This is a time-tested, practical guide for nurses and other health care professionals who wish to transform their health care systems through the promotion of caring values. It describes a model created by nurses to transform the culture of health care systems at all levels, and features specific strategies for planning and instituting change.

A cornerstone of this approach is the engagement of the leadership team in implementing change and promoting intra- and inter-professional dialogue. At its most basic level, this model, the Dance of Caring Persons, expresses the fundamental beliefs that each person in the health care system cares meaningfully in unique and valuable ways, and the contributions of each person are significant to the whole of the enterprise. The book features examples of how various units of the health care system can successfully apply specific strategies to their work, and describes in detail how to engage and sustain authentic dialogue among and between stakeholders.

The book also includes a timetable to change a culture as well as practical strategies for transforming the organizational mission, leadership structures and processes, communication, and outcomes of the system. Chapters feature information from a variety of health professionals. The book reflects the interests of such major stakeholders as patients, families, nurses, physicians and other providers, administrators, and managers. Chapters include questions to consider and suggested resources to help with implementation of strategies. The text incorporates professional standards and essentials from The Joint Commission, ANCC, and AACN (DNP).

**Key Features:**
- Presents a theoretically grounded and proven caring-based model for health care system change for all stakeholders across the continuum of care
- Provides practical strategies for transformation
- Describes how health care system change happens, who initiates it, and how to sustain it through caring science
- Includes success stories from patients and their families, nurses, physicians, ancillary service providers, health care administrators, and others
- Promotes intra- and inter-professional dialogue and collaboration
Anne Boykin, PhD, MN, founding dean of the Christine E. Lynn College of Nursing, Florida Atlantic University, is currently professor emeritus (retired). She is recognized internationally and nationally as an authority on caring science, and has coauthored and edited several books including Nursing as Caring: A Model for Transforming Practice (1993, 2001) and Living a Caring-Based Program (1994). She is a contributing author for many book titles and has authored more than 20 journal articles. Dr. Boykin is the past president of the International Association for Human Caring, and has served as a member of several boards at the international, national, state, and local levels, including the American Association of Colleges of Nursing, National League for Nursing, Southern Education Board Council on Collegiate Education for Nursing, and the Florida Association of Colleges of Nursing. She now serves as a consultant on nursing, nursing theory, and transforming health care environments, and works with a growing list of hospitals and hospital chains locally and nationally.

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We dedicate this book to all health care providers, especially those in leadership roles, who commit themselves to humanize and transform systems of care.

To my husband, Steve Staudenmeyer, whose love, support, caring, and encouragement allow me to live my passion for nursing.—Anne Boykin

For Gwen, Carrie, and Emma, my love and gratitude.
—Savina Schoenhofer

To my husband George DePuy and the extended circle of family, friends, and colleagues who help me to grow in caring.
With love, always.—Kathleen Valentine
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We are deepening our understanding of the operation of a complex world and the structures and processes that demonstrate its interactions. The introduction in the United States of concepts associated with complex adaptive systems has radically changed our understanding of human dynamics and the organizations and structures that support and advance them. Traditional industrial and linear notions of structure, culture, and leadership have essentially been eclipsed by the deeper richness of the levels of understanding of how people live, relate, interact, and work in highly complex systems.

As a result of this deeper understanding gleaned from the translation of complex adaptive systems into human organizations and relationships, much conflict and confusion with traditional structures and approaches to aligning, understanding, and applying developed processes to human dynamics have emerged in our traditional organizational constructs. The architecture, structure of work, characteristics of interaction, management and leadership capacities, and relational dynamics that developed over the full course of the 20th century have become less relevant and viable, and increasingly lacking in effectiveness. The more linear two-dimensional, vertical, hierarchical models and mechanisms of structuring work and relationships that were developed throughout the 20th century have become nonrelevant in a 21st-century social context.

The growing digital reality that increasingly defines and influences contemporary human experience has substantially changed the rules of the game with regard to human dynamics, interaction, and work. In the industrial age, models of work were fixed, finite, functional, and institutional. Twenty-first-century work and workplaces are characterized by structures and processes that are more fluid, flexible, portable, and mobile. The portability and mobility of human life, relationships, interactions, and dynamics have altered our understanding of the operation of systems structures, processes, relationships, and leadership. This deepening understanding of the complexity that characterizes life at both the universal and subatomic levels has redefined the parameters within which human interaction unfolds and progresses.

Our understanding of complex adaptive systems leads us to raise questions about our ability to predict and adapt these forces for good use and their implications and
actions in human dynamics and on human organization and work. Our awareness is now informed by such wide-ranging complexity characteristics as follows:

- The continuous interaction of large numbers of intersecting elements
- No one element ever understanding the operation of the entire system
- The depth in degree of rich interaction between elements and “agents” of the system
- Continuously open, transforming, altering, changing conditions and circumstances
- Unending operation and confluence of positive and negative feedback loops
- Continuous demand for disequilibrium in the environment
- Agents can influence others and are simultaneously being influenced by others
- Systems and organizational behavior are continuously emergent
- Patterns of synergy and effectiveness can be unknowable and unpredictable
- Big systems’ changes emerge and generate from small causative drivers
- Systems interact with their environment in dynamic and nonlinear ways
- Effective systems operate best on the edges of chaos and stability
- All systems succeed as a function of their interaction with their own history

All of these characteristics, elements, and forces are acting constantly and consistently and are reflected in human experience and call us as leaders to a deeper understanding of their actions and operations as we more clearly develop mechanisms for engaging environmental dynamism, transformation, change, innovation, and leadership. Whatever approaches are undertaken by organizational leaders must now reflect the clear and abiding understanding of the normative action of these universal forces operating as both the backdrop of human action and the context that gives such action impetus, clarity, understanding, and veracity.

Societal and professional leaders must now make, as a part of their work obligations, the translation of these emerging realities into mechanisms, toolsets, and frames of reference that guide those we lead. This leadership must be expressed in ways that help those we lead reflect on their own responses and patterns of behavior and have a deeper understanding of the forces that can both enable or disable their best efforts. This is especially true as health professionals are challenged with fundamentally transforming the health care system that clearly represents the same many characteristics of complexity, and demands our deepening understanding of health care professionals’ actions and influences on the relevance and effectiveness of the health system. In addition to the growing translation of the attributes of complexity to health care are the political and economic challenges codified in the Patient Protection and Affordable Care Act of 2010 (PPACA), which represents a substantive recalibration from a volume-based economic and delivery model for American health care to one that is grounded in a value-based, effectiveness-delineated health script attempting to advance the nation’s health and provide a level of universal access.

Traditional and historic industrial-grounded approaches to transforming American health care simply can’t succeed. Much of the historic industrial and linear thinking and models are no longer relevant, neither to the times nor the demand. Furthermore, the firmly entrenched digital infrastructure of social and human experience with all of its implications now demands entirely fresh thinking, innovations, and models disciplined by experimentation and testing in a wide variety of social and systems approaches.

Clearly, it is leaders who must understand this sea change within the health system in the broader social culture. Leaders must suspend attachment to traditional grounding in
their leadership learning and experience and become increasingly available to approaches that may at first appear counterintuitive and even uncomfortable. Traditional attachment to historic transactional and even transformational models developed within an industrial/postindustrial paradigm must be suspended in a way that increases availability to a richer level of understanding of complexity leadership and its application to the challenges of the time.

This textbook serves as both a challenge and a bridge to nursing and health care leaders as they grapple with the need for changing structures, approaches, and skills necessary to support sustainable health transformation. Practice frequently changes; principle rarely does. The foundational and sustainable principles in caring so central to the nurse’s role do not themselves change, yet, the expression of caring and its applications are necessarily constantly refined and altered to reflect the contemporary character of their expression. With all of the necessary incorporation, translation, and application of complex adaptive systems to health care, there is a strong need for a principle-based, theoretically grounded set of tools for transforming the culture of care in contemporary health care systems. There is a crying need for translational and practical strategies for living the shift to value-grounded caring throughout the health care system. While our understanding of systems and applications may be more deeply evolving, along with it comes a greater demand for intentional reflection and articulation of the living of caring values that sustains the focus on essential human relatedness and the need for refining and developing the enterprise in a way that demonstrates value for caring by translating it within a complex adaptive frame. Engaging stakeholders in the essential partnerships for caring creates both the urge and the obligation to align the contemporary complex culture with the principles and patterns of human caring that will both humanize it and sustain it. To do so creates a culture responsive to the environmental demands and shifts of the time, the converging forces of a complex adaptive milieu, and a community of careers guided by principles and practices that reflect the unique health needs of individuals and the collective sustainable health requisites of the human community.

The authors’ approach to creating a transforming culture through use of foundations laid in the theoretical development of Nursing as Caring offers a solid foundation upon which to recalibrate and reconfigure toward a caring organizational health system. The use of the Dance of Caring Persons, grounded in value-based principles, serves as an effective vehicle for guiding and refining organizational and human systems in a way that grounds the further work of transforming health care systems in sustaining values of caring. While many of the beliefs, elements, and attitudes in the Dance of Caring Persons will need continuous further refinement as they are translated into complex adaptive systems, the fact that the approach requires the engagement of all organizational constituencies in the process of care transformation ensures continuing relevance and adaptation.

