculty at the Institute for Healthcare Improvement. Most recently, I've worked with long-term care leaders with Project ECHO. I am excited to be working with the American Health Care Association and engaging with you in this course.

I want to let you in on a little secret I've learned along the way. None of this is rocket science. We all know what it feels like to trust someone and to be trusted. We recognize when a person is worthy of trust, and when we behave in ways that are trustworthy. We also know what it's like to lose someone's trust, or to have someone lose faith in us.

Our lived experiences make us all experts in trust. There are also people whose job it is to study, research and understand it. In this course we're drawing on the work of one of those people, Frances Frei, a professor at the Harvard Business School.

SLIDE 13
Frei explains that people experience trust when three key drivers of trust are in place: empathy, logic and authenticity.

Empathy is the belief that the other person cares about them. Empathy is demonstrated by focusing on a person during conversation, acknowledging how that person feels, asking for their thoughts, ideas or opinion, making sure they get the credit for their ideas or work. If you believe that my empathy is genuine and directed at you, you are more likely to trust me.

Logic is experienced as having faith in a person's judgment and competence. Logic is demonstrated by being consistent with what you say and do, explaining your rationale or reasoning, making sure others understand not just what to do but why something needs to be done. If you believe that my explanation of my logic makes sense, you are more likely to trust me.

Authenticity involves feeling like a person shows up as their true self. Authenticity is demonstrated by being transparent, sharing how you feel, acknowledging different perspectives, accepting and acting on feedback from others, and making sure people understand and see you act upon your values, vision and goals. If you believe that I am being authentic, you are more likely to trust me.

Here's an example of the three drivers of trust in action. After COVID-19 vaccines rolled out, we talked with long-term care leaders about how they encouraged uptake among staff. Leaders who took the time to have one-on-one conversations with staff, who listened to and sought to understand their concerns or fears, who acknowledged other people's feelings before explaining the science behind the vaccines – these leaders had higher vaccine uptake than those who did not.

We're going to come back to these three drivers of trust – empathy, logic and authenticity – again and again. In fact, they're so important, we've designed the remaining lessons around them. Lesson 2 is dedicated to empathy; Lesson 3 to logic; and Lesson 4 to authenticity.

No Slide- Video Only
Now, most of us generate a stable pattern of trust signals. But research shows that when we are what Frei calls “wobbly,” or inconsistent, with one or more of these drivers – empathy, logic or authenticity – trust erodes. We wobble when we don’t demonstrate the features of these three drivers. The good news is that once we know *why* we’re wobbly, a small change in our behavior can go a long way to building or rebuilding trust.

And it turns out that everybody has a trust wobble, and it’s often inadvertent or unintentional. Stressors, like a global pandemic, can exacerbate wobbles; we may not even realize we are experiencing one. Part of our work in Lesson 1 is to identify your trust wobbles so that you can use the remainder of the program to steady yourself.

SLIDE 14
For example, leaders have an empathy wobble if they tend to micromanage others, multi-task during conversations, fail to ask people for their opinion, jump to providing solutions, take credit for others’ ideas, appear to have hidden agendas, do not invest in others’ learning and growth, are uncooperative, or are not there for their team members when they need you. These behaviors demonstrate to others, whether intentionally or unintentionally, that your needs come before others. That you lack empathy.

One example of an empathy wobble would be a leader who focuses only on how a staff member can improve during an annual performance review, rather than acknowledging and building from that person’s strengths. Another example would be a leader who takes action against a staff member who is newly late to work, rather than seeking to understand why they are running late. They are common among people who are analytical and driven to learn, who get impatient with those who take longer than they do to understand something.

SLIDE 15
Leaders have a logic wobble when they say one thing but do another, explain their judgment poorly, or fail to communicate consistently, effectively, and regularly.

Examples could include a leader who takes time off after getting the vaccine but does not provide paid time off for staff after being vaccinated, or a leader who works at home but requires staff to come into work. Or a leader who rolls out changing guidance from the Centers for Disease Control but does not take the time to explain why the guidance is changing or why it’s important.

This logic wobble lowers trust. As Frei notes, logic is not just about having sound reasoning; it’s about being able to also communicate it effectively. You may have sound logic but if you can’t or don’t communicate it, then others may have a different perception of your logic. The perception of wobbly logic matters as much as the reality of it.

SLIDE 16
Leaders have an authenticity wobble when they are not transparent with people, withhold information, manipulate others, or lie. Authenticity wobbles are also present when leaders do not express their authentic selves or feelings, or do not make it safe for others to do the same. Authenticity wobbles also show up when people are not open to feedback such as becoming defensive, are unwilling to change, and fail to inspire.

An example would be a leader who asks for feedback but becomes defensive and angry when they receive it. This demonstrates an authenticity wobble.

No Slide- Video Only
It turns out: everybody has a trust wobble. It doesn't make us inherently bad leaders – it makes us human. Wobbles are rooted in behavioral habits that may even reflect our inherent strengths. For example, a person who is analytical may have an empathy wobble.

