GLOBAL JOURNAL OF
Community Psychology Practice
PROMOTING COMMUNITY PRACTICE FOR SOCIAL BENEFIT

Creating a Sustainable "Healing Culture" Throughout a Healthcare System: Using Community Psychology Principles as a Guide

William D. Neigher, Ph.D. [1] and Sharon Marie Hakim, M.A. [1,2]

[1]*Atlantic Health System [NJ],* [2]*Wichita State University*

June 17, 2011

Key words: sustainability, healing culture, community psychology practice

Running head: HEALING CULTURE

Recommended citation: Neigher, W. D. & Hakim, S. M. (2012). Creating a Sustainable "Healing Culture" Throughout a Healthcare System: Using Community Psychology Principles as a Guide. *Global Journal of Community Psychology Practice*, 2(3), 1-25. Retrieved Day/Month/Year, from (http://www.gjcpp.org/).

Creating a Sustainable "Healing Culture" Throughout a Healthcare System: Using Community Psychology Principles as a Guide

William D. Neigher, Ph.D. 1 and Sharon Marie Hakim, M.A. 1,2
1Atlantic Health System [NJ], 2Wichita State University

Abstract

This presentation describes foundational initiatives to create a sustainable "healing culture" within a large, multi-hospital healthcare system, the Atlantic Health System [AHS] in northern New Jersey. We will describe our guiding principles, implementation process, barriers and facilitators, progress to date, and next steps.

Introduction

Perhaps you are puzzled already: "isn't a hospital system by *definition* a healing culture?" Of course it is. However these two words, "healing culture," have meaning together beyond their distinct definitions, and each brings challenges and opportunity in our current operating environment.

U.S. hospitals are facing extraordinary pressures to balance "mission with margin." Decreasing reimbursement from commercial and federal payers [Medicaid and Medicare], competition from physician-owned facilities, the shift from inpatient to outpatient care, tighter staffing ratios, focused efforts to reduce mortality and infection rates, the skyrocketing cost of new technologies, the shortage of primary care doctors in many areas, information system mandates, and upkeep on aging physical plants are among the challenges. All of which contribute to the uncertainties of expected changes under new healthcare reform legislation [Patient Protection and Affordable Care Act, PL 111-148, 2010].

However a healthcare system today is more than just an acute inpatient setting. AHS includes in its continuum of care: emergency and trauma, post-acute and rehabilitation; same day surgery, ambulatory care [outpatient], and home health and hospice services. Yet the hospital setting may present the greatest challenge for creating a healing culture. When we ask who in an audience has ever been a patient in a hospital for an illness or injury, most raise their hands. When asked "for how many of you was it among the *best* experiences of your life?" there is usually not a single hand [having a baby is usually a great exception].

The corollary, in contrast, evokes nervous laughter and many hands raised: "for how many of your was your hospital experience among the *worst* experiences of your life?"

Our AHS workplace has a legacy of over a century of community service; like other hospitals it has never closed-- even for a minute, even in the worst disaster. And it is emotional place for patients, families, visitors, medical staff and employees: every day here life begins, life ends, lives are saved, and everything else in-between.

"Above all, do no harm, cure whenever possible, treat appropriately, and heal always."

These guiding principles of medicine and healthcare are familiar and profound; if we try our best to follow them why do we need a special effort to create a healing culture? For the most part we only begin the healing process. We say that about 15% of healing takes place within our walls; the rest is up to the patient and a host of other factors within and outside of their control.

Our patients can face sudden and life-changing events for themselves and their families. Their recovery can take months or even years, and their return to pre-illness or injury levels of functioning is not always certain. How can a healthcare system prepare our patients better for the challenges of recovery—whether they are physical, psychological, social or economic? In other words, how can we make them more "**adaptable**?" That is one major challenge in creating a "healing culture," and the topic of our presentation.

To get started we will take a look at how we define and express our healing culture in the context of our healthcare system's mission, vision and values, and how the principles of community psychology inform the process.

Introducing Atlantic Health

Atlantic Health, #54 in the 2010 Fortune's "100 best companies to work for", is a multi-provider health care system serving northern NJ. In addition to three acute care facilities with

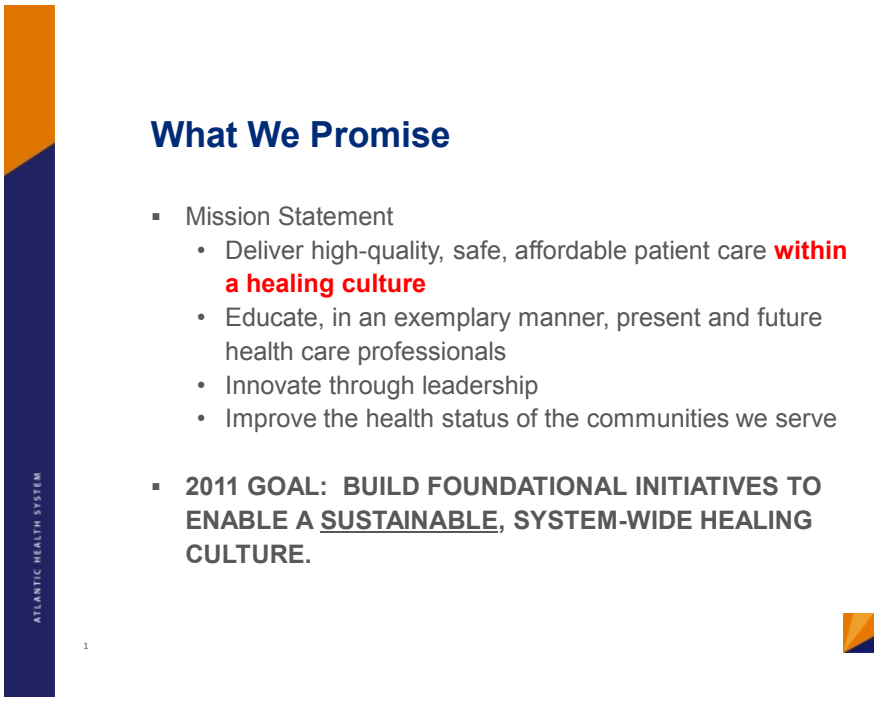
more than 1,200 beds, the system includes the second largest cardiovascular program in the NY metropolitan area, a children's hospital, neuroscience and rehabilitation institutes, and comprehensive cancer centers.

Founded in 1892, **Morristown Medical Center** has evolved from a community hospital into a state-designated, five-county tertiary care referral and trauma center.

Founded in 1906, **Overlook Medical Center, located in Summit, NJ**, serves a diverse population in Essex, Morris and Union counties. Overlook Hospital provides comprehensive

acute and emergency care, and offers a full range of specialty services including oncology, surgery, cardiology, and a regional neuroscience institute.