The increasing recognition and intentional articulation of the core values of respect for persons and sincere appreciation for the community of contribution of all participants in the health care systems’ effectiveness are essential. This work will need collaboration from patients, families, nurses, physicians, and other health professionals, as well as administrators and managers in conjunction with the systems and models within which they operate as an essential construct for a sustaining transformation. Grounding that transformation in values and principles of caring ensures that the system and approaches will be open and responsive and that the essential elements of care will remain at the core of the collective conversation of service transformation. How systems respond to environmental changes and economic and resource challenges associated with human action, and how personal and collective human caring responses are calibrated, are addressed.
and will help maintain the caring-centric focus of both human design and response. In this way the authors and those who respond to their work will demonstrate the fundamental and essential core of our human existence and sustenance—the continuing capacity to love and care for each other.

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This book offers a perspective that health care systems are human systems as portrayed in the Dance of Caring Persons. It provides a values-based, theoretically grounded guide for transforming the culture of health care systems. It provides practical strategies for living the value of caring in the workplace using the Dance of Caring Persons as the framework for transformation. The Dance of Caring Persons emerged in the context of the nursing theory, Nursing as Caring. Although the theory of Nursing as Caring offers a theoretical framework for the study and practice of nursing, the Dance of Caring Persons is a value-based model designed to guide the organization and functioning of human systems, including health care systems, thus transforming the cultural environment. At its most basic level, the Dance of Caring Persons expresses certain fundamental beliefs and attitudes: Each person in the health care system lives caring meaningfully in unique and valuable ways; and the contributions of each person to the whole of the enterprise have a prized place in the enterprise.

The book addresses all stakeholders in the health care system—patients and families, nurses, physicians and other primary and adjunctive professional care providers, ancillary service providers, and administrators and managers. It also addresses all aspects of the system—organizational model, delivery of health care, human resource functions, and outcomes of all aspects of the system. Although broad in the scope of addressing all components of health care systems, there is a focus on specific caring-based strategies for transforming the culture of health care systems.

The book is organized into three sections. Embedded in each chapter are provocative questions intended to engage the reader and stimulate thinking. In addition to the traditional references, at the end of the book the reader will find a list of related resources. Section I includes three foundational chapters that offer a context and framework for the later chapters that address specific strategies relevant to aspects of the health care system. The first chapter emphasizes the inevitable need for transformation in health care systems compelled by health care reform through the Affordable Care Act. For persons not steeped in the issues confronting health care systems in the 21st century, this chapter provides a valuable overview of those issues, and an understanding of the value of bringing a caring perspective to the transformation of health care systems. Persons who are deeply aware of the world of health care and the significant
challenges affecting that world may choose to begin with another chapter, depending on their background and interests. Chapters 2 and 3 establish the necessary foundation and framework for the remaining chapters. Chapter 2 provides a substantive understanding of the Dance of Caring Persons model that grounds the design and implementation of specific strategies; Chapter 3 focuses on the relationship of cultural aspects of a health care system to the experience of those within the system and ultimately to the success of the organization. These chapters are essential to understanding concepts in subsequent chapters.

Section II addresses strategies to prepare people and processes in all functions for whole system transformation. Chapter 4 focuses on “getting ready,” by discussing ways in which leaders at all levels of the organization propel the desire for change into commitment for action. It addresses specific strategies for planning and designing for transformational change, and for engaging the leadership team in preparing for implementation. Chapter 5, focusing on “getting set,” describes the functional timetable for specific actions for transforming the culture. Both of these chapters provide important, detailed guidance on the “how to” of transformation for leaders in health care and for students preparing to be leaders.

Section III offers practical strategies for living caring values throughout all aspects of the organization and infusing all functions of the health care system with the core values central to the Dance of Caring Persons. Successive chapters address practical strategies for transforming the organizational mission (Chapter 6); leadership structures and processes (Chapter 7); communication (Chapter 8); and outcomes (Chapter 9). Although there is a logical flow of ideas in these chapters, they do not necessarily have to be read in sequential order. For example, if the organization is focusing on transforming the mission of the institution, it would make sense to begin with reading Chapter 6, although Chapters 2 and 3 would provide valuable insight and support for transforming the organizational mission.

In keeping with the inclusive and dialogic character of the Dance of Caring Persons model, responses from health professionals representing a broad range of participants in health care are included in each chapter. The method of achieving dialogue in the book varies from formal written responses to chapter content, to transcriptions of small group conversations about the chapter topic and its contents. Also included are “questions to consider,” exemplars, and suggested resources to assist with the implementation of suggested strategies. We offer this book for your consideration because of our fundamental belief in the value of caring and its ability to transform the health care system, and the practical value of the Dance of Caring Persons model as an overarching framework.

Anne Boykin, PhD, MN
Savina Schoenhofer, PhD, MEd, MN
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We thank those who contributed to this book, those who influenced our understanding of caring and health care systems, and those aspiring to transform health care systems, all for whom we hope this book will be of value.
Health Care System Transformation for Nursing and Health Care Leaders: Implementing a Culture of Caring describes a new approach to transforming our health care system based upon a model grounded in caring as an essential human value. Using the Dance of Caring Persons framework (originally developed as the nursing philosophical framework, Nursing as Caring) for transforming health care system culture, the book provides a values-based, theoretically grounded guide for transforming organizational culture with detailed, practical strategies for living the value of caring in the health care system workplace.

SO WHY IS TRANSFORMATION NEEDED IN HEALTH CARE?

The U.S. health care system has struggled for decades against seemingly intractable problems: safety problems, including more than 100,000 unexpected hospital deaths annually (Committee on Quality of Health Care in America, Institute of Medicine, 2000); incomplete and unequal access to care; perverse payment incentives that fail to reward good outcomes; fragmented, uncoordinated, and highly variable care processes that result in significant waste; a disconnect between quality and price; rising costs; inadequate consumer engagement and empowerment; and the absence of productivity and efficiency gains common in other industries.

Beyond life expectancy and other macro variables, even small, seemingly “controllable” variables often score poorly when measuring the performance of the U.S. health care system. For example, in 2003 McGlynn and colleagues showed that typical patients received only just over half of the recommended care. Later the study was repeated with children (Mangione-Smith et al., 2007) and showed that they received even less of the recommended care at just under half. These problems have resulted in various reform proposals including significant, and often emotional, dialogue during each of the 2008 and 2012 presidential political campaigns. Most proposals have focused on providing greater access to care, with intermittent focus on controlling the costs of care. Although understandable, this approach ignores the fundamental problem: Health care value (defined here as health outcomes relative to input costs) simply must increase.

Yet despite these valid concerns, health care is not just another “product or service.” It is intensely personal, often consumed at the most vulnerable times of our lives, and highly dependent upon the values, desires, and beliefs of both those treating and...
those being treated. Unlike other industries, price transparency is noticeably absent—consumers often lack the knowledge to “know” what they need and frequently bear only a small fraction, if any, of the actual costs of the services provided, and physician and other provider intermediaries who “choose” for consumers have potentially conflicting incentives. These conditions are far different than the “perfect markets” described by economists in college texts.

So what to do given these circumstances? Enter Boykin and colleagues, who propose a radically different perspective on health care transformation. In contrast to the bottom-line, productivity, and benchmark-driven approaches exclusively used so often within health care, the authors recognize that health care is the “ultimate team sport” by explicitly defining that each person in the health care system lives caring meaningfully in unique and valuable ways and that the contributions of each person to the whole of the enterprise are meaningful and valuable and have a place in the enterprise. At Mission Health, we agree with this concept and explicitly refer to all staff—whether at the bedside, in billing, housekeeping, administration, or otherwise—as “caregivers.”

The book approaches the opportunity for transformation in different ways, from formal written responses to chapter content, to transcriptions of small group conversations about the chapter topic and its contents. The approach is very practical, with each chapter including “questions to consider” relevant to the particular chapter topic, exemplars, and suggested resources to assist with implementation of strategies suggested. The Resources section provides invaluable information that can be used to support practical implementation of the model. This book explicitly questions how the organization might address traditional “myths” that have contributed to our dysfunctional system today, including the following:

- Hierarchy trumps collaboration
- Most legitimate outcomes are financial
- Change must come from the top
- Caring is a luxury
- Finance and caring are opposite poles
- Professional disciplinary accountability will ensure positive system accountability
- External task force recommendations drive system quality

The book offers specific strategies for engaging the executive leadership team:

- Gaining buy-in throughout the system by defining the blue-sky vision and the climate for change
- Designing detailed features of transformation—specific steps for gaining sponsorship and champions throughout the system
- Budgeting for transformation—how the efforts involved in the change are accounted for in budget priorities
- Establishing broad structures and processes for ongoing dialogue to make the model live
- Prizing, valuing, and growing in all dimensions of the system—outcomes management

Specifically addressed are two critical aspects of health care system communication. The first focuses on internal communication and reporting strategies that maximize effectiveness of the organization. This includes leadership tone, presence, visibility, and consistency, recognizing the influence of each aspect on sustained and effective forums for
collegial dialogue and action. The second focuses on communication between patients/families and members of the system—nurses, physicians, other professional providers, and ancillary service providers; and between and among all participants in the system in relation to health care delivery. This includes methods for including and involving patients and families as active and valued members in designing the care experience they desire and deserve. At Mission Health, we have found the inclusion of patients and family members to be particularly transformational in nearly all aspects of care redesign.