The good news is with a little self-awareness and understanding, a little change can go a long way. For example, when a staff member tells you they are worried about the safety of the vaccine, instead of jumping to an explanation of the data or downplaying their concern, a trusted leader would acknowledge their feelings and show curiosity to understand them more deeply. This shows empathy and helps establish trust.

Once you identify your wobbles, we'll help you find your footing. We'll offer ways to think and act differently to interrupt an inadvertent spiral into mistrust. And we'll ask you to test these strategies, not just with colleagues, but with family members, and maybe even the very next person you meet. We'll also invite you to try it when you least want to do it: when a colleague is angry, you're hurrying from one place to the next, or you're exhausted. We ask that you practice these strategies and even seek feedback from a colleague or friend. As I said, the strategies are not rocket science; the hard part is to adapt and apply them when you need them most.

Lesson 1, Lecture 4: A Common Barrier in Building Trust: People's Resistance to Change (7 min) (Kate)

No Slide- Video Only
Building trust involves being mindful of common barriers and intentional in addressing them. In this lecture, we explore a psychological barrier to trust building – people's resistance to change – and offer some ways to address it.

Resistance to change is normal. When our brains detect change, neurologically, they detect a threat. Our emotional brain first feels something about it, and then the rational brain kicks in and thinks of reasons to defend that feeling.

SLIDE 18
Change consultant William Bridges illustrated common psychological stages in people's experience of change. People's psychology toward change can be experienced as denial, or shock that something needs to change in the first place. This can shift to resistance, experienced as fear, anger, frustration, and uncertainty. After that, exploration, demonstrated as asking questions or experimenting with change. Finally, people may commit to a change and integrate it into their habits and practice.

I might suggest that we are complex humans and that our experience of change may not follow this exact order. People may also feel more than one emotion at once, or they may be experiencing multiple changes that lead to more than one feeling at the same time.

For instance, when it comes to the COVID-19 vaccine or booster, people's feelings of fear and uncertainty may underpin their reasons for not getting it. They may then state a myriad of reasons that appear unrelated to fear and uncertainty to defend that feeling, such as not being at risk of getting COVID, or that COVID is not dangerous. They may become angry that they are being told or made to take the vaccine. Over time, they may talk to trusted friends who got the vaccine and start to ask more questions, exploring the option to become vaccinated, followed by a commitment to get the vaccine.

As a leader, you will experience many different forms of resistance, even within yourself.

When you experience it yourself, notice how you're feeling. Consider speaking with a friend or colleague to get underneath your resistance, and to gain perspective on how others may experience it.

When you experience resistance in others, it is important to approach people in a manner that builds trust. Here are three things that you can do.

SLIDE 19
First, don't fight the resisters. Avoid getting into a dueling stand with people by stating 'why I am right, and you are wrong.' People will defend their own story – in fact, our brains are hard-wired to do so. But fighting the resisters violates all three drivers necessary to build trust – empathy, logic and authenticity.

SLIDE 20
Rather, invite people to explore their sources of resistance, rather than confronting them with forceful arguments. Practice a form of jujutsu with them. Expect and embrace their resistance. Show curiosity. Seek to understand. Listen to what they care about – or are worried about. The

opportunity to reflect and be seen is a gift – and a strategic opportunity to surface fears through inquiry, not blame or shame. *The Conversation Guide to Improve COVID-19 Vaccine Uptake* includes good examples of what this sounds like in conversations about vaccine uptake.

SLIDE 21
This approach comes to us from Dr. Bruce Perry, a neuroscientist in the field of trauma, who explains the neurological responses that occur in our brains that regulate our fight-flight-freeze response. When humans encounter a threat, we feel out of control, anxious or stressed, and our brain's primitive area protects us through the release of adrenaline and cortisol, which rev up our body on high alert. Too much of these hormones are physically harmful to us, especially over a long timeframe. Relaxation techniques help, such as breathing, meditation, and yoga. What does this mean for us as leaders? To help people understand the feelings that underpin their resistance, we need to remain calm (not reactive), and invite others into safe spaces to regulate and calm their fight, flight, and freeze responses to the perceived threat. This is often done by acknowledging their feelings and concerns and taking an intentional moment to slow down breathe together.

Next, we can target the limbic areas involved in our behavior and emotional relationships by relating to their feelings and connecting to them. That means being in an empathetic and authentic relationship: asking them questions, listening for understanding, and repeating back what we are hearing to make sure we understand what was said. For example: "Thanks for sharing, Mary, I understand you are concerned about vaccine's side effects, is that right?" or "So your worried that the vaccine may contained a micro-chip; I certainly understand why you would not want a micro-chip." Confirming that you are listening activates the limbic system, which regulates our emotions and releases the hormone dopamine, which generates feelings of pleasure.