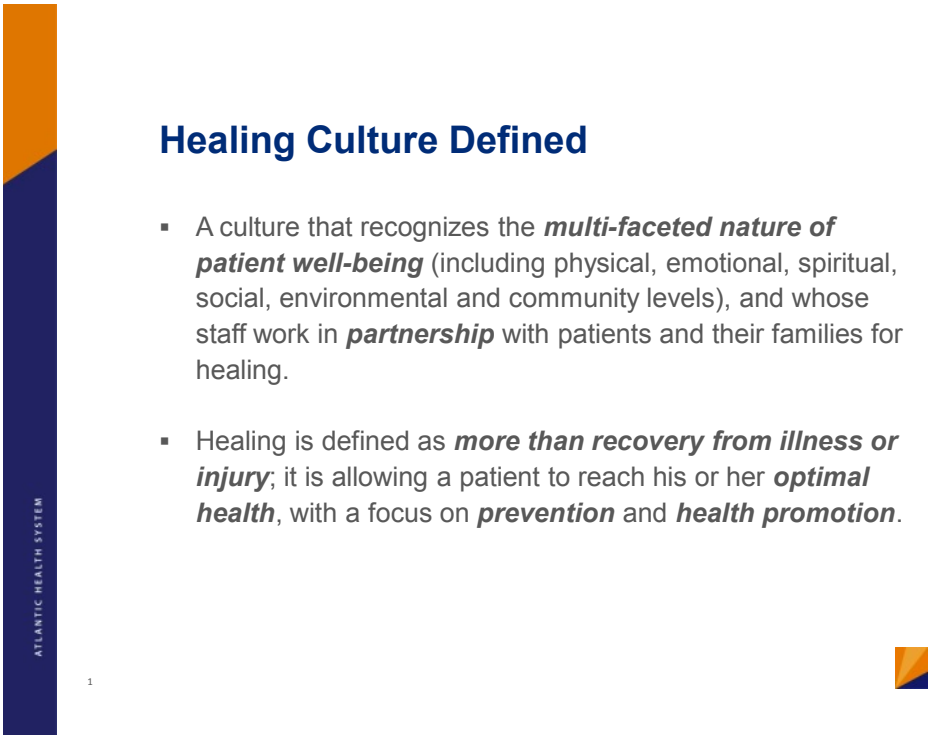
Founded in 1932, **Newton Medical Center** is a short-term, fully accredited, 148-bed acute care, not-for-profit hospital serving more than 250,000 people in Warren and Sussex counties in New Jersey, Pike County in Pennsylvania and southern Orange County in New York



Atlantic Health System sets a high bar for its vision statement; "Demonstrate quality performance comparable to the nation's best healthcare systems." Within that definition of quality, we adopt the Institute of Medicine definition – Safe, Timely, Effective, Efficient, Equitable Patient Centered.

In November of 2009, we added four new words to the first part of our Mission Statement: "…within a Healing Culture." The four elements of our Mission Statement are described below.

- Deliver high quality, safe, affordable patient care ***within a healing culture***
- Educate, in an exemplary manner, present and future health care professionals
- Innovate through leadership
- Improve the health status of the communities we serve



Healing Culture Defined

What do we mean by a "healing culture?" For AHS it is a culture that recognizes the multi-faceted nature of patient well-being (including physical, emotional, spiritual, social, environmental and community levels), and whose staff work in partnership with patients and their families for healing. Healing is defined as more than recovery from illness or injury; it is allowing a patient to reach his or her optimal health, with a focus on prevention and health promotion. We amplify below:

The AHS stakeholders shared a pragmatic, organizational tenant that we need to create *sustainable, second-order change*. In order to do so, we set a goal for 2011 to build foundational initiatives to enable a sustainable, system-wide healing culture. As you would imagine for a hospital system where its individual institutions have served their communities for more than a century, there are not only cultures that are unique to these hospital and their elements of care, but also within each hospital are centers of excellence and programs that have their own unique leadership, champions, values, behaviors, and rewards systems.

More specifically some of these challenges which cut across our institutional cultures are also some of the most difficult issues for healthcare systems to face. These include end of life care, integrative medicine, pastoral care, community health, delivering a uniform patient experience, and engaging more than 2,000 members of the medical staff and consistently delivered patient centered care.

If "culture" can also be defined "values in action," we needed a clear set of values, instantly understandable to a workforce of more than 15,000 that includes physicians and allied health professionals, support personnel and management, volunteers, and advisory board members. Our goals was to create "line of sight" understanding between every individual, their workgroup and job description, and the vision, mission, values in strategies of the organization.

Diffusion of Expectations

Like many large, multi dimensional organizations, both within healthcare and outside, we had three dozen expectations for behavior among our employees, medical staff and volunteers. This diffusion made it difficult for us to forge one set of expectations for our staff and our patients. Working through a group process, we distilled these into a new set five "shared-values" using "PRIDE" as a pneumonic acronym.

We'll conclude our presentation with a discussion on implementation challenges and the roadmap we built to achieve our goal of building sustainable system-wide initiatives to serve as the foundation for a healing culture. We turn to healthcare reform next, however, because it provided with a context and opportunity for change. This "burning platform" of legislative, regulatory and reimbursement reform brought with it a need to exam everything from the business model under which we practice to the community psychology values and guiding principles we discussed earlier. With the Patient Protection and Affordable Care Act [PL 111-148, 2010], comes the most sweeping change in federal healthcare policy in 50 years. With the change from incentives based upon ***volume*** of care to the ***value*** the care based on efficacy and efficiency, healthcare systems have both opportunity and challenge.

Healthcare Reform and Community Psychology

Healthcare reform presents a unique opportunity for community psychologists to make an impact at the national, local and state levels. Various actions stipulated by the bill align with the priorities of our field and require application of our core competencies. Although the typical community psychologist may not identify as part of the "healthcare system," we argue that the field has a necessary contribution to make.

On the national level, healthcare reform creates a "consumer" for prevention and health promotion. The new business model now incentivizes government, businesses, and insurance companies to keep people healthy. The bill establishes a national fund for prevention and public health programs, including incentives for prevention of chronic disease in Medicaid recipients. Community psychologists should be in possession of the skill set needed to see these actions through.

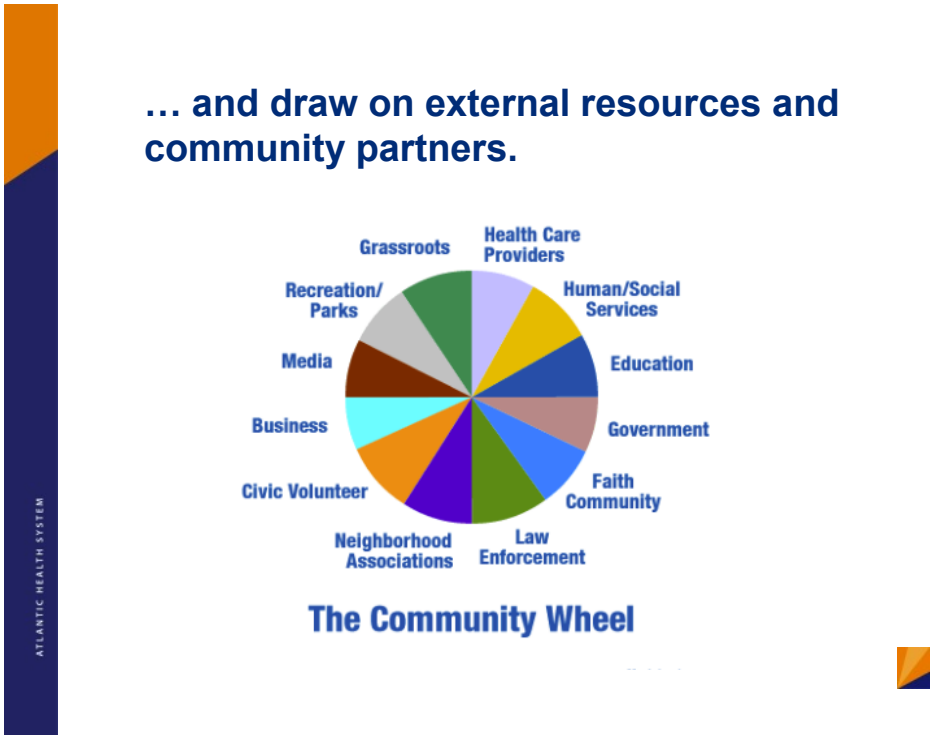
In addition to prevention, health care reform aims to address the health disparities that prevail in our country and provide training for providers in cultural competence, two areas that community psychologists have long worked in, and can add value. Further, there will be a national task force created to review the effectiveness of community interventions to ensure that money is being spent effectively and efficiently and that community members are getting the services they need.