With so much time and energy focused on transformation, health care leaders and participants would benefit from a careful read of this book, before passing it along to friends and colleagues. Regardless of one’s entering perspective—whether hierarchically driven, finance focused, consumer centric, or otherwise—the insights and lessons from *Health Care System Transformation for Nursing and Health Care Leaders: Implementing a Culture of Caring* will cause you to pause, reflect, stay patient centered, and stay caring in all that you do. After all, isn’t that why we entered this field in the first place?

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REFERENCES


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Section I provides the foundational information used to frame the subsequent practical approaches (Sections II and III) that apply caring values and the Dance of Caring Persons model as essential guides to successful health care transformation. Section I addresses the complex issues inherent within health care systems that are prompting efforts at transformation, and provides an exposition of a model of caring as a credible, powerful, and essential guide for meaningful whole system transformation, in the context of cultural transformation. Section I provides the framework for moving health care systems from a focus on continuous subsystem changes, often defined by external regulatory and accreditation bodies, to a whole system transformation focus guided by a unifying framework. The authors of this book have heard the call for whole system transformation that is authentic, values based, practical, understandable, achievable, meaningful, and generative. Our goal is to help readers of this book become confident using the language of caring as credible, strong, and integral to successful transformation of the health care enterprise using the Dance of Caring Persons as a model. Each author has specific experience with the whole system change based on caring.
What are the challenges to the effectiveness of health care systems, and why is transformation needed? This chapter addresses the multiplicity of issues facing health care organizations that prevent them from focusing on their primary service mission of caring and patient-centered care. Some of these issues include quality, safety, lack of coordination and collaboration among nurses, physicians, and other health care providers and units of care, stressful workplace environments, inefficiencies, hospital–physician alignment and reimbursement, and monetization/output/revenue imbalances. The chapter is organized in sections that address the following issues:

1. A historical perspective about the carative or caring and curative traditions in health care that have helped to define the current state of health care systems
2. A framework for examining the challenges in today’s health care system, organized according to seven initiatives proposed in 2003 by a leading health care system chief executive officer (CEO) and a chief medical officer (CMO), a proposal that calls for more accountable care rather than our current ineffective, inefficient, and costly system (Halvorson & Isham, 2003)
3. Our own perspective on Halvorson and Isham’s accountable care framework, along with highlighted comments made from a national gathering of health care CEOs meeting to dialogue and reflect on changes in the health care system
4. An invitation to you to contemplate health care’s current standing in achieving this more accountable health care system and your insights as to how that may enhance or obscure a way for caring to be acknowledged substantively as an essential foundation in the provision of health care services

HISTORICAL PERSPECTIVE

Health care used to be a local service and is now a global enterprise. The challenges and opportunities facing the health care system and health care providers involve whole system transformation. How did we evolve from a local community service to a global enterprise? What are the implications of that evolution for the caring foundations of health care?
The health care system was largely a cottage industry prior to the 1980s, when health care began to be structured within the business model of managerial corporations. As a cottage industry, each community defined and provided health care services for the catchment area served. Although larger health care systems and academic medical organizations with broader missions existed, for the most part health care was a local service.

The cottage model, with its local service characteristic, changed as the managerial business model became more embedded and as reimbursement for services became more complex. Diagnostic-related groups (DRGs) began to operate on a prospective payment system, putting hospitals and associated providers at greater risk for the care episode for patients, rather than for the quality, satisfaction, and cost of a specific unit of service. Hospitals received a set fee for a given diagnostic category—and if they were able to reduce the length of stay and the overall costs for an entire episode of care, the difference between the cost per DRG and the payment for it could be retained. Payment incentives structured in this manner drove organizations to search for efficiencies in care delivery through implementation of care pathways, which in turn called for standardized treatments and specialized care teams. As a result, one of the most sustained effects from this era was to reduce variations in care that arose through individual physician practice preferences. Significant variations in care were subject to peer review, which applied accountability through the expectation that practice or science-based evidence be used to support variations in practice rather than individual practitioner preference alone.

This prospective model was born from calls for cost accountability from a coalition of large manufacturing companies that were seeing more of their budgets going toward health care and interfering with their competitive positioning in the global market. Over time, increased calls for cost accountability led to more emphasis on capitated-managed care insurance plans that were expected to manage both costs and quality. Capitated-managed care means that a fixed insurance fee is paid per-member per-month based on a set number of enrolled members covered in the insurance plan. If the overall health of members in the plan is good, and costs and expenditures are controlled, the per-member per-month fee can be moderated. However, managed care plans experienced considerable consumer and provider backlash in which the insurance company was seen as a barrier to decisions that should be reserved to be between patient and provider. Though costs for health care were stabilized during this era, this model at its height became unacceptable to most.

Health care organizations searched for ways to maximize revenue streams through niche services, horizontal integration (multiple same type of service sites aggregated into one larger organization, e.g., hospitals or cancer centers), or vertical integration (in which a single entity merged with units of service across the continuum of care). Organizations are complex adaptive systems and as such are constantly evolving to new models of service care delivery that serve simultaneously as an opportunity for growth and a challenge to the traditional forces within the health care system. The corporatization of health care is said to have spawned interdependency across health care sectors, sometimes labeled as the medical industrial complex. These multiple and interdependent aspects of the health care system together account for a large percentage of our gross domestic product (GDP) when considered as costs, while at the same time driving employment opportunities that ultimately are intended to serve societal growth needs. These factors, in addition to the aging population, increased technology, aversion to rationing, and so on, all shape the health care system we face today and provide momentum for transformational change.

On the one side of the equation, traditional health care costs have outstripped the ability to pay for them and ultimately this affects the overall health of our national economy. Evidence of this is seen in the number of uninsured persons in the United States (over...
48 million, according to the 2010 U.S. Census)—persons who might be employed, but whose employers do not sponsor health care insurance benefits due to cost. The cost of employer-based health care insurance is rising at a rate that affects the viability and competitiveness of all industries.

Because health insurance has been associated with employment, or government-sponsored programs such as Medicare or Medicaid during the Great Recession of the first decade of the 21st century, the care access problem has become more acute for both the providers of health care and patients alike. This reality has led to calls for wholesale transformation of the health care system to realign health reimbursement payments toward lower cost and illness prevention, with a shift of access to health care insurance away from employer-based models to more community-based models open to all citizens. These dynamic forces have contributed to the passage of the 2010 Patient Protection and Affordable Care Act (ACA). The ACA has used a phased-in approach toward making this shift with an ultimate goal of providing coverage for all citizens while at the same time improving quality and controlling costs. The opportunity to improve quality through this large-scale national ACA initiative will promote transformational changes in which each health care discipline can exert significant leadership.

Leadership during this time of historical circumstances leading to passage of the ACA calls for widespread transformation of our current systems. We are at a crossroads—our current system emphasizes fee-for-service revenue streams, specialization, and volume-based care, while there are simultaneous calls for a different system, one that focuses on person-centered care, prevention, and lifestyle changes related to chronic conditions and illness. In addition, there is a consumer movement toward holistic health—a multibillion dollar industry, focused on personalized services, a large segment of which exists outside the parameters of the traditional health care system. Though there are some points of integration of complementary health care practices within “mainstream” health care, they are inconsistently available and largely uncompensated through traditional payer mechanisms such as third-party insurance. Thus, consumer desire for personalized, holistic access to care and the costs of delivery of care create inconsistent and contradictory expectations for personalized health. In the United States we spent 17% of our economy on health care in 2011 (Bloomberg News, June 13, 2012), more than any other nation, and yet our health care rankings do not reflect good value for the money invested. For example, we are 29th in the world for healthy life expectancy and 30th in infant mortality (Zakaria, 2012).

As spelled out in Valentine’s (1988) historical analysis of the carative tradition in nursing and health, our mainstream health care system has increasingly become a movement away from holistic care focused on the person toward fragmented care focused on the segmented service provided by each discipline. This trajectory away from caring has led to increased emphasis on specialization and curing, and less emphasis on caring, integration, and care coordination. Business models have evolved to focus on specialized dimensions of the health care industry, eliminating less profitable centers in favor of those that have a greater return on investment. High-tech fields tend to be more costly and better paid than low-tech fields and are often associated with more specialization and treatments, not necessarily coordinated care that crosses the continuum from acute to home care. Thus, we have a health care industry that accounts for about 17% of the economy and because of its size and complex interdependencies, presents as a major factor in political discourse about how public dollars should be spent. Procedural care, based on a fee-for-service model focused on volume, has dominated our health care climate. However, the question is raised, is this the best way to approach the dilemma of high cost and poor outcomes in the future?
I. PREPARING FOR THE DANCE OF CARING PERSONS

In his classic predictive study of health near the end of the 20th century, Selby (1974) wrote that in the future, as chronic conditions become the focus in health care, there would be less delineation between health and social problems. Just as during the industrial revolution there were public health efforts to deal with clean water, workplace safety, and food safety, in today’s world there is again an emphasis on workplace safety (the hazards of sedentary work, pollutants, chemicals) and the food supply (highly processed, calorie-dense food) in relation to the epidemics of diabetes, obesity, heart disease, cancer, and memory disorders. Thus, it becomes even more imperative to assure that healthy food choices, safe water, and opportunities to exercise are all part of the healthy community equation.