Last, we shift to activating people's prefrontal cortex, which is the area in our brain where we reflect, learn, remember, articulate and become self-assured in our thinking. It's where we are creative, come up with ideas and strategies to change. If we want people to change their behavior, we have to work to make sure the primitive and limbic areas are working to help activate this part of the brain function optimally, or the primitive and limbic areas will stop us in our tracks. Commitment to change requires our prefrontal cortex to work.

SLIDE 22
When we deploy this approach, it's important not to tell people what to do. Instead of asking, "How can I get this group of staff to do what *I* want them to do?" pivot to, "How can I get this group of staff to do what *they* want to do?" Listen. Tap into what motivates or matters to them. Be willing to change your approach based on what you hear and learn. Respect their choice. From the start, be explicit that it is *their* choice to get vaccinated, *their* choice to improve infection control, *their* choice to support other staff. Activate their choicefulness. For example, rather than asking if they will get vaccinated, you can ask them "how can we most effectively reduce the chance that each of us gets sick from COVID-19 or spread to our residents?"

SLIDE 23
Finally, focus on the people who are already committed to change at all levels of your organization. For example, start with CNAs who are already vaccinated, who embrace infection control. Better yet, identify those who are respected and looked up to by other CNAs. They can act as your champions with other staff. By starting with those who are committed, rather than those who resist, you can build a network of positive change agents across your organization.

They can propose changes that may be less threatening than the “supervisor” or “manager” telling them what to do.

These are a few trust-building mindsets for addressing people’s resistance to change.

Lesson 1, Lecture 5: A Common Barrier in Building Trust: A History of Broken Trust & Present-Day Inequities (13 min) (Jerald)

No Slide- Video Only
Building trust means being mindful of common barriers and intentional in addressing them. In this lecture, we explore the second of two barriers to trust building – the impact of a history of broken trust and present-day systemic inequalities, starting with racism.

Let me begin by saying: mistrust is a rational response to injustice. Leaders must be sensitive to the historical impact of the injustices faced by those of us who identify as Black, Indigenous, or People of Color, who may experience discrimination at work and while accessing and using health care. A history of mistreatment and neglect spans from slavery to the Tuskegee experiment where government public health sponsored a study, from 1932 to 1972, of untreated syphilis and knowingly withheld treatment when it became available for African Americans, to Henrietta Lacks whose cancer cells were collected and used for medical research without her consent and compensation to the present-day. As a result, black and brown people may not trust health care services, research or government-funded initiatives. This can impact people's willingness to trust the COVID vaccine, and even their willingness to trust a leader of another race.

This data may be difficult to hear. None of us want to think that this is happening, or that we could have a role in unfair treatment. At the same time, it is critical to understand and address its impact in our settings, especially concerning staff uptake of vaccines and boosters and other preventative measures. We care for people, and we depend on people to care for people.

SLIDE 25
Data from a national survey asked how ethnic minorities perceive biased treatment in health care generally. When asked to respond to the prompt "I would have received better care if I were a different race or ethnicity," compared to white people, black people were 10 times more likely to agree, so were Latinos and Asians. That's a remarkably large difference.

And when asked to respond to the prompt "I was treated unfairly based on how I speak English," almost no white people agreed, while 3.7 percent of black people, 7.6 percent of Latino people agreed, and 4.1 percent of Asian people agreed. This is an important finding as it's not just related to English spoken as a second language with an accent. African Americans whose first language is English felt they were treated in a biased manner based on how they spoke English.

SLIDE 26
What's the impact? African Americans and Latinos participate less in communications with their physicians which leads to making fewer decisions about their care when their physician is white. White providers are more verbally dominant in care conversations with minorities, graded by how often they speak, and they have less positive affect, meaning they sound less friendly or interested. In contrast, in visits between doctors and patients of the same race, conversations are two and a half minutes longer, people are more relaxed, and there is more participatory decision-making with higher satisfaction. Greater rapport and psychosocial connection are built. And when multiple social characteristics are the same between people, such as race, age and gender, it has even more cumulative effects on communications and perceptions of care.

SLIDE 297

This distrust has extended to the COVID-19 vaccine. A survey by the Kaiser Family Foundation before the vaccine's became available shows fewer blacks said they would definitely or probably get the vaccine. This is exactly what we saw when the vaccine became available.

SLIDE 28
Building trust within minority populations can help change views and practices. Among blacks admitted to a hospital in Baltimore, those who were trusting of the health care system compared to those who are not, were more likely to believe that people with chronic conditions were at higher risk for infection and dying. They also were more likely to have had a COVID test prior to hospitalization and reported they planned to be vaccinated.

No Slide- Video Only
In other words, when people perceive that they are treated with respect and without bias, it is shown to be associated with high trust. The converse is also true. When people perceive that they are treated with disrespect or bias, it is associated with low trust. And when people are engaged in discussions about their health by people with whom they identify, they are more likely to experience feelings of trust.