Opportunities also exist for community psychologists at the state and local level. States will now be required to conduct needs assessments for communities with high-risk populations and a prevalence of other social problems (e.g. poverty, low high school graduation rates, etc.). Community transformation grants, recognizing the importance of evidence-based local programming, will be available for the implementation, evaluation and dissemination of activities to promote health within our communities. Continuing into the center of the ecological model, all of these new efforts will be enhanced by the complete coverage of preventative health services (including inoculations and annual wellness visits) to individuals.

Optimizing Health through a Healing Culture beyond discharge

Because at Atlantic Health our goal is not simply fixing the illness or injury patients present with, it's restoring them to optimal health, we recognize that we cannot do it alone. Healthcare systems, doctors, nurses and medicines are just one part of the healing process. The average length of stay in an Atlantic Health Facility is 4.5 (according to the Centers for Disease Control, it is 4.8 days nationwide). Clearly, what happens on the other 360.5 days of the year has a great impact on one's health status.

In order to help patients optimize health even when they are outside of our facilities we need to better utilize community partners and resources, as well as patients themselves, in the healing process. Working on the strength and breadth of our community connections is the first step. Community partners with aligned interests include social services, government agencies and the faith based community. These agencies have traditionally partnered with hospitals. In order to truly promote population-based health, we need to expand the potential partners to include the whole community wheel. Businesses, the media law enforcement and education entities all have a vested interest in the health of the community, as well as that of their own employees and customers– what new programs, resources, and perspectives can they bring if invited to the "health table"? We cannot control the environment that our patients live, work and play in; what we can do is help enable community partners to create environments that support health in recognition of the fact that optimal community health will only be achieved by three-sixty degree partnerships with the community.

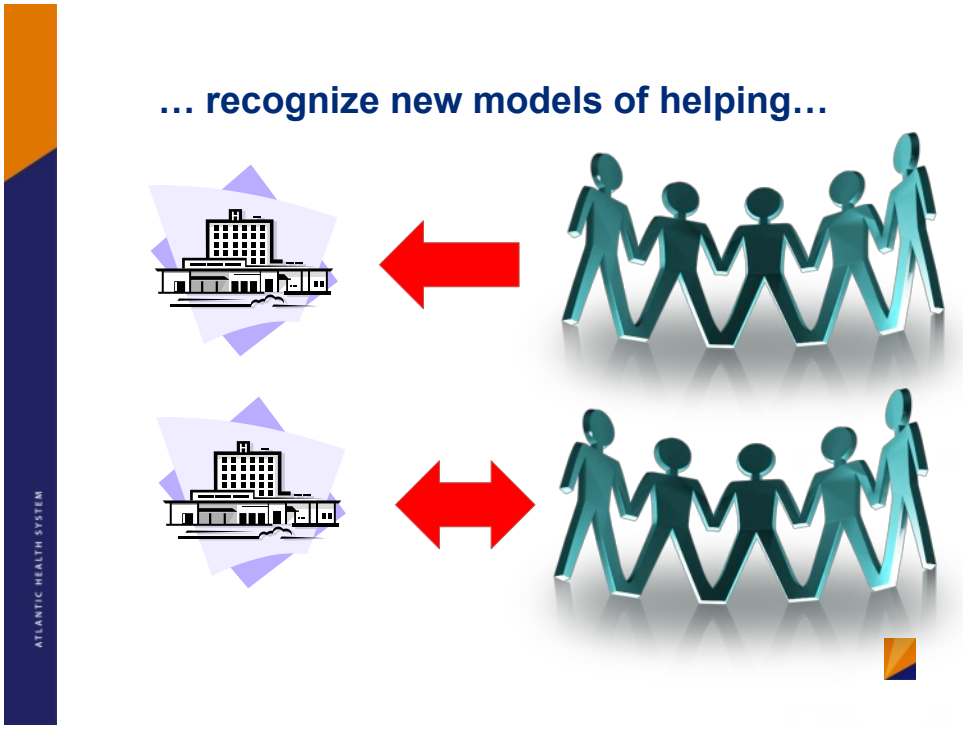


Further, crediting the individual for his or her own role in the healing process is important. Although patients have long looked to us as the "source" of healing, most of the responsibility for health relies on them – properly administering medicines, choosing healthy behaviors, monitoring their conditions, etc. If the healthcare industry can stress how much of the responsibilities lay on the patient him or herself, we can begin to empower patients to embrace this role.

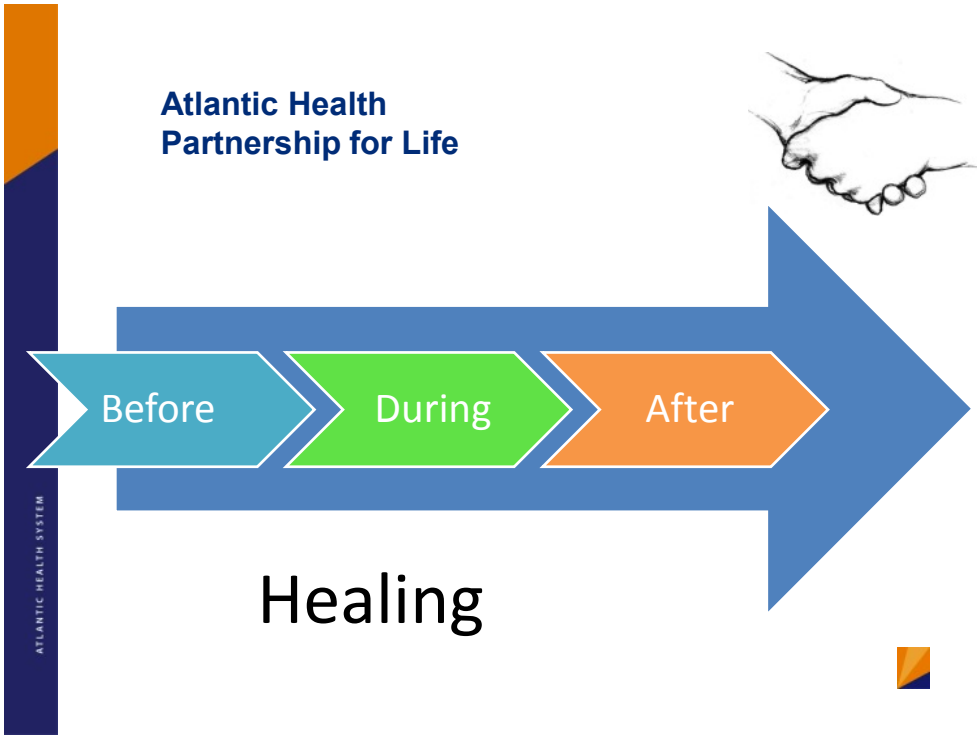
Recognizing New Models of Helping

Embracing the role of the patient and the community in health requires recognizing new models of helping. The traditional medical model dictates that individuals do not become

"patients" until they become ill. From that point forward they leave their home and come to the hospital for treatment.