A FRAMEWORK FOR HEALTH CARE POLICY CHANGE

More recently, leaders within major health care systems offered a perspective on what is needed to move toward a more holistic, health-oriented system. Our analysis of the need for health care system reform is organized around Halvorson and Isham’s (2003) framework for health care policy change. A brief introduction to the background of these two leaders in the management of integrated health care systems will make clear the significance of their call for “safer, better and more accountable health care” (p. 1). In 2012, George Halvorson was completing his 10-year leadership role as the CEO and chairman with Kaiser Permanente, the largest not-for-profit integrated health care organization in the United States. Prior to that he was the CEO of HealthPartners where Dr. George Isham served as a medical director. Together, in 2003, they offered a still-relevant perspective on the challenges of the overall health care “nonsystem.” In that work, they proposed seven major initiatives needed to move toward a health care system that improves the health of citizens through measurable outcomes that make a difference in the quality of life. These seven initiatives are:

1. Improve quality of care and patient safety
2. Address consumer choices, creating an improved market model for buying and selling health care
3. Improve population health
4. Prevent monopolistic and anticompetitive behavior
5. Create workable framework for dealing with the uninsured
6. Fund training, medical education, medical research, resupply of the health care workforce, re-engineering of health care delivery particularly in hospital settings
7. Adopt an automated health care record to give point-of-care information for consistent delivery of best practices based on known evidence (pp. 156–157)

A decade later, and with the new Patient Protection and ACA in place, what is the status of the health care “nonsystem” relative to these initiatives? These initiatives will be used to frame further discussion related to the need for health care transformation.

DANCE OF CARING PERSONS MODEL: ITS RELEVANCE TO 21ST-CENTURY HEALTH CARE INITIATIVES

The Dance of Caring Persons is a model to guide the whole of an organization, including the functioning of human systems, in a way that is person centered and caring focused. Core dimensions of caring represented in this model include the following:

- Acknowledgment that all persons have the capacity to care by virtue of their humanness
- Commitment to have respect for persons in all institutional structures and processes

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Recognition that each participant in the enterprise has a unique and valuable contribution to make to the whole and is present in the whole

Appreciation for the dynamic, rhythmic nature of the Dance of Caring Persons, enabling opportunities for human creativity

These dimensions of the Dance of Caring Persons taken together and sometimes individually are the touchstones for transformational strategies, some that are known and some yet to be imagined. This model, which will be more thoroughly described in Chapter 2, represents the values-based unifying framework we propose for the transformation of health care systems in the 21st century. Now, more than ever, there is a call for creative integration of values that on the surface may be considered incompatible. A major strength of the Dance of Caring Persons model is that it offers solid ground for transcending seemingly insurmountable differences between for-profit values and altruistic values. As we present the analyses of the seven initiatives, we invite you to contemplate how the model might be evident in the changing health care system of the future. How might:

- Acknowledgment that all persons have the capacity to care become evident in the design and delivery of an accountable care organization (ACO)?
- Respect for persons in all institutional structures and processes be reflected in the partnerships that are formed within and across health care organizations and within provider/patient relationships?
- Recognition that each participant in the enterprise has a unique and valuable contribution to make to the whole change the way that we form interprofessional teams, our communication, and governance structures?
- Appreciation for the dynamic, rhythmic nature of the Dance of Caring Persons enable opportunities for human creativity, ultimately improving quality, access, and cost dynamics in a way that humanizes the care experience for all partners in the dance?

Proposed Initiative: Improve Quality of Care and Patient Safety

Overall there is a desire to have patient-centered organizations rather than patient satisfaction-focused organizations. Focusing on the patient as person improves both quality and satisfaction, while focusing on satisfaction alone leads to organizational compliance without necessarily understanding the underlying values. A truly patient-centered organization has patient and family engagement evident and welcomed as an integral part of the culture. Patients and families play an active role in improvement activities. The Institute for Healthcare Improvement is a leader in helping organizations address the question: Is our organization engaged in “patient-centered leadership… or patient-satisfaction leadership?” (American College of Health Care Executives, 2012).

Forces are converging to begin a shift from the recent emphasis on fragmented and isolated parts of the health care system to a demand for ACOs. Both the federal and state governments are adopting new payment and delivery system models aimed at improving the quality of health care services and reining in costs. Identification of patient-centered medical homes (PCMHs) and ACOs are aligned to follow the course of a person’s condition beyond an immediate procedure and include coordination throughout an episode of care. For example, treatment for the person with diabetes involves not only the acute situation in which the patient might enter the ER in crisis, but the continuum of services also includes helping the person begin to bring his diabetes under control to prevent such hospitalization in the future. An example about diabetes and the dynamics involved in
shifting incentives from volume-based services to value-based services is presented in the Resources section.

PCMHs tend to be primary care practices, while ACOs focus on partnerships across several medical homes and across a continuum of care services from inpatient through rehabilitation, including social services. In the new model, ACOs will be paid to coordinate care. The expectation is that a focus on prevention will allow more people to be served before acute exacerbation of illnesses, will save money, and will increase quality of life. What is transformative about this initiative is the attempt to align payment incentives to organizations that allow them to move away from an emphasis on isolated services paid on a fixed fee to caring for the whole person and populations of persons experiencing a chronic condition (Guterman et al., 2011).

In addition to a wide range of reforms enacted in the Patient Protection and ACA, some states are also seeking policies and processes to align with the goals of the ACA. The challenge will be coordinating between federal, state, and private initiatives to assure that the coordinated care system meets its care delivery and payment goals in providing patient-centered, effective, and efficient quality care.

Though the Supreme Court of the United States struck the mandated state expansion of Medicaid as proposed within the ACA (Kaiser Family Foundation, 2012), there still will be considerable expansion of the number of persons eligible for Medicaid. The way that the ACA unfolds will be very locally determined within communities, based on their culture and their resources. By 2019, “up to 25% of Americans could receive coverage through the program (Medicaid), and it could account for as much as 20% of national health care spending” (Bachrach, Bernstein, & Karl, 2012, para. 3). Medicaid expenditures account for over 70% of states’ health care expenditures and constitute the first- or second-largest item in the budget of every state. Implementing coordinated, accountable delivery systems could help contain costs and achieve better outcomes for Medicaid beneficiaries (Bachrach et al., 2012).

The debate about the public/private nature of the health care system was very evident in the American presidential election process of 2012. With one candidate vowing to repeal the Patient Protection and ACA “on day one” after the inauguration, and the other having championed the act toward its full adoption in 2014, the two worldviews were sharply contrasted relative to market versus public/merit good. A market good is one that responds to the dynamics of supply and demand. A public or merit good is one that is available to all. In the United States we operate from both a market and merit perspective. We allow market forces to drive access to some care (elective, specialized, cosmetic), yet we do not deny care to anyone in an emergency and cover that through public funds (i.e., everyone merits access to health care in an emergency). Thus, eventually the cost of health care is paid by all citizens often in an ineffective, inefficient manner and at the costliest point of service, such as an emergency department.

Though the reelection of President Obama gives momentum to enact the ACA health care legislation, its adoption will be uneven and fraught with controversy as it is enacted on a state-by-state model. The ACA does signal the beginning of a systemic shift in all sectors of the health care industry to prepare to share the risk for providing services for “low-power, low-tech” chronic conditions such as obesity, diabetes, and Alzheimer’s. Some prevention and payment for annual wellness exams is already initiated, along with other mandated prevention services (women’s health) offered without copays. For example, Medicare now also provides payment for visits focused on obesity (previously denied as an acceptable code for reimbursement). Simultaneously, hospital organizations will be asked to be accountable for patient outcomes across the continuum of care. These changes begin to acknowledge that care for chronic conditions related to lifestyle and longevity requires personalized treatment focused on the person rather than
on the diagnosis. Lifestyle changes are made at the personal level of choice and behavior, amidst the array of choices available within the environment.

Proposed Initiative: Address Consumer Choices, Creating an Improved Market Model for Buying and Selling Health Care

There is an increased awareness of the need to focus on consumer needs versus system needs and to create “patient-centered” care. At the 2012 Huron Healthcare CEO Forum, a gathering of top health care system CEOs, consumer choice was acknowledged as an important focus. Kate Walsh, CEO of Boston Medical Center and former COO of Brigham and Women’s Hospital and Novartis, noted that “we need to think of service lines from the perspective of the patient’s experience, not our experience” (Huron Healthcare, 2012, p. 10).

The Institute of Medicine (IOM) defines patient-centered care as “health care that establishes a partnership among practitioners, patients, and their families…to ensure that decisions respect patients’ needs and preferences, and that patients have the education and support they need to make decisions and participate in their own care” (Barr, 2009, slide 2). There is substantial evidence that health systems that have a strong primary care foundation deliver higher-quality, lower-cost care overall, and greater equity in health outcomes. Research also shows that patient-centered primary care is best delivered in a medical home—a primary care practice or health center that partners with its patients in providing enhanced access to clinicians, coordinating health care services, and engaging in continuous quality improvement (Commonwealth Fund, 2012).