As a leader, be aware of the impact that broken trust with the medical system, and more broadly with society, has on your facility and the personal decisions made by your staff. And remember that the harmful effects of bias extend past race to differences in age, gender, ethnic background, income and education levels, and professional roles, as well as the intersection of multiple identities. Take a moment to reflect on how your race may impact trust with your staff.

What can you do to address it?

SLIDE 29
First, do *not* give up on conversations with people who are different than you, and do not ignore topics like racism, ageism, and other forms of bias. Do not pretend like you don't know it or see it. Do not sugar coat it, don't make assumptions, and don't speak for others. Use terms like "Black, Indigenous, Latinx, and People of Color" to acknowledge people's lived experience. Seek to understand where you may have a blind spot. And most importantly, be authentic in your concern and curiosity.

You do not need all of the answers, nor have a solution. Perfection is not necessary. Remember that trust is more than skin deep. People are diverse within their diversity. Do not rely solely on matching skin tones to make a difference. You don't have to be Latino to speak with a Latino. Or just because you're white doesn't mean you will automatically make a connection with another white staff member. When it comes to bias, think about people's multiple identities and experiences.

Consider what it means for Black, Indigenous and other People of Color to be pressured to be vaccinated, whose anxieties are rooted in this history of racial discrimination. Say things like: "Learning more may help the two of us in our relationship begin to build trust that has been historically broken." Or "I can see how you would not trust the vaccine given what you have told me about past discrimination." Show up ready to acknowledge, respect and be present to people's lived experience. Get comfortable being uncomfortable. Expect to encounter people's anger or frustration. Be empathetic.

Remember that your expertise and experience are not drivers of trust. Don't persuade, pressure or convince people as an expert. Show them that they can trust you – consistently and repeatedly. Trust is not given, it's earned. It might take a long time. Be patient.

You may or may not speak the language of your staff or use terms that everyone understands. You may find it helpful to partner with other leaders or staff who are well-liked and influential in different staff groups who can coach you and communicate alongside you.

When it comes to your language, be thoughtful, identify it as a vulnerability if you perceive it as one, and ask others for their help. Show good intent and ask people to correct you.

Say things like: "During this conversation, please tell me if I misunderstand or am just plain wrong. My intent is to honor your experience and how the effects of racism impact you. I am here to listen and learn. I respect that all decisions are yours to make."

Ask people for permission to discuss their experiences with you. Say things like: "I recognize that far too many Black people have had bad experiences, and I want to understand yours. Is it okay if we discuss it?" Recognize that not everyone is used to or comfortable with having this conversation, and that people have a wide range of internalized experiences with racism. Respect that.

When people share their experience, thank them.

Finally, remember that people closest to an injustice are those closest to the solutions to that injustice. Be present. Listen. And take notes. You have a connection to all staff within your community. As long-term care professionals, we have so much in common with each other. Those similarities were compounded by the pandemic. We are all senior living professionals.

Lesson 1, Lecture 6: Common Barriers to Building Trust: Burnout (7 min) (Kate)

No Slide- Video Only
A lack of trust is a big reason for staff turnover. Staff leave when they don't trust or feel respected by their leaders or organizations. The turnover itself further decreases trust among the staff who remain. This vicious cycle is a common barrier to building trust. Ironically, part of the antidote is trust building.

SLIDE 31
A healthy happy and productive workforce is driven by three universal drivers: feelings of physical and psychological safety, a sense of autonomy and control over one's work, and an experience of meaning and purpose. Other things that contribute include teamwork and camaraderie, appreciation and recognition, and management that engages staff in problem-solving and decision-making.

SLIDE 32
Trusted leaders drive job satisfaction, retention and people wanting to come and work for you. Take a moment to self-reflect on why your staff value working in your organization and with you? Ask yourself (or others): why do people want to join my team? Why would they do their best work here? Why would they want to stay?

SLIDE 33
Ask yourself (and others too): Do employees have the opportunity to "do what they do best"? Do they have "work-life balance" here? Do they have job stability and security? Are there opportunities to increase their income? Do they feel they work for a company with a great reputation? Do they refer to the organization as "we or us" or do they say, "they or them"?

SLIDE 34
Consider whether you tend to follow traditional supervision approaches or employ a coaching approach to management. A coaching approach is grounded in the three drivers of trust and builds trust, whereas a more traditional top-down management approach can undermine trust.

No Slide- Video Only
The reality is that long-term care is one of the most highly regulated industries. As a result, CNAs report low levels of autonomy and control over their workday. Senior leaders frequently tell them what to do to because the regulations say so. Providing staff with the ability to work flexibly is further compounded by thin staff numbers and traditional staffing models. Some administrators and senior leaders are effective at engaging staff in decisions that affect them, but often the realities of the day-to-day challenges of running a long-term care facility prevent leaders from investing time in these practices. For example, changes are just announced rather than pilot-tested on one unit. Input from staff prior to announcing the change is dismissed because the change needs to be made right away. Announcements may be made by memo or email rather than in person to allow for questions and clarifications. Being told what to do without an explanation of the reason, without an opportunity for input and without consideration of its impact on others leads to distrust.