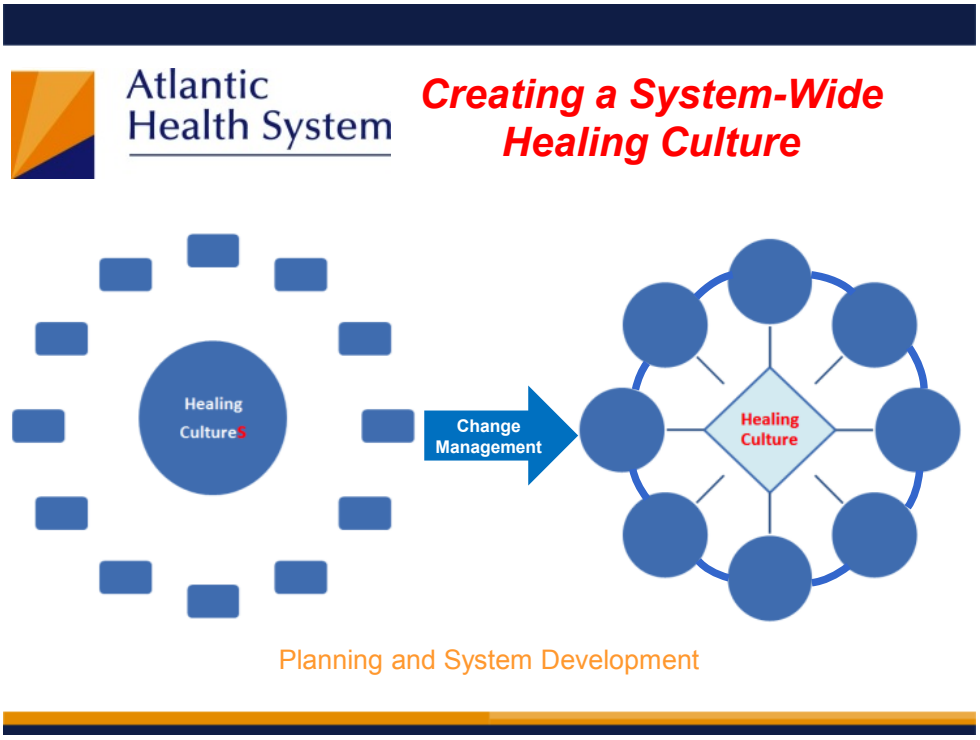


New models of helping start with healthcare initiatives leaving the hospital and going into the community. Although hospitals have long conducted community health programs (e.g. screenings or lectures), the opportunity arises to do them in a more strategic and proactive manner. Further, viewing the individual as an empowered partner in their own health and wellness program means creating a relationship with him or her before an illness or injury begins. Preventative care is and should be a foundational element of the healthcare equation.



Cultures to Culture

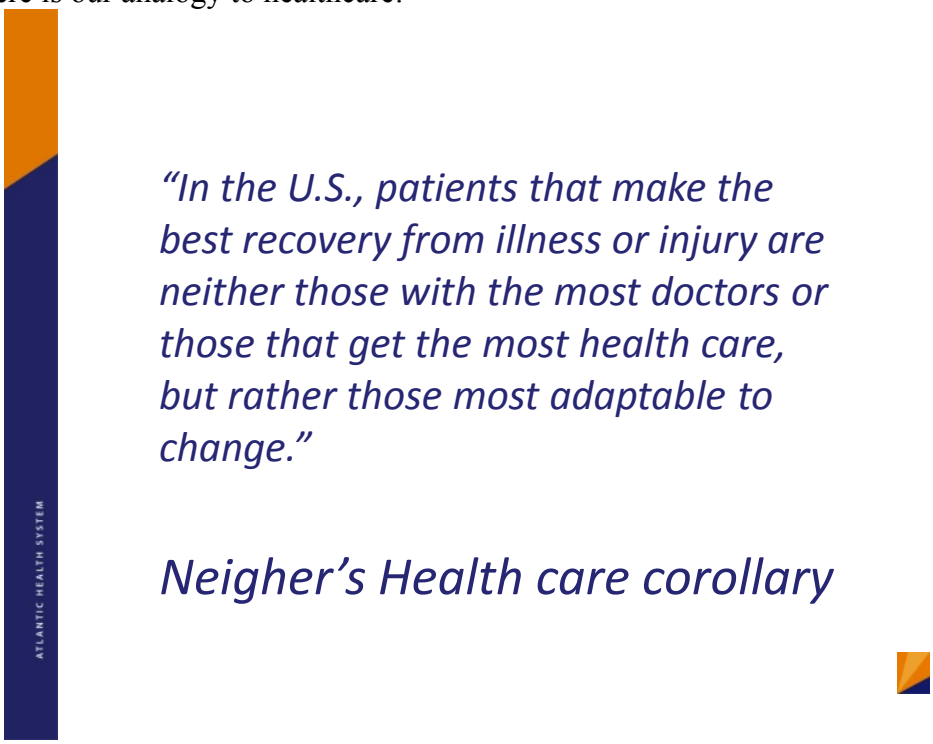
Throughout our system, many of the elements which we posit make up a "healing culture" already existed. From integrative medicine and pastoral care to palliative medicine and community health, from our hospitals to our out-patient facilities, the ingredients were there. The challenge was taking these disparate, segmented, and often isolated cultures related to specific departments or locations and integrating them into one ***unified, system-wide healing culture.*** A healing culture that is present throughout the organization will not only help to ensure a uniform standard of care and deliver the Atlantic Health brand promise, but it will enhance our mission, galvanizing resources and staff energy behind it.