Proposed Initiative: Improve Population Health

Health care systems are at the beginning of the adoption curve toward ACOs in which ACOs take responsibility for a defined population, coordinate their care across settings, and are held jointly accountable for the quality and cost of care. In a national survey of hospitals’ readiness to participate in accountable organizations, the necessary infrastructure was lacking for many organizations and less than one third of hospitals have implemented population-based health management (Audet, Kenward, Patel, & Mauliks, 2012). Reasons cited included having the capacity to initiate population health management through the predictive identification information systems. Almost half of health care systems noted a lack of financial strength to take on the financial risk of becoming accountable for outcomes. The accounting systems to track costs and utilization combined with tracking revenue streams are complex. Current information systems often separate cost and clinical information, making tracking difficult. Aspects of care found in population health include the following:

1. Telephonic outreach to discharged patients
2. Case management
3. House calls by MDs or ARNPs
4. Safe and seamless transitions—sharing information summary of acute care stay

These would be minimal investments to obtain the necessary performance measures related to clinical quality, satisfaction, utilization, and financial measures. The challenges within population health management are to reduce clinical care variation and cost of care while developing and maintaining partnerships across social and health care organizations and providers (Audet et al., 2012).
I. PREPARING FOR THE DANCE OF CARING PERSONS

Community health centers and nurse-managed centers are seen as the precursors to the PCMH. The National Committee for Quality Assurance (NCQA) provides this definition:

A healthcare setting that facilitates partnerships between individual patients and their personal physicians, and when appropriate, patients’ families. Care is facilitated by registries, information technology, health information exchanges and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner. (NCQA as cited in Community Volunteers in Medicine, 2012, p. 22)

Federally qualified health centers, recognized community health centers, and nurse-managed centers are early adopters of the type of provider entities that combine social and health services and assume accountability for the continuum of services. A national organization called Community Health Partners for Sustainability (2013) aims to strengthen health care for residents within public housing through coordinating care and social services. This organization is an example of partnerships forged across sectors of the social and health care systems. For example, Independence Blue Cross (IBC) Foundation of Pennsylvania provides some of the funding for the organization and also supports pilot programs that promote patient-centered care through the patient PCMH. The focus of the pilot is to be sure that when the patient does come for a primary care visit, it is coordinated around what matters most to that person. Between visits, care managers, nurse educators, and patient navigators consult with patients related to follow-up and care coordination for tests, services, and medication. Electronic health records help to coordinate across providers and settings. This type of medical home only works if the payment systems are aligned so that the cost of coordinated care can be covered in the payment. The Chronic Care Initiative by IBC showed significant clinical outcome improvement related to diabetes, cholesterol, and blood pressure measurements (Snyder & Gerrity, 2012). Pilot participants also included nurse-managed centers with interprofessional teams and these too showed the clinical outcomes as well as increased quality of life, lower anxiety, and better vitality. These pilots “present a return to truly personal care, supported by modern technology, and information improving the quality of care and leading our region and nation to a brighter, healthier future” (p. 6). These types of initiatives are committed to a “culture of caring,” in which it is recognized that “how persons are treated is as important as the medical care they receive” (Community Volunteers in Medicine, 2012, p. 22).

Health care executives recognize the challenges of population health. One CEO participant at the Huron Healthcare Forum (2012) put the situation in very direct terms, saying that “healthcare systems are currently working on the ‘spoiled child’ model—spend what you want and expect the best. We will have to move to an accountability model with a focus on relevant levels of care and getting out in front of big expenses by taking responsibility for population health. At the end of the day, the hospital is accountable, but we are not reimbursed to support this model” (p. 8). Another CEO at that conference expressed the view that “we as a society need to have a greater understanding of the impact investments in social infrastructure could have on public health. For instance, we need to start helping very young grade-school age children develop the capacity to manage their lives in healthy ways by investing in things like education and housing” (p. 9).

The key challenges that CEOs face are presented by the transformation from a volume-based system to a value-based system as the care delivery model is changed and there is greater emphasis on wellness and prevention services. They see that it is the right thing to do for patients and that it is an economic necessity. A key dimension of the success will be the ability to partner with physicians and other providers to meet the goals of cost containment, access, and improved quality (Huron Healthcare, 2012). Before sharing risk, ACOs have to first establish the care coordination and management infrastructure so that
population health will evolve from focusing on individual services to meeting the needs of persons over the long term and prioritizing care needs. Chronic conditions do not occur in isolation but are often clustered together (e.g., diabetes, heart disease, and arthritis), which put individuals experiencing these at risk for access to coordinated care. Having access to predictive tools and using them is not yet a widely adopted practice. A combination of health, cognitive, and social needs that affect poor health outcomes remains to be identified and acted upon in order to affect population health in a meaningful way.

Proposed Initiative: Prevent Monopolistic and Anticompetitive Behavior

Health care CEOs gathered for the Huron Healthcare Forum in 2012 reflected on the challenges of the current health care system. They were in agreement that the existing model of health care would not be sustainable in the future, and acknowledged that they will be required to transition from a fee-for-service model to one in which affordable, higher quality care is delivered at lower reimbursement rates within an economy that is emerging from what has been labeled the great recession (see https://www.russellsage.org/publications/great-recession). Regardless of the specifics of the Patient Protection and ACA, the business model shift from volume- to value-based services is the biggest challenge that CEOs identified. However, designing strategies to successfully meet this challenge was recognized as both a matter of survival and an opportunity to substantially reform health care for the better and for what matters most to patients. Making this transition, or more accurately this transformation, will require a greater emphasis on partnerships focused on wellness and preventive care while driving out waste from the system. The United States National Health Expenditures (NHE) are projected to account for 19.3% of GDP by 2019 according to Centers for Medicare and Medicaid (CMS.gov, 2011, p. 7). The issue in this transitional stage is running competing models at the same time; one that is volume based and one that is value based as measured by health outcomes and community health status. Halvorson and Isham (2003) cautioned that consumer expectations for miracle care at budget prices without engagement in changes related to lifestyle and chronic conditions are not sustainable.

CEOs see that the current model is not sustainable, and they recognize that there has to be care coordination, clinical and financial alignment, and a seamless delivery model supported by a robust information technology (IT) system. Current organizational structures include hospitals, Medicare, some insurance providers such as Blue Shield of California, and free-standing physician and specialty practices. The shift away from traditional payment toward an emphasis on prevention and health promotion is difficult to accomplish simultaneously with the current model of payment. Despite that, Medicare announced 150 ACO contracts and another 400 organizations are planning to apply in 2013 (Evans, 2012).

The mechanism for the payment model is found in the Patient Protection and ACA. The Centers for Medicare and Medicaid (CMS) has funded 32 Pioneer ACOs already experienced in coordinating care across settings. The payment models are:

- Simple shared savings: share savings from payer sources without penalties if cost targets are exceeded
- Shared savings with shared risk: in this model, organizations lose revenue if costs exceed targets
- Global payment: fixed payment per patient, which involves sharing some financial risk for some patients but does not apply to all services

The technical aspects of actually determining the payments, adhering to quality measurement and reporting requirements, and the tracking of expenditure benchmarks all must be successfully addressed in order to make the shift to value-based and Medicare-
shared savings programs (Evans, 2012). It is expected that over time there would be a decrease in fee-for-service and an increase in hybrid fee-for-service and shared savings approaches. Over time, private pay systems would reflect the ACO payment features. The most likely participants are hospitals that are larger, urban, teaching, and nonprofit. Of concern to organizations are current antitrust laws that could be called into play during the transitions from volume to value models. Additionally, the New York Times reported that physicians concerned about integrated care models may allow “too much concentration of power over every aspect of the medical pipeline, dictating which tests and procedures to perform and how much to charge and which patients to admit” (Creswell & Abelson, 2012, para. 5). This type of consolidation that limits competition and raises prices is the warning that Halvorson and Isham cautioned against in 2003.

Organizations will be expected to have the required skills and staff to do case management, while managing relationships between primary care and specialty physicians in order to achieve performance measures on these five variables:

1. Emergency department visits
2. Admissions
3. Readmissions
4. Length of stay
5. Network care coordination

Major challenges in the transformation from volume to value base is the ability to motivate physicians to participate in developing and sustaining a common organizational culture dedicated to reducing clinical variation and costs, while increasing the population served through a team model. Developing leadership capacity in both physicians and nonphysicians to make the transformation as well as setting up governance structures to reflect provider and patient partnership are also challenges. The financial investments required at a system level will require capital in order to build the capacity for care. The question will be where will this capital come from?

Proposed Initiative: Create Workable Framework for Dealing With the Uninsured

The mechanisms for dealing with the uninsured have to happen at the broadest levels of federal and state government. Though charitable care is part of the safety net of services within many communities, it still does not address the lack of access to affordable insurance for the broader population. The reimbursement rate for many states is so low that providers restrict or decline to see Medicaid patients within their practices. Raising the reimbursement rate is a strategy enacted with the anticipation that more providers will agree to see more patients. This assumes that there are providers available to offer services, a problematic assumption because of projected shortages of physicians, nurses, and other health care professionals.