To make matters worse, many CNAs are told they had to get the COVID-19 vaccine because its policy and made to feel that they are 'wrong' or 'selfish' if they choose not to get one. This makes them object even more. Why? Because it is one of the few things that they have control over.

CNAs have experienced a steep decline in physical and psychological safety since the start of the pandemic. Trust may have been breached early in the pandemic when we all experienced a world-wide shortage of PPE. Although the first month of COVID is different from today, some leaders and staff worked from home while other staff risked their lives to come to work to care for their residents. When leaders said things like “we’re all in the same boat,” their actions unintentionally said differently. Some administrators telecommuted thinking their physical presence was not needed and would lower the risk of COVID transmission. And when they did come into work, some spent time in their office to minimize spreading COVID to others and conserve PPE. However, this was perceived by CNAs, some of whom came to care for residents infected with COVID-19 with inadequate PPE, as not being in the same boat. Dissonance between your words and your actions, even when well-intentioned, can break down trust, particularly with the overlay of different circumstances for people in different roles, ages, income levels, races and other power disparities.

In some cases, staff were blamed and shamed for the spread of the infection in their facilities, even when state and federal agencies did not provide us with adequate resources, information or training. Sometimes family members made negative comments to the media from the safety of their homes while teams risked infection to care for residents. The trauma of caring for and losing residents, colleagues, friends and family to COVID-19 has taken its toll. In its wake, staff are experiencing stress, anxiety, grief and other mental health issues.

Put these conditions together and it’s a recipe for burnout. Add in a lack of trust with leadership, and you will find it hard to retain and hire staff.

However, it’s not all bad news. An all-hands-on-deck approach and working side-by-side helped build trust in many facilities. Many staff derive tremendous value, meaning and purpose from their jobs as caregivers. They tend to some of the most vulnerable and at-risk populations. They care for beloved residents as if they are their own family and take pride in caring for them.

Many staff also feel a deep sense of teamwork and camaraderie at work. Some CNAs, for instance, are extremely loyal to administrators who support them. We have even heard anecdotes of CNAs who have followed administrators they trust to new jobs when they leave. One administrator of a facility in rural Georgia, who gained a 90 percent staff vaccination rate early on, told me: once you build trust with your staff, and they understand that you genuinely care about them, they will do almost anything you ask them to do.

To improve staff satisfaction, wellbeing and retention, leaders must work to improve these drivers of a healthy, happy and productive workforce. Focus an effort on improving staff experience of autonomy and control, physical and psychological safety, or participating in problem-solving and decisions that affect their work. This will help to restore trust.

Lesson 1, Lecture 7: Am I Ready to Build Trust? (16 min) (Jerald)

No Slide- Video Only
As we have discussed, the past two years have not been easy on all of us working in long-term care. We have experienced the trauma of watching our residents and staff die from COVID-19, not being made a priority by government officials, managing the ever-changing regulations that often don't seem to be designed to help our residents. On top of that we are often being blamed despite our team's heroic efforts.

These traumas, and others, may affect you and your staff's mental and emotional state. They have mine. These traumas may serve either as a source of broken trust between people, or as catalyst to build trust in one another. Either way, it has been an exhausting and emotionally draining time.

And yet every day you and your staff show up and care for very sick and disabled residents at greatest risk for COVID-19 infections. You show courage in the face of fear and uncertainty. You belong to a special group of people: caregivers. You love your residents. You care for our revered elders with dignity and respect. You are family to each other and your staff. And you are leaders.

Leadership is needed when things are confusing and not working – not when everything is easy and working fine. The fact that leadership is needed most precisely when we are least prepared is what makes it most challenging.

SLIDE 36
Leadership, then, can be viewed as taking responsibility to enable others to achieve shared purpose in the face of uncertainty. This is a form of servant leadership, in which leaders focus on the growth and wellbeing of people. Even when regulations require us to enforce mandates, servant leaders take a commitment-based approach.

Here leadership is less about knowing than about learning, less about asserting control over uncertainty than developing a capacity to respond to uncertainty with purpose. It is less about a position, and more about practice, a way of doing things.

SLIDE 37
The servant-leader shares power, puts others first, and helps people develop to perform as highly as possible. Servant leaders are empathetic and authentic. They are selfless, patient, open-minded and humble. They are honest and self-aware. The all-hands-on-deck philosophy during the pandemic, emergencies and other crises epitomizes the servant leader. For example, I saw DONs working the floor alongside CNAs when short staffed, showing up on different shifts to show support and help staff on evenings or weekends, or sweeping the floors when the housekeeper is out sick. Before the pandemic, I recall being told of an administrator and all administrative staff turning out each afternoon to help during change of shift and get everyone ready for dinner. These behaviors build trust. Leaders who practice servant leadership see staff as the customers. But we cannot wait for a crisis to practice servant leadership. To incorporate this approach all the time, one leader shared with me that their company turns the traditional hierarchy upside down, putting frontline staff on top.