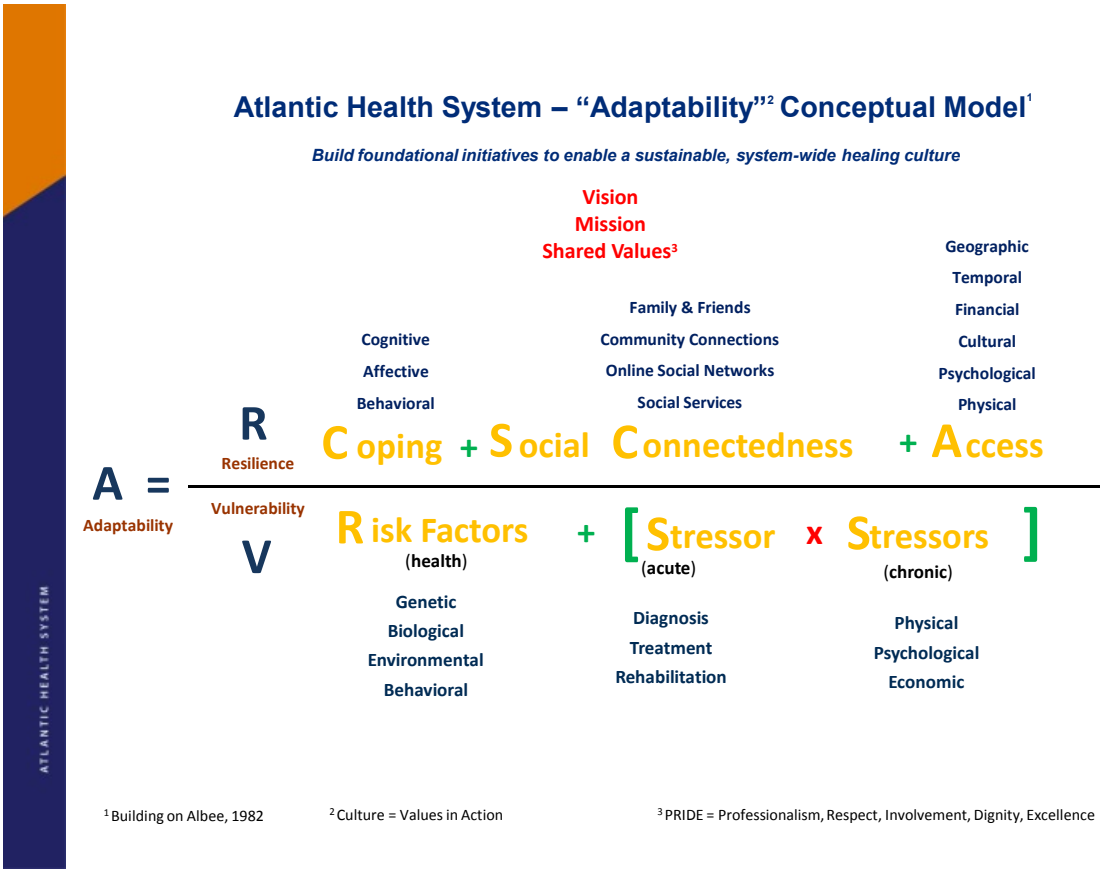


Increasing Healing by Increasing Adaptability

Our mission change ushered in not only attempts to change the culture of the organization, but also a parallel process aimed at increasing the adaptability of our patients. We are re-framing the goal of our healthcare delivery system – instead of fixing your illness or injury, what we want to do is discharge more adaptable patients. We want patients to leave our doors not only healthier, but better equipped to deal with the challenges of recovery and healthy living (i.e, Albee, 1982). Adaptability is the ability to change with and deal with a changing environment. Operationally, we define it as the ratio of resilience to vulnerability. By defining it this way, we are recognizing the individual nature of health and healing. While we can't always decrease an individual's vulnerability to illness, we can help them load the top of the equation, increasing their resilience and in turn their adaptability, by connecting them to resources, teaching them coping skills, otherwise intervening along the continuum of care to promote healing.

And here is our analogy to healthcare:





Unpacking the Adaptability Equation

Here is our working "taxonomy" that informs the terms in the Adaptability model, in their most concise narrative:

Adaptability: The ability to respond to continuing challenges to health status.

Resilience: The ability to bounce back from injury, illness, or adversity.

Vulnerability: Combined present or future risk of adverse change to physical, psychological, environmental or social status.

Positive Coping: Managing the physical and emotional challenges that accompany an illness or injury and their progression over time.

Social Connectedness: The characteristics of social relationships (quantity, quality, diversity and strength) and their perceived or potential social support.

Access: The ability to get timely, appropriate, patient-centered services across the continuum of care.

Health Risk Factors: Elements that increase an individual's vulnerability to poor health or outcomes during treatment or recovery.

Stressor (acute): The physiological or psychological factors that define an individual's current health status.

Stressors (chronic): The "baggage" a patient is dealing with over and above threats to his/her current health status, including but not limited to coping with other physical, economic, psychological or social conditions.

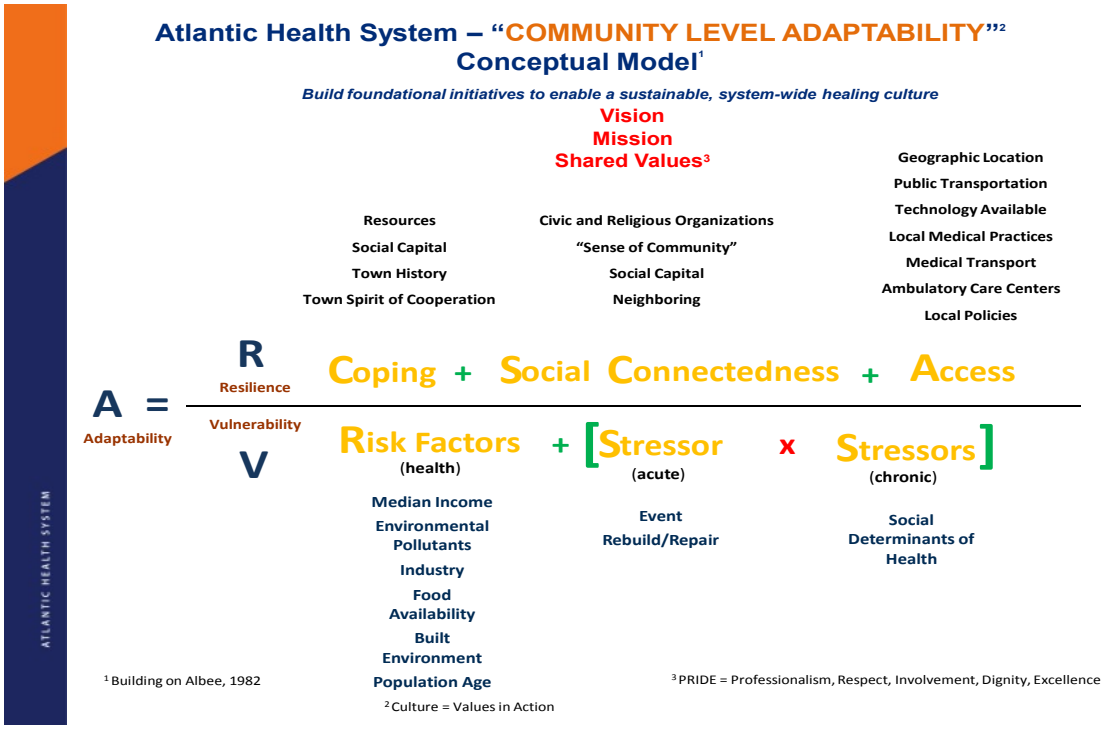
In broader context however, it is also important to place these elements in their research domains to be most inclusive of a bigger picture. This consideration is in the table below:

Adaptability	The ability to successfully adapt to change. Operationally defined as the ratio of Resilience to Vulnerability.
Resilience	The ability to "bounce back" from, or have positive outcomes "in the face of" adversity; successful adaptation to illness, injury or hardship. (Connor & Davidson, 2003; Curtis & Cicchetti, 2003; Luthar, Cicchetti & Becker, 2000; Masten, 2001; Zautra, Hall & Murray, 2008)
Positive Coping	Managing the physical and emotional changes that accompany an illness or injury and its respective treatment in a way that is active and helpful in the long term.
Social Connectedness	The number, diversity and strength of connections that a person has with others.; the quality and quantity of relationships (Mitchinson, Kim, Geisser, Rosenberg & Hinshaw, 2008). Coupled with this measure of social integration comes a measure of perceived social support – what resources can an individual gather from his or her social network (Cohen, 1985, 2004).
Access	The ability to get appropriate and prompt care when needed; traditionally defined in terms of insurance coverage and "usual" access to care, expanded definitions of access to care include geographic, temporal, and cultural dimensions (Bacus, 2008; Hall, Lemak, Steingraber & Shaffer, 2008). Atlantic Health adds in psychological and physical to this definition.
Vulnerability	Overall risk of poor physical, psychological and/or social health (Aday, 1994). Framed in the Community Psychology, this concept can be understood as overall risk factors. Vulnerability comes with an increased risk of morbidity and mortality (Shi & Stevens, 2010)

Health Risk Factors	Conditions that increase an individual's vulnerability to poor health or suboptimal outcomes during treatment and recovery. Risk factors can be genetic, biological, environmental, behavioral or psychological in origin (World Health Organization, 2009).
Stressor (Acute)	Incidents that are threatening or disruptive in the immediate situation. Under our healthcare framework, we are talking about the reason a patient comes to the hospital – his or her presenting complaint.
Stressors (Chronic)	More than the "hassles" of day to day life, these are the are negative forces whether at work, in the home environment, within relationships, or inside one's own body that cause a person to be constantly stressed (in a state of heightened arousal). Chronic activation of the sympathetic nervous system can leave us overrun, put us at higher risk for certain medical conditions, and impair our immune system's ability to function.

Our goal is to be able to assess individuals on each one of these elements before we begin an intervention, ideally at the assessment (diagnostic) phase. Their "Adaptability Index" score will give us an idea of the whole patient in ecological context, and thus better understand how they might interact with treatment recommendations. The initiative at hand is to create a measure with predictive validity (related to patient outcomes) so that we can risk-stratify our patients, giving necessary attention to potential high-risk patients and thus the ability to maximize their chance for the best outcome with lowest cost [value].

The *conceptual model* places our three elements—adaptability as a function of resilience and vulnerability—in dynamic proximity; a formula from the healthcare provider's vantage point in our case. As community psychologists we recognize the importance of other ecological perspectives, and the graphic below looks at adaptability in community context. Here we identify examples of both measures and resources that can address sources of community support, a critical buffer for many patients and their families. In addition to offering help with recover from illness or injury, these factors can increase resilience and reduce vulnerability when conditions recur, or when co-morbidities present new challenge.



First Steps on a Long Journey

No one ever said that making sustainable, second order change was easy in any organizational setting, let alone health care settings. With "eyes wide open" to wanted to align support for change by taking a number of critical baby steps. The first was to change the Mission Statement, adding those four foundational words: "…within a healing culture." Adopted with the approval of a ten year vision and strategic plan to get there, it had the unanimous vote of Atlantic Health System's Board of Trustees. What these four words would mean in practice on the other hand was somewhat of a leap of faith.

To manage the change process we had the active support of two important Trustees, the Chair, Karen Kessler, and another Trustee, Anne Rooke who chaired the Community Advisory Committee of one of our hospitals. She became our Board "champion," co-lead the process, came to every meeting, and could focus the attention of senior management because of her position and passion for this project. [In 2011 the New Jersey Hospital Association recognized Anne Rooke, RN, MSN as Hospital Trustee of the Year].

Supporting the process was the System President and CEO, and the Chief Administrative Officer. Establishing a sustainable healing culture was one of the System's annual strategic initiatives, and many in middle and senior management were evaluated and financially incented to a degree on achieving its objectives. [It may also be worth noting the both the President and CEO, Joseph A. Trunfio, Ph.D., and the senior author [WDN] are community psychologists.]

The table below was our "roadmap" for the 2011 initiatives that created the foundation for the Healing Culture programs. We share this format because the journey was a challenging one, and because the sequence of our "roll out" needed to be done in a thoughtful manner. We adopted a cascade model which we leveraged training and education, the launch of our new shared values [PRIDE], a video contest involving staff and units to illustrate their involvement in the PRIDE initiative, and activities involving community resources.

Healing Culture Roadmap

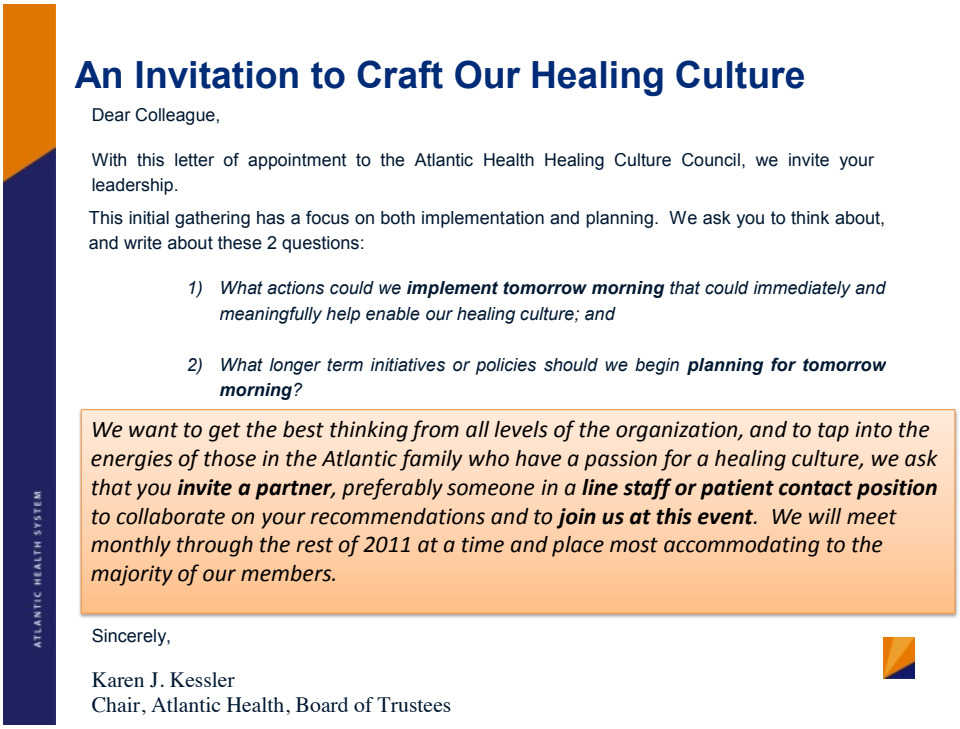
Atlantic Health System

Mission Statement	Mission Development	Performance Measurement
Deliver high-quality, safe, affordable patient care within a healing culture	2011 Healing Culture Initiatives	% Defining Healing Culture and their Roles
Educate, in an exemplary manner, present and future health care professionals	The expression of our Mission and Values is enabled through a Healing Culture in which we:	THRESH / TARGET / MAX
Innovate through leadership	- Share responsibility with patients, families and the community;	New Hires 75% / 80% / 90%
Improve the health status of the communities we serve	- Demonstrate respect for diversity through cultural competence;	Workforce
	- Embrace synergies among physical, emotional and spiritual healing connections;	Physicians 30% / 40% / 60%
AHS Family / Shared Values	- Recognize optimal well-being, prevention and health promotion as integral parts of the healing process.	Employees 50% / 60% / 80%
Employees and their families / New	2011 GOAL: Build foundational initiatives to enable a sustainable, system-wide healing culture.	Volunteers 60% / 70% / 80%
Med Staff & their families / Professionalism		
Volunteers & their families / Respect		
Board Members & their families / Involvement		
Community partners / Dignity		
Suppliers / Excellence		