Proposed Initiative: Fund Training, Medical Education, Medical Research, Resupply of the Health Care Workforce, Re-Engineering of Health Care Delivery Particularly in Hospital Settings

Health care executives contemplating the future of health care pointed out that it will be necessary to assure that licensed personnel (such as NPs and physician assistants [PAs]) are practicing to the full extent allowed by their licenses in order to have the capacity to
provide preventive, population-based health care. “More and more care will be delivered by providers other than doctors; nurse practitioners and physician assistants are well equipped to deliver care and are an excellent way to leverage our increasingly scarce physician workforce” (Huron Healthcare, 2012, p. 11).

This kind of interprofessional team approach will help to match the needs of the patient with the skill of the caregiver. Though care is rendered by many different disciplines within a health care setting, it does not necessarily follow that the model of care is designed intentionally as a team-based approach. Within ACOs this intentional coordination of members of the team will be taking a team approach—getting more people working up to license level. The chief executive’s role within health care environments will be to lead the efforts and to “model optimism” as new partnerships and patterns of care delivery are developed. This will require attracting talent to the workplace with diverse skills.

At a 2012 conference for the Fifth Annual Retail Clinician Education Congress panel on executive and health systems leadership colloquium in Orlando, Florida, an interprofessional panel discussed trends in primary care. They represented various health care disciplines and shared their perspectives about what will be required of interprofessional teams within ACOs and the health care system in general. Scott Shipman, MD, MPH, of the American Association of Medical Colleges and Dartmouth Institute for Health Policy and Clinical Practice, projected that primary care is the backbone of the emerging system and that primary care physicians will have an increased role to play relative to population health. However, attracting new physicians into primary care is difficult because of the relative reward and reimbursement differentials associated with payment. Given the cost of medical education and associated loans, new physicians often choose specialty care. Dr. Shipman projected that medical students trained in primary care “as a team sport” will be attracted to the benefits and ability to affect health outcomes.

Dr. Kenneth Miller, associate dean for academic administration in the Catholic University of America School of Nursing, also on the same panel, discussed the vital role family nurse practitioners (FNPs) and other advanced practice NPs play in primary care. They are currently providing services within primary care and at a level that has been shown to deliver safe, cost-effective health care. NPs work closely with the medical community; but scope of practice issues vary by state, in ways that either enhance or hinder the ability of NPs to fully apply their skills to the needs of the population served. This is an issue that CEOs identified and believe needs to be resolved as well. Challenges for the supply of the NP workforce relate to the faculty available to teach, salary issues in academic nursing, and availability of clinical sites for training. Dr. Miller sees that eventually scope of practice issues will be addressed through a national license to overcome unnecessary variations in scope of practice defined at a state level. The possibilities for interprofessional education with new medical students and NPs may be able to facilitate the growth of team-based primary care.

Additional members of the interprofessional panel at that conference included physician assistant Ann Davis, PA-C, senior director, State Advocacy and Outreach American Academy of PAs and P. J. Ortman, RPh, MBA, Medvisors, LLC. Both PAs and pharmacy representatives each have a role in the interprofessional team. For example, PAs have one national curriculum and exam. There are currently 84,000 PAs in the workforce with about 6,000 being added per year, with approximately 54% practicing in primary care (Davis, 2012). Though rules about practice supervision are determined locally, most are able to fully prescribe medications. The role of the pharmacist in the interprofessional team is crucial to medication adherence. Within 6 months of prescription about 50% of patients fail to take the medications prescribed. Medications are often
an important aspect of chronic care management. Finding ways to successfully engage patients in this aspect of health care provider–patient collaboration is important to overall health outcomes.

Since nurses are the single largest group of health care providers, other major organizations also see the development of NPs as part of the effort to improve health care delivery. This includes the Robert Wood Johnson Foundation (RWJF), the IOM, and the American Association for Retired Persons (AARP), groups that worked together to identify pathways for the “Future of Nursing” (Institute of Medicine [IOM], 2011). There is a projected nursing shortage that has been obscured during the great recession, yet it is projected to increase between 2013 and 2020. In the past, nursing shortages were addressed by increasing supply of new graduates. Now, nursing faculty is in short supply and the problem will get worse because nursing faculty is older and retiring at a faster rate than previously. Senior faculty represents the greatest loss in part because compared to other disciplines, nurses receive terminal degrees at an older age and, therefore, have shorter academic careers. Fewer senior faculty limits the ability to prepare an increased supply of advanced practice graduates. To address this situation, these foundations have sponsored the formation of action coalitions aimed at increasing the number of doctorally prepared nurses for research (PhD) and practice (DNP), both of whom could fulfill roles as faculty in preparing the next generation workforce.

These same foundations (IOM, RWJF, and AARP) are also looking at ways to increase the development of interprofessional team-based care. RWJF has a national center for interprofessional education and practice with the aim of addressing quality, access, and cost issues. Together with the Health Resources and Services Administration (HRSA), the Josiah Macy Jr. Foundation, and the American Board of Internal Medicine Foundation (ABIM Foundation), the RWJF convened an expert panel from the Interprofessional Education Collaborative (IPEC) formed in 2009 with representatives from six national educational associations of schools of health professions:

1. American Association of Colleges of Nursing (AACN)
2. American Association of Colleges of Osteopathic Medicine (AACOM)
3. American Association of Colleges of Pharmacy (AACP)
4. American Dental Education Association (ADEA)
5. Association of American Medical Colleges (AAMC)
6. Association of Schools of Public Health (ASPH)

This expert panel reviewed prior efforts to define interprofessional competency in the United States and Canada. Two appointees from each association formed a group that worked to develop a set of core competencies for interprofessional professional practice, published in 2011 (IPEC, February, 2011). This gives some indication of the relatively new or renewed focus on interprofessional education and collaboration. The group identified four competency domains:

- Values/ethics for professional practice: “Work with individuals of other professions to maintain a climate of mutual respect and shared values” (p. 3)
- Roles/responsibilities for collaborative practice: “Use the knowledge of one’s own role and the roles of other professions to appropriately assess and address the health care needs of the patients and populations served” (p. 4)
• Interprofessional communication: “Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to maintaining health and treatment of disease” (p. 5)
• Interprofessional teamwork and team-based care: “Apply relationship-building values and principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable” (p. 6)

These competencies and their associated behaviors apply to each graduate of health professions schools and each should be able to be performed within the context of patient care and population health across the full spectrum of care (IPEC, 2011, p. 2). In general, the team approach being called for will become increasingly important as demand for services grows concurrently with a shortage of physicians as well as other health professionals.

Proposed Initiative: Adoption of an Automated Health Care Record to Give Point-of-Care Information for Consistent Delivery of Best Practices Based on Known Evidence

The health care CEOs gathered through the Huron Group agree that “cost savings can come from standardizing care at the bedside; evidence-driven care will reduce unnecessary care variation,” indicating that currently too many wrong decisions are being made at the discharge process (Huron Healthcare, 2012, p. 15). Halvorson and Isham (2003) are advocates and early adopters of electronic health information systems that support the goals of population health improvement and reduce unnecessary clinical variation. Kaiser Permanente has made a major investment in its integrated health care system that serves over 8 million members across nine states (Porter & Kellogg, 2008). They are often compared to the Veterans Administration and the United Kingdom as having the largest integrated health information system. Given their point of view, it is not surprising that they see the automated health care record at the point of care as essential to health care transformation, particularly the vital role it could play if it performs well enough to reap the benefits of patient information and clinical management for improved health outcomes and financial data.

The necessity for this technology adoption is evident within ACOs. Electronic medical record (EMR) adoption and other related ITs are of concern to CEOs because of the cost and complexity of their implementation.

Despite the challenges, it is well recognized that operational IT substantially improves health outcomes. A study conducted within Kaiser Permanente showed that the use of a population health panel support tool (PST) integrated in its electronic health system significantly improved primary care teams’ performance on preventive care, monitoring, and recommendations to patients based on therapeutic evidence. Improvement was seen at each measured 4-month interval and sustained over 20 months (Zhou et al., 2011). This type of decision support is desirable and yet difficult to achieve in less tightly integrated health care systems.

Health information systems that enable collecting, aggregating, analyzing, and applying health information for health improvement across different health and social systems present technical as well as privacy issues for patients. Yet, it is widely accepted that mechanisms need to be in place to do just that through health information exchanges.
Health information exchanges facilitate sharing of information across different types of software and across different sites of service to maximize continuity of care. This is an area ripe for technology innovation, while simultaneously focusing on protecting patient privacy and patient rights.

Current health IT systems are often locally hosted and provide local results, yet the desire is there to integrate data with a larger pool to monitor quality and health outcomes. As health care systems adopt electronic health record systems, incentives have been offered to underwrite part of the cost if “meaningful use” (CMS.gov, 2013) can be demonstrated, that is, if the system is helping to track and monitor outcome data and contribute data to a larger data pool. To be effective health IT systems must: (a) help primary care providers follow practice guidelines, (b) provide disease registries for individual care planning and population care management, and (c) provide feedback to physicians and other health care professionals about performance (Zhou et al., 2011). Each of these features hold technical challenges for keeping guidelines current, and data relevant, retrievable, comprehensive, and personalized enough to be applicable to use to counsel patients during the patient care visit. Finally, it is helpful for providers or provider teams to receive feedback about their management of the patient and patient population so that the information can be used for quality improvement. Though 40% of medical practices now report using some sort of electronic health record, the level of integration required for ACOs is not widely available.