Servant leadership begins not when others trust us but when we trust ourselves. When we are authentic. If we don't trust ourselves, why should anybody else trust us? When we trust

ourselves, no job is beneath us; no staff is less important than another, no idea on how to do something differently is to be dismissed.

We cannot give what we do not have. It takes internal safety to extend safety to others; it takes internal joy to extend joy to others; and it takes internal trust to build trust.

SLIDE 38
Recall the three drivers of trust. People trust us when they believe that we care about them (by showing empathy), when they have faith in our judgment and competence (how we communicate our logic), and when they sense that they are interacting with the real you (by being authentic). Trust creates the emotional conditions in which we can enable others to choose to act and we have trust they will do the right thing without being instructed to do so.

No Slide- Video Only
That's why our Lesson 1 practice exercise focuses on taking an inventory of yourself around trust.

To take advantage of this program, we must self-reflect on how ready we are. On the inside. To show up the way that trust requires of us. To do the work that trust takes.

When it comes to the trauma of the past few years, begin by taking your own temperature. How are you doing? Do you feel able to build trust with others given what you have experienced? Is there processing that you need to be aware of? Answering these questions about your current mental wellbeing is important before starting on the trust building journey. If you're ready, we can move to self-assessment of your empathy, logic and authenticity.

SLIDE 39
When it comes to empathy, whether we are working toward improving staff booster rates, or improving infection control, or supporting our workforce's wellbeing – ask yourself how you may feel or react to those who are resistant. Do you ask people for their thoughts, do you seek to understand their concerns, and do you acknowledge their feelings or concerns are valid? Are you prepared to get curious? Or is your instinct to try to persuade or convince people? Why do people make different choices than what I would make? Curiosity builds trust; persuasion and pressure don't. The inner work of showing up with empathy requires leaders to meet people where they are, with curiosity and without judgment, and to remember that how they feel is not a reflection on you. Do you micromanage others? Have you taken credit for others work inadvertently when you were rewarded for success due to the team's work? Do you inadvertently demonstrate that people you are with matter less than others by multi-tasking during conversations, checking your I-phone during meetings, or show up for meetings late or leave early? Do you invest in others learning and growth? Who was the last staff person you helped get additional professional training? Do you pressure or persuade people, or do you ask them for their opinions and thoughts on how to achieve a new goal?

SLIDE 40
When it comes to logic, ask yourself how effective are you at communicating your own logic, especially during a time of shifting guidance. How effective, consistent and frequent is your communication with staff? Do you say one thing but do another? Do you ask people to show up on time for meetings but show up late yourself? Do you ask your staff to not use their cell phones while on the unit, but you take calls on your cell phone on the unit?

Do you demonstrate curiosity about another person's logic? If a person believes the vaccine has a microchip in it or causes infertility, then a reasonable logical response to many would be to refuse the vaccine. Logic may be based on misinformation. The logic is not incorrect, the information used to support the logic was. We can't always convince people based on our set of facts, or on the basis of our expertise on a topic. Although our inner dialogue might be "Are you kidding me? I can't believe you think that is true," it is important to seek to understand other people's logic, experiences and facts they are using, even when we disagree with them, or their sources. The inner work here is not to be dismissive or get frustrated but to understand their logic and explain your logic. Do you spend time talking with them about their logic to help them reach and understand their logic or do you try to persuade them they are wrong?

SLIDE 41
To be authentic, are you willing to recognize that people's previous experiences with racism, or other forms of discrimination or power disparities, in the workplace or in health care may affect how they feel? The facts of Tuskegee, were government public health withheld effective treatments for syphilis to see what would happen among black men in Tuskegee, are facts that you many not consider in your logic about vaccine effectiveness, but black staff do. Are you willing to acknowledge what is going on? Leaders must be ready to recognize people's lived experiences, ask people's permission to discuss them and acknowledge one's own bias.

Do you share information used to make your decision or recommendation? Do you acknowledge differences of opinion and experience? Do you accept feedback and self-reflect, or do you get defensive and dismissive that it will not work because we already tried that idea? Do you inspire others to be authentic by rewarding, thanking, and publicly appreciating their ideas, approaches, and differences?

SLIDE 42
Are you also prepared to make the commitment it requires and stick with it? Trust building is an ongoing series of conversations, not a one-time event. Trust is not transactional but built over time. People will not trust a hurried response or quick fix to something that concerns them. Trust is not a one and done proposition. It's not built at one's convenience. It takes real time, patience and persistence. It is about tending to the person, not the outcome. It requires us to be patient, slow down and listen. If we aren't willing to do that, we will erode, not build, trust. When you hear yourself start to provide a solution, that should be a trigger to stop and tell yourself to "listen" or show curiosity about "how the person feels" or to better understand.