2011 Initiatives	Leadership	Q1	Q2	Q3	Q4
Roll Out					
Board of Trustees	Anne Rooke				
Med Ex/Leadership	John Vigorita				
Leadership Counsel	William Neigher				
Employee Orientation	Lynn Turner				
PASTORAL CARE					
Multi-faith Counsel	Steve Alderson				
AH Consolidated Clinical Pastoral Education	Trish O'Keefe, MaryPat Sullivan				
Congregational Partnership					
CULTURAL DIVERSITY					
Cultural Competence (Clinical)	Deb Visconi				
Workforce Sensitivity	Alan Robinson, Team				
COMMUNITY HEALTH	Vicky Hughes, Joyce Passen				
ACCESS NOW [866.CallAHS]	Nancy Kaminski, Team				
INTERGRATIVE MEDICINE	Linda Reed				
BIOETHICS	Bioethics Council				
PALLIATIVE CARE	Team				
HUMANISTIC MEDICINE	Jeffrey Levine				
EMPLOYEE WELLNESS/HEALTH PROMOTION	Jan Schwartz-Miller				
COMMUNITY CONNECTIONS	Jan Schwartz-Miller				
VOLUNTEERISM	Lynn Turner				
NEWTON MEMORIAL HOSPITAL INTEGRATION	Andy Kovach				
AH EXPERIENCE (PRIDE)	Mark Holtz, Team				
HEALING ARTS	Marla Lupo				
BRAND IDENTITY	Mike Samuelson				
Website					
Marketing					
Brand Promise					
Brand Identity					

At the end of the day, all the support in the world from trustees and senior management will not sustain meaningful change in an organization, especially in hospitals where an inpatient may see from 95 to 135 different care providers during a typical four day admission. While most are our AHS employees, attending members of the medical staff are not for the most part, and their impact on patients and their families is obviously crucial. But so are line staff. These are the people in any organization who are the thought and opinion leaders, have the passion to lead and sustain change, and are often the role models that influence others.

We needed those people. In the words of our President and CEO we simply had to find them—everyone would know who they were—and empower them to make change. In the letter below from our Board Chair, Karen Kessler, we put out a call for those people:



An Invitation to Craft Our Healing Culture

Dear Colleague,

With this letter of appointment to the Atlantic Health Healing Culture Council, we invite your leadership.

This initial gathering has a focus on both implementation and planning. We ask you to think about, and write about these 2 questions:

1) *What actions could we **implement tomorrow morning** that could immediately and meaningfully help enable our healing culture; and*

2) *What longer term initiatives or policies should we begin **planning for tomorrow morning**?*

*We want to get the best thinking from all levels of the organization, and to tap into the energies of those in the Atlantic family who have a passion for a healing culture, we ask that you **invite a partner**, preferably someone in a **line staff or patient contact position** to collaborate on your recommendations and to **join us at this event**. We will meet monthly through the rest of 2011 at a time and place most accommodating to the majority of our members.*

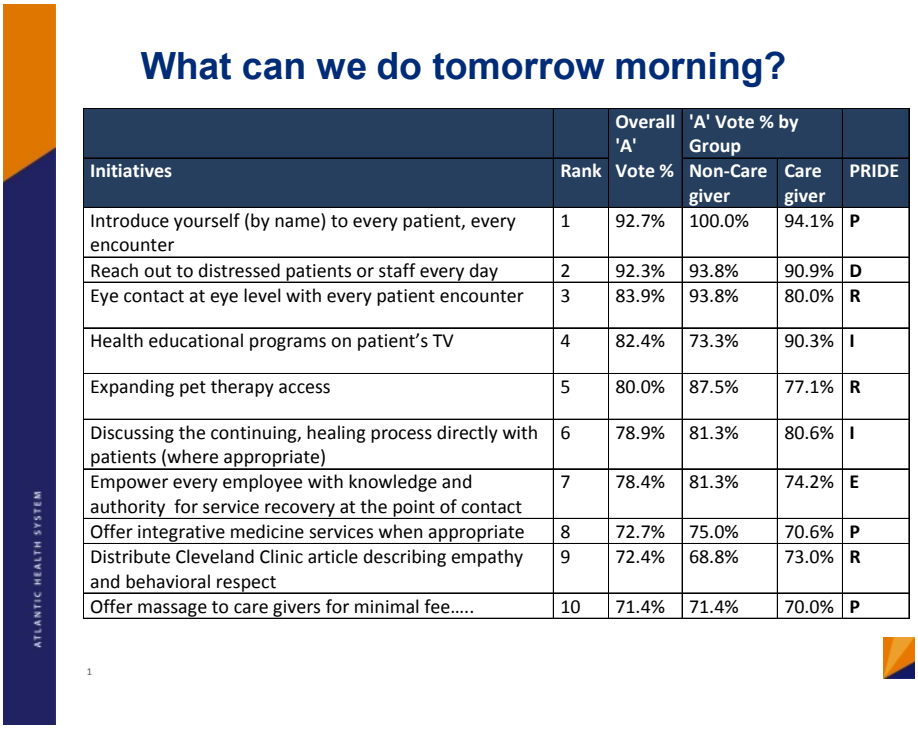
Sincerely,

Karen J. Kessler
Chair, Atlantic Health, Board of Trustees

ATLANTIC HEALTH SYSTEM

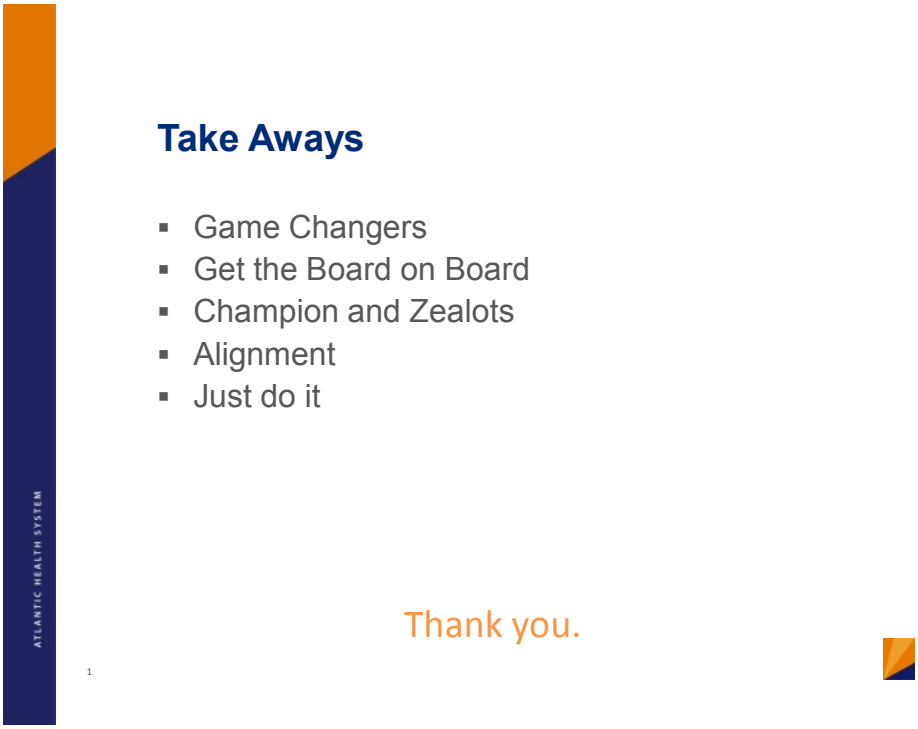
Now for the empowerment part: Before the initial meeting of Healing Culture Council we solicited ideas that could help us move forward. At the first session they were presented on slides without attribution—some were from a hospital president, some from a nursing assistant, others from non-clinical staff. Our "A" vote was for initiatives that we "could just do it;" it had merit, a burning platform, did not need tons of resources or permissions, and was consistent with our healing culture attributes. In fact, we could "just do it" Monday morning, the first day of National Hospital Week. [The "B" ranking category was for initiatives that may need more time and resources to complete, and the "C" category was for those cases where raters were unsure of the concept or didn't think it matched our criteria.]