CONTEMPLATING THE DANCE OF CARING PERSONS MODEL AS AN ESSENTIAL FOUNDATION FOR HEALTH CARE SERVICES

Based on Halvorson and Isham’s proposal in 2003, it appears that there is significant and yet varied movement in each of the seven initiatives throughout the health care system. It also is clear that the ACA is structured in a way to further develop transformation in these areas. (For a summary of alignment between the ACA and the Halvorson and Isham’s proposed initiatives, please see the Resources section.) Health care CEOs are recognizing the challenges and realizing this is a likely and necessary direction for the future. Similarly, professional associations are also seeing that their educational and practice initiatives both individually and interprofessionally must reflect these trends and directions. This is no small task and partnerships, integration, and collaboration are essential to success. What we must contribute to this future transformation is the Dance of Caring Persons model, as a means to keep caring centered as a substantive, meaningful foundation that will help guide these efforts and assure that health care system transformation is authentically and truly person centered. What follows is a patient’s story reflective of his experience of being the person around whom care was centered by an interprofessional team.

As you read the story we invite you to contemplate, as we have, how the story reflects the foundational values of the Dance of Caring Persons. In what way does Mr. Whittington’s story support or refute the idea that members of his health care team created an experience that:

- Acknowledged that all persons have the capacity to care by virtue of their humanness?
- Demonstrated respect for persons in all institutional structures and processes?
- Recognized that each participant in the enterprise has a unique and valuable contribution to make to the whole?
- Appreciated the dynamic, rhythmic nature of the Dance of Caring Persons as an enabling opportunity for human creativity?

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To the team responsible for saving my life:

There’s not really a way for me to begin this letter other than to say the one thing that it is meant to convey.

THANK YOU!

I ask your apologies for sending you this letter in typed format. I assure you that if you had received a hand-written letter from me, you would have probably only been able to read about two-thirds of it and may have never known what I was trying to say to you.

As I sit here with my fingers on the keyboard typing this letter—a letter that has been months in the composition stage—I realize that it has been exactly four months since the team wheeled me from the ER into the operating room. It’s been four months since I had a left leg.

I made some really bad choices and those choices led to my losing that appendage but there are three choices that I’ve made in my life that I can most assuredly tell you were good ones. The first choice, made when I was a teenager, was the one that has given me the promise of eternal life through my Lord and Savior, Jesus Christ. The second, made on October 25, 2000, was to spend the rest of my life with Cristy. The third decision, one that I made the morning of October 8, 2012, was to have Cristy take me to the University of Mississippi Medical Center. I want to tell you all that those second and third decisions were mine and mine alone, but the truth is that I believe wholeheartedly that the first decision set me on the path to making them.

Most of you already know that Dr. Boland came out of the operating room and told my wife to contact my family and prepare for the worst. He truly didn’t have much hope that I would make it out of the hospital alive. I guess Dr. Boland didn’t realize that God isn’t finished with me—and to tell you the truth, I didn’t either.

I’ve had the chance to thank Dr. Boland for taking care of me and saving my life. I showed him a video I posted on YouTube. The video, shot exactly 1 month ago today, showed me on my first day at the gym with my physical trainer/therapist. Dr. Boland had tears in his eyes when he told me that he could take credit for being the team leader and being the surgeon, but—as he pointed to the video—he told me that I was the one responsible for dragging myself up and reclaiming my life.

I’ve had some time to digest that statement and realize there’s some truth to it, but without all of you, I could have never done it.

I laid in the bed for the first couple of weeks and felt completely hopeless, but thanks to the tireless dedication of the team that you are part of, I was shown the light.

Every single one of you reading this letter, and probably many more that I was too sedated to remember, played a part in my journey from the darkness, but there are four people that I want to mention here.

The first is Nurse Ron.

I was having a tough time with the pain after the initial amputation but one night in particular was extra hard. I’d been having trouble getting to sleep and was receiving doses of Benadryl intravenously. I had finally fallen asleep that night and somewhere about 4 o’clock in the morning, I rolled over in the bed and hit my stump on the bed rail. The pain was excruciating. I tried to call out to Cristy, who was asleep across the expanse of room 327, but I had no voice. It was that kind of pain. I pressed the “call” button and could only get the word “hurt” to come out faintly. Ron came rushing into the room a few seconds later—it seems that I was one of only two patients he had that evening (Thank the Lord). He saw the tears falling from my eyes and tried to understand what I was trying to say. He finally surmised that I had banged my stump and told me to wait just a few. He left the room and returned with a dose of morphine and then sat by the bed and held my hand until I fell asleep again.

I will never forget that tenderness. I will always strive to live up to that example.

The next person is Wendy, the physical therapist.

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Wendy is a ruthless woman who can look into the soul of a person and see what they’re capable of. Maybe that doesn’t sound ruthless, but that comes into play when she demands that you—no matter that you don’t believe that you’re capable—accomplish the task that she wants done. Whether that task is getting out of the bed, sitting on the toilet or walking across the hall, you’re gonna do it and there’s no giving up allowed. She pushed me to the edge of sanity but there was no way for me to fall into the abyss. She (with the tireless assistance of the love of my life) showed me that I was capable of much more than I could see at that point.

I will never forget the look in her eyes—those beautiful, all-seeing, ruthless eyes—the first day I made it across the hall. Those ruthless eyes were welled up with tears, but she never let me see her cry. I will always remember that and will strive to push myself and others to limits like that, knowing that I am capable of catching both myself and others before they fall into a darker place.

The third person is Dr. Thompson, from Dr. Boland’s vascular team.

I was having tremendous difficulty with depression and realized that I was in desperate need of talking to a counselor. I mentioned this to her one day and she put in the request to have someone come by. The chaplain, Jeff Murphy, came by, but the psychology and psychiatric departments both refused to see me. That’s when Dr. Thompson did something really creative. She contacted Harry at University Rehab and asked his assistance. She asked him to contact the psych department and ask them to evaluate me, claiming he was worried that I was not “stable” enough to come to rehab. It worked.

That level of creative problem solving is not something I had ever seen from a doctor before. I will forever be grateful that Dr. Thompson was that creative. Without it, I would have never met Dr. Manning or my therapist, Daniel, and may have not been able to begin to deal with my depression and other issues until it was too late.

I will always strive to be as creative in solving problems that I’m facing, and sincerely hope that Dr. Thompson keeps that spark. I believe that it will truly set her apart from her peers as she grows into the leader I can see in her.

The fourth and final person I have to thank for pulling me from the darkness (besides my wife and mother) is Nurse Becky.

Becky was the first nurse I came in contact with who realized that I actually had a sense of humor and she constantly worked on appealing to that side of me. That tireless effort, even though she knew how dark things seemed to me at the time, actually helped me to get back to being myself much faster than therapy (physical or mental) did. Becky, regardless of my mood or pain level, would walk into the room with a smile on her face and would make jokes and poke fun. I guess she subscribes to the belief handed down to us in the bible: “A merry heart does good, like medicine, but a broken spirit dries the bones.”—Proverbs 17:22.

Much like Becky, I’ve always had a sick, twisted sense of humor...so much so that I asked Dr. Boland for the last piece of bone he cut from my leg so that my friend could attempt to turn it on his lathe and make a duck call out of it. I have her to thank for making that sense of humor reappear inside me.

I will never forget my “MB”—ask Becky if you’re curious about that nickname. She taught me the true importance of laughter and reawakened a spirit I truly thought was dead. I will always strive to bring that sort of light into any room I walk into.

Now just because I mentioned those four people, does not mean, under any circumstances, that the rest of you reading this letter played any lesser role in my recovery. To the contrary, you all are responsible for getting me to the point of writing this letter.

I’ll begin with the last face I saw before leaving the hospital for my home. Nurse Lacey actually took the time to wheel me downstairs and aid Cristy in loading our things into the van. It was a bit cold and rainy that night so she and I sat in the lobby while Cristy fetched the van from the garage.

Those of you who know Lacey will enjoy this story. The first time I met her was Halloween night. She was wearing a pair of Grey’s Anatomy scrubs when she came into the room and informed me that she would be my nurse. She checked on my IV and then bounced out of the room as swiftly as she’d come in. I looked at Cristy and told her that she
needed to call security because we had some trick-or-treating teenager acting like a nurse. Cristy laughed and tried to reassure me that Lacey was actually a hospital employee. I, in all seriousness, looked at my wife and tried to explain that this child who was just in our room was definitely not a nurse. First, the scrubs were obviously a Halloween costume, seeing that they were from a TV show. Second, Lacey had the legs of the scrubs rolled up like the girls in my high school used to roll their jeans.

Between Halloween and November 28th (the day I got to come home), Lacey was the nurse most often assigned to my room. Cristy and I got to develop a friendship with her that I will treasure until the day I leave this mortal coil. As we sat in the lobby talking about Lacey’s upcoming days off—days she was looking forward to such as celebrating the birthday of one of her children—I realized that I was going to miss being in the hospital almost as much as I was looking forward to getting home to my dog and my own bed.

Cristy pulled up out front and we lugged all the stuff out to the van—and yes, even though I was in a wheelchair, I helped . . . not much, but I did. Lacey started to lean down to give me a hug and say goodbye and I told her to wait. I stood up, holding on to one of the columns for balance and gave her a big hug and thanked her for her care and friendship. Lacey was smiling and tears began to fall from her eyes as she quickly turned her head and walked over to hug Cristy.