How much time in your day do you spend building trust? We are always busy. Our communities run at a fast pace, and there is always something that requires our focus. Add to it the oversight and real consequences when things go wrong. Not many people can lead in our space. Trust may not match the tempo of our communities. But, instead of seeing the time it takes to build trust as a constraint, see time as an ally. Take an inventory of where you spend your time with staff now. How can you be more intentional in using that time to build trust? What could you be doing and communicating that you are not doing now? How can you rearrange your workflow to spend more time shoulder-to-shoulder with staff? How can you effectively, efficiently and clearly deliver needed information about changing guidance to your staff, so they see you as a trusted source?

Finally, are you ready to manage any negative feelings directed toward you? In systems where trust is broken, people might meet your good intentions with sarcasm, ridicule, cynicism, indifference, or anger. Do you have sources of support? Identify a trusted colleague, a friend to whom you can speak about your feelings. In fact, we encourage you to find a trusted colleague

to work with throughout the course to help you on this journey. Most successful leaders have a trusted colleague at work. Who is your trusted colleague? Do they know they are your trusted colleague? Remember, our strength comes from our community!

No Slide- Video Only

We are flagging readiness not because anyone is ever ready, or not ready, to build trust – simply to help you be thoughtful about what you may need to feel ready. Self-awareness is where our own self-development begins. An honest self-assessment will help you intentionally take stock as a leader and maximize this course.

Lesson 1, Lecture 8: How Can I Build Trust Across My Organization? (10 min) (Kate)

SLIDE 44
Every conversation is an opportunity to build trust across your organization.

That means – to build trust at scale – we must be more intentional about those conversations. As leaders, we can do this by developing a relational strategy. A relational strategy means developing new relationships or deepening existing relationships in a planned and strategic manner. It enables leaders to build community through trust to achieve outcomes.

Here are six steps to scale up trust across your organization.

SLIDE 45
The first step is setting a clear aim. For example, you might set a goal that 95% of staff receive the booster when they are eligible. Share your logic for this goal.

Second, identify key stakeholders and build a relational strategy around your work colleagues. Keep your focus on your people. Who are the groups of staff you need to focus on? Who are all the different types of staff, what are their races and ethnicities?

To determine who is at the center of your relational strategy, combine verbal and non-verbal insights you gather from your staff. Non-verbal signs of resistance may include crossed arms, eye rolls, walking away from the meeting angrily. Non-verbal signs of commitment may include head nods, eye contact and smiles.

Track data on booster uptake to make sense of variation on issues such as booster uptake by unit, shift and staff positions across your facility. Group the data by race, age, language, role within the organization, or other distinguishing characteristics.

Gather qualitative insights through conversations with staff. Pay attention to unintentional wobbles of authenticity. If you say you want input from everyone, make sure you talk to staff from the evening, night and weekend shift. Seek ways to reach out to staff who may not work a regular schedule. If you only talk to staff you know, or who work the same times you work, then you may have an unintentional wobble in authenticity.

Identify individuals and groups that have expressed the most concerns about receiving the COVID-19 booster, or another safety effort. Look for patterns and trends on specific reasons or concerns about the booster. Remember the first or second stated reasons may not be the real reason for reluctance. Work to understand their feelings, values and interests. Listen to staff with the lens of systemic racism. Use your curiosity and seek to understand without judgement. Use empathy to explore their concerns.

Third, identify and recruit peer influencers (or champions or opinion leaders) - in other words, staff who are respected by their peers and looked to as informal leaders or who staff listen to. Invite them to serve as vaccine ambassadors. These folks will deploy the relational strategy.

For example, identify leaders who already received boosters, who are willing to model a belief in their efficacy through their actions. Just a as importantly, recruit peer influencers as vaccine ambassadors from groups of staff that have expressed the most concerns about receiving the COVID-19 vaccine. Look for trusted messengers and members of the community to whom people relate. Recruit those who have informal influence among their peers and reflect the

identities and backgrounds. You may want to identify both a young female CNA as well as an older CNA from different race because people trust others who are like them either in looks, language, class or job position. At the same time, remember that people are diverse in their diversity. So, for example, you may want to recruit not just one person from housekeeping but two are three individuals who represent the different groups of housekeepers who hang out together.

Co-produce your relational strategy with vaccine champions. Avoid taking a top-down approach. Collectively decide on tactics that they believe would be effective and culturally appropriate. Ask them what incentives or approaches may work to increase booster. You may think a monetary gift card will work, but they may tell you that staff will feel this is coercive and would rather receive an extra PTO shift. You many think they should hold town hall meetings with all their staff, but they may explain many of their peers feel uncomfortable talking in large groups or sharing their concerns publicly. Invite them to come up with a plan, such as conducting one-to-one discussions with five peers in the next five days to learn about their concerns about getting the booster. Distribute power to those willing to accept responsibility to build trust person-by-person, and on all shifts. The creativity of the staff empowered to come up with their own approaches is invigorating because it offers them choicefulness, autonomy and control.