Using audience response transmitters [Turning Point Technologies] we had our rankings after each item in under a minute each. The table below gives the rankings for those "A" votes getting more than a majority [50%], in descending order. It also categorized the vote percentages for those on Council who were bedside caregivers and those in support or administrative positions. The final column aligned the initiative with the corresponding PRIDE shared value.



Initiatives	Rank	Overall 'A' Vote %	'A' Vote % by Group		
			Non-Care giver	Care giver	PRIDE
Introduce yourself (by name) to every patient, every encounter	1	92.7%	100.0%	94.1%	**P**
Reach out to distressed patients or staff every day	2	92.3%	93.8%	90.9%	**D**
Eye contact at eye level with every patient encounter	3	83.9%	93.8%	80.0%	**R**
Health educational programs on patient's TV	4	82.4%	73.3%	90.3%	**I**
Expanding pet therapy access	5	80.0%	87.5%	77.1%	**R**
Discussing the continuing, healing process directly with patients (where appropriate)	6	78.9%	81.3%	80.6%	**I**
Empower every employee with knowledge and authority for service recovery at the point of contact	7	78.4%	81.3%	74.2%	**E**
Offer integrative medicine services when appropriate	8	72.7%	75.0%	70.6%	**P**
Distribute Cleveland Clinic article describing empathy and behavioral respect	9	72.4%	68.8%	73.0%	**R**
Offer massage to care givers for minimal fee…..	10	71.4%	71.4%	70.0%	**P**

Implementation Guiding Principles and Next Steps



This process is a journey as much as it is a destination. If we do not create sustainable second order change in our culture none of these initiatives will endure for very long. And there is much

in the organizational development literature to guide us. The five bullet points above capture our strategy:

1. Go for initiatives that can make major change quickly, consistent with the organization's Mission, Vision, Values and strategies;
2. Secure support from the Board of Trustees; they and other stakeholders must demand change and accountability for results;
3. Pick a champion who has the respect of the organization, and find those with the passion and leadership skills to make it happen;
4. Everyone needs to sing from the same hymnal; from the Board to senior management to line staff. Insure "line of sight" understanding for everyone of how this fits into my job, my work group, and #1 above; and
5. Identify consensus initiatives, demonstrate early success, remove the barriers, empower those who can get it done, and "just do it."

Our year two effort focuses on keeping our initiatives "evergreen"—sticking with those priorities that made the cut, celebrating small gains, providing immediate resources to make things happen, removing bureaucratic obstacles, and involving key stakeholders Trustees and Senior Management in supporting the process and the individuals who are our champions.

Our strategic initiatives as a healthcare system include partnerships with technology and software innovation leaders. An emerging discipline which we call ***"predictive assistance"*** is at the intersection of mobile health and telemedicine. It connects devices such as smart phones with real-time biometrics monitored by computer algorithms or oversight by clinicians. The difference between what largely exists *today*, the identification of symptomatic conditions, and the promise of predictive assistance is exciting: the ability to anticipate clinically meaningful biometry *before* the person experiences the symptoms, and to have the capability of early intervention [primary prevention].

We are also measuring process and early outcomes, trialing some initiatives at one of the three hospitals before system-wide implementation. Mid-course corrections are appropriate many times, but for others it is a "stay the course" bearing because it is simply "the right thing to do."

A good place to end is with a paraphrase of Margaret Meade's famous admonition: All it takes to change an organization's culture is a few committed individuals; in fact it has never happened any other way.

REFERENCES

Albee, G.W. (1982). Preventing psychopathology and promoting human potential. *American Psychologist*, 37, 1043-1050.

Aday, L. (1994). Health Status of Vulnerable Populations. *Annual Review of Public Health, 15,* 487-509.

Baucus, M. (2008). Call to Action: Health Reform 2009. Retrieved from: www.finance.senate.gov

Cohen, S. (2004). Social relationships and health. American Psychologist, 59, 676-684.

Cohen, S., Mermelstein, R., Kamarack, T., and Hoberman, H. N. (1985). Measuring the functional components of social support. In I. Sarason, and B. Sarason (Eds.), *Social support: theory*, *research and applications*. Dordrecht, The Netherlands: Martinus Nijhoff.

Connor, K. & Davison, R. (2003). Development of a New Resilience Scale: The Connor-Davidson Resilience Scale. *Depression and Anxiety, 18*, 76-83.

Curtis, W.J. & Cicchetti, D. (2003). Moving Research on Resilience into the 21st Century: Theoretical and Methodological considerations in examining the biological contributors to resilience. *Development and Psychopathology, 15*, 773-810.

Darwin, Charles Robert. *The Origin of Species.* Vol. XI. The Harvard Classics. New York: P.F. Collier & Son, 1909–14; Bartleby.com, 2001. www.bartleby.com/11/.

Hall, A., Lemak, C., Steingraber, H & Shaffer, S. (2003). Expanding the Definition of Access: It isn't just about health insurance. *Journal of Health Care for the Poor and Underserved, 19*, 625-637.

Luthar, S., Cicchetti, D. & Becker, B. (2000). The Construct of Resilience: A critical Evaluation and Guidelines for Future Work. *Child Development*, *71*(2), 543-562.

Masten, A. (2001). Ordinary Magic: Resilience Processes in Development. *American Psychologist*, *56*(3), 227-238.

Mitchinson, A., Kim, H., Geisser, M., Rosenberg, J. & Hinshaw, D. (2008). Social Connectedness and Patient Recovery after Major Operations. *American College of Surgeons, 206*(2), 292-300.

Patient Protection and Affordable Care Act, PL 111-148, March 23, 2010. http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ148.111.pdf

Shi, L. & Stevens, G. (2010). Vulnerable Populations in the United States. 2nd Ed. San Fransisco: Josey-Bass

World Health Organization (2009). Global Health Risks: Mortality and Burden of Disease Attributable to Selected Major Risks. WHO Library. Retrieved from http://www.who.int/healthinfo/global_burden_disease/GlobalHealthRisks_report_full.pdf

Zautra, A., Hall, J. & Murray, K. (2008). Resilience: A new integrative approach to health and mental health research. *Health Psychology Review, 2*(1), 41-64.