It’s that kind of compassion—a compassion that was not uncommon from each of you—that will stay with me forever.

There are lots of nurses who took care of me during my stay on 3 North. I’m absolutely positive that I’m forgetting some of you, even though I began writing names down almost as soon as I came home. Pain meds are great for controlling pain but not so much for the memory center of the brain!!! If your name isn’t on this list, I apologize . . . it’s not like I’m not thankful, but there was a great deal of time—especially those first two or three weeks—that seems jumbled together in my mind, as if it were only a couple of days.

Delorise—I know things got off to a really rocky start and that my attitude toward you (and everyone else) was less than stellar. I thank God every day for your patience and understanding and will never forget all the times you stuck your head into my room just to say hello, even though you weren’t my nurse!

Jennifer—I know there are two of you, but I want you to know that my mom fully expects you to take her up on the offer of a room and a tour guide to Colorado. All you have to do is let her know when you want to come! I’ll look forward to hearing all about your trip. Thanks for listening to me whine and letting me know that it’s okay to be scared.

(The Other) Jennifer—Don’t ever let your smile leave your face. You truly do brighten a room when you walk in. Thanks for your endless devotion to your patients.

Linda—You scared me half to death one morning. I was totally gone. Sleeping is not the proper word for what I was doing. You came into the room and I wasn’t expecting it and I honestly almost had to have my bed changed! Your positive attitude helped pull me out of some really dark places as well . . . don’t ever lose it!

Wendy—I don’t know if you remember walking in on me having a pity party one day. I tried to hide it, but you sensed something wrong. You stood in my room for much longer than you could afford to and talked to me until I was doing better. I can’t thank you enough for taking the time to do so.

Mioshi—There’s a lot that I could say about you, your attitude, your smile, but I want to thank you first and foremost for making me a glass of tea. Cristy was at home and her brother was staying at the hospital with me. He had just started talking to his new girlfriend and spent hours away from the room. I had been wanting something to drink and was too drugged to get out of bed. You will never know how good that tea tasted! Thank you!

Bryce—you are too bubbly for your own good. One of these days, those bubbles are going to pop and you are going to kill someone with kindness! Thank you for infecting me with your bubbliness. Spell check just told me that isn’t a word, but I can’t think of a better way to describe you!
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Parminder—You have a terrific personality! Don’t ever hide that from anyone! Your warmth is something that endears you to patients and that kind of feeling means far more to us than you can possibly imagine!

The other nurse I have on my list is not on 3 North, but rather in Pre-Op. Paula (my second wife)—I had a total of 12 surgeries at UMMC. I believe that you were there for all but the first one. Your care is second to none and I thank God every day of my life that you were there to hold my hand before surgery and let me know that everything was gonna be alright. Your tears, welled in your eyes on the day of my skin graft, speak more about your soul than you will ever know. Thank you!

There were five Patient Care Technicians that I can remember sharing my stay at UMMC. To Rhonda, Sally, Cynthia, Linda and Calvin: Thank You! Letting me sleep through some of those vital sign checks was wonderful…even the times when you got my vitals in spite of my sleep. You guys are a wonderful support to both the patients and the staff on the floor. I will never forget any of you!!!

My other physical therapist, Alyssa, was just as ruthless as Wendy, but she didn’t have to dig me out of the deep hole like her predecessor. It is because of their tireless work (and immense patience) that I was able to transition from the hospital to home without having to go to rehab in between. Being able to show her the video of my workout at the gym put a smile on both of our faces. I hope that I was able to convey to her how truly grateful I am for keeping me on my toes and making sure that I didn’t give up! Randy, my occupational therapist, really helped me along in being able to skip the rehab part of the journey, too. Thanks to Randy’s innovative exercise routines, I was able to build some extra upper body strength and that has made a world of difference in my life.

Dr. Manning assigned his assistant Daniel, whose last name I believe is Ray, but I could be mistaken, to be my therapist. Daniel helped me to find a better place in my head and taught me how to stay there. There is no level of gratitude that will ever be enough for that. Daniel, please don’t ever lose the “it-factor” you have as a therapist. God gave you those talents for a purpose and I believe you will go on to help many others, many worse than I was, to find there [is a] better place. Do me one favor though…buy yourself an MP3 recorder and don’t worry about trying to figure out smart-phones!

Jeff Murphy was the chaplain assigned to me. His guidance and compassion helped me to see that God had not forsaken me. I got to see him during my last visit to the hospital and was truly happy to do so. He is an inspiration to me and, no doubt, countless others. Jeff, THANK YOU. Whether it was praying over my sleeping self after one of my surgeries, praying with me, listening to me cry about my life or providing a shoulder for my family and friends. Your kindness will never be forgotten and I am sure that God has a special place reserved for you in His Kingdom! God Bless and keep you in his arms!

Finally, I’d like to thank the entire team of physicians who cared for me during my stay—and beyond.

Doctors Dinning, Sparkman, Richardson, Lange, Wofford, Atchley and the many, many more who I cannot name…I owe you my life and my unending gratitude for leading me to a life beyond October 8, 2012!!!

I hope that each and every one of you had a joyous Christmas and New Year’s; 2012 kinda sucked for me, given the fact that I had two legs and a job when it started and now I’m one less in both of those departments, but 2013 has begun and I have my life and a brand new family to thank for leading me here. (Whittington, 2013)

REFERENCES


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1. CHALLENGES TO THE EFFECTIVENESS OF HEALTH CARE SYSTEMS


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What is the value of a caring-based perspective in health care transformation?

The value of introducing a caring-based perspective into the transformation of health care is undeniable. In part, some of this work is currently being accomplished by Magnet nursing initiatives since some health care agencies/systems have emphasized nurse caring and added nurse caring and nurse self-caring agendas to their missions, visions, and strategies. What the impact of the Magnet phenomenon is on the perceptions of nurse caring by patients, families, and communities is difficult to estimate.

Some acute care agencies have recognized the impact of nursing care, perceived as caring, on patient satisfaction. Within the current focus on relationship-based and patient-centered care exists an opportunity. The time may be ripe to clarify practice models that operationalize a culture of caring. Caring-based perspectives can start where many health care facilities and nurse leaders are already working to disseminate patient-centered care. Maybe this is the beginning of a paradigm shift that will welcome a transformation to a caring culture. Perhaps a look at Duffy’s model and others is worth the attention. She and others have piloted an intervention, but not in a hospital setting. In addition, Watson’s work as operationalized by exemplary nursing service organizations already has some lessons learned. An old article by Joiner noted that when caring was on the agenda within a nursing service organization, the other departments wanted to join and they did. The values were advertised in a simplistic way as I recall.

I think it is essential to examine what is meant by a culture of caring. Cultures have beliefs, norms, and values, and the building of an interdisciplinary culture of caring may start with shared values. A strategy to put this into action could begin with teams of providers in dialogue about the meaning of caring as well as formal presentations on the elements of a culture of caring.

Many providers believe that their agenda is the welfare of the patient, but few seem to have work like Gaut’s on which to base their assertions. Intentionality and authenticity are crucial.

Chronic illness, sometimes a combination of chronic illness diagnoses and disadvantaged, poor populations, has challenged our health care system to transform.
Although the Affordable Care Act will shift care to lifestyle changes and prevention of illness and disability, this will be a difficult path and reimbursement will evolve with rewarding quality services and outcomes. Public health initiatives that emphasize prevention are essential; those of us who are spoiled and who order many expensive diagnostic tests will not be very happy, but we will adapt.

It is not an impossible goal to achieve cost containment, patient-centered care, perceptions of caring services, and caring providers. Hopefully the paradigm shift has begun toward this goal, and nurse leaders, once onboard with transforming health care to a culture of caring, will move service delivery closer to this end point.

Health care agencies, very dependent on outcome measures and dashboards, will need measures of perceived caring that businesses like Press-Ganey will need to incorporate into their surveys and analyze and present the results back to subscribers.

Stories can be powerful agents for change. Maybe caring stories will predominate and one, two, or three good ones receive national attention and accomplish an initial shift to promote the desire for a culture of caring.

**In your experience, what would have to be in place in order to bring the ideas presented to fruition?**

Start with exemplary nurse education programs that have caring theories as part of their foundational thinking. Publish examples of their curriculums and try to discern the effect of graduates from programs that have been strong “in caring” for some time. Determine this: Have their caring ways affected changes in organizations? Write about the substantive knowledge gained from this and make it a part of fundamental nursing textbooks, as well as other disciplines’ fundamental textbooks.

Model the caring culture phenomenon on organizational change theory, create a consultation business that creates culture of caring “packages,” and disseminate the model. This means that the model must be based on the caring literature, stellar organizations known for caring, and cultural theory presented in a manner to convince health care agencies to purchase your product.

Since strong primary care practices may be the best foundation of a more affordable and lifestyle-changing health care service, start here. Nurse practitioners are becoming increasingly more appreciated by patients and families as effective primary care providers and could be effective leaders in this transformation.

**What ideas would you like to contribute to making the content even more practical?**

The language of caring needs to be included in electronic health records. These projects need to go forward and I believe that they will, given recent articles I have reviewed for the *International Journal for Human Caring.*