Discuss how to deploy a variety of relational tactics such as one-to-one meetings, staff meetings, unit meetings and action events. One-to-one meetings help you identify and recruit leaders, develop trusting relationships, and sustain trust as people grow and learn together over time. This relational tactic is so foundational that we dedicate an entire lecture to it in Lesson 2.

Staff or department meetings can be designed to raise everyone's collective consciousness around an agenda of mutual concern. They can be used to communicate key issues, equip people with new skills, surface emerging leaders, and plan action events. Consider using "pair-shares" and other small group breakouts to surface people's values and build relationships between staff. As the staff meeting agenda moves back and forth between smaller groups and the large group – be intentional to listen and surface what is heard. Show empathy with questions, concerns and resistance. Acknowledge that it is an individual choice. As we have discussed, this is more effective at getting them to accept the change than trying to persuade and convince them their decision is incorrect.

Another important, but often overlooked tactic is unit meetings or team huddles, which offer an opportunity to enhance existing relationships and the commitment team members make to each other and their collective work.

Action events are tactics used to take a collective step forward toward our goals. A vaccine clinic is an example of an action event. At action events we invite staff to join us and strategize with people in real time. Action events take place anywhere where we can gather people together in one place.

Tie these tactics together in your relational strategy. Like a campaign, build in engagement measures and set targets over time. For example, how many one-to-one meetings will vaccine ambassadors have, and by when? Targets help us evaluate and learn from our success and failure.

As part of your strategy, also look to external supporters, whose values and interests align, such as employee unions or trusted societies for long-term care. For example, when COVID-19 vaccines were first distributed, medical directors from AMDA, the Society for Post-Acute and

Long-Term Care Medicine, who come from diverse backgrounds and are well-regarded by CNAs, participated in informational webinars with long-term care staff to answer their questions that resulted in meaningful dialogue. They did not try to persuade, yet these webinars led to increased vaccine uptake.

Fourth, use improvement methods to test and measure your approaches to increase vaccine uptake. Did booster rates increase? Among which staff positions, units, shifts, age or ethnicity groups has booster shots increased. This allows you to see what approaches may be working and what groups need more attention and work.

Build trust through the process you deploy together. Conduct weekly huddles across vaccine ambassadors and other stakeholders to share challenges and learning in an open and inclusive way. Credit and celebrate vaccine ambassadors for their contributions to your facilities' booster uptake. Include data and stories such as updates on booster uptake and learning from conversations. Prioritize key barriers that need to be addressed. Ask them how you might overcome barriers as they are identified. Ask them what resources they need to help overcome the barriers. You should not be providing solutions and directions.

Draw on assets of the group to co-produce new tests of change. Adapt methods that don't work and spread those that do. Identify specific actions with clear timelines.

Fifth, draw on collective learning to improve your approach to conversations. Work with your staff to use, adapt and improve the methods in this course. Training staff in trust-building methods signals the importance of trust to your organizational culture; and the trainings themselves can result in formal and informal trust building among participating staff. Likewise engage staff in trauma-informed care.

Finally, connect your relational strategy to other system-level strategies to advance your aims. For instance, offer to set up all of your staff members' booster appointments and provide them with paid-time off to receive them and recover from side effects. Demonstrate a supportive environment that provides benefits to workers for their participation. Celebrate successes but be mindful to not embarrass or shame staff either. It's a tricky balance that requires you to listen and talk to your team and staff.

When your effort is over, the work of trust building is not. Do not drop in and out on trust – it requires constant nurturing to sustain. Share results. Partner on next steps. Close the loop. The work of trust is constant and continuous. It is not there only for the duration of the initiative. Be there for people, always, and they are more likely to be there for you.

Lesson 1, Lecture 9: Learning Summary & Practice Exercise (2 min) (Courtney)

Thanks for your engagement with the Lesson 1 lectures. I hope you enjoyed and were able to take something helpful or meaningful from the information we've shared with you.

SLIDE 47
To review a summary of concepts, download the Lesson 1 "key takeaways" document. This document highlights the important ideas raised, such as why trust matters, what it is, common barriers to building trust, readiness, and relational strategies to deploy to help you build trust across your organization.

SLIDE 57
Next, you will hear a story from a long-term care leader and a staff person on their success with empowering vaccine ambassadors in their organization.

SLIDE 49
Finally, you will complete the Lesson 1 practice exercise that we discussed in lecture 7. Please download and complete it and invite a colleague to give you feedback on your responses. It's a self-assessment of your empathy, logic and authenticity, the drivers of trust, as well as your readiness to practice the methods in the program. It also invites to you develop a relational strategy to build trust at scale across your facility.

Reflect with your partner about what the exercise raises for you, and how you can use the remainder of the program to improve trust and apply trust-building methods in your setting.

No Slide- Video Only
Thank you again for joining us. We look forward to sharing lesson two with you.