CHAPTER 2

Person-Centered Care

Jeana M. Holt, PhD, DNP, MSN, RN, FNP-BC, APNP

Introduction

What Matters to You?/What Is the Matter With You?

What emotions, feelings, or thoughts do these similarly worded phrases prompt? The first question, *What Matters to You?*, is an initiative that began in Scotland in 2016 to shift health conversations to listening and prioritizing what people want and need to achieve their best health. The second question, *What Is the Matter With You?*, still predominates health conversations in the United States. This chapter will explore the history of Person-Centered Care (PCC), its foundational concepts, applications, implications, and competencies. As you read the chapter, remember the image of a person surrounded by family, friends, and loved ones; surrounded by their neighborhood, work, and environment; surrounded by policies, government, and dominant cultural norms (see **Figure 2-1**). This chapter focuses on PCC, but advanced practice nurses (APNs) and those in advanced nursing practice specialties (especially those with a doctor of nursing practice [DNP] degree) must always understand that a person lives within a context that directly and indirectly affects their choices, opportunities, and health outcomes.

The National Academies of Medicine (NAM, 2001) (formally the Institute of Medicine) wrote a seminal book, *Crossing the Quality Chasm: A New Health System for the 21st Century*, that defined healthcare quality as effective, timely, efficient, safe, equitable, and patient-centered. However, there is a difference between patient-centered and person-centered care. Person-centered care is respectful and responsive to individual preferences, needs, and values, all pillars of nursing practice (Lauver et al., 2002). Emancipatory knowing is the human capacity to be aware of and critically reflect on the social, cultural, and political status quo and determine how and why it came to be that way (Chinn & Kramer, 2014). Emancipatory knowing calls for action to reduce or eliminate inequity and injustice. It validates that a person's context is central to a person-centered approach. The epistemology recognizes that social, political, economic, and gender injustices and professional forces support health and healing inequalities (Chinn, 2018). Current oppressive structures that exist in health care impede an individual's ability to engage in health-seeking and healthful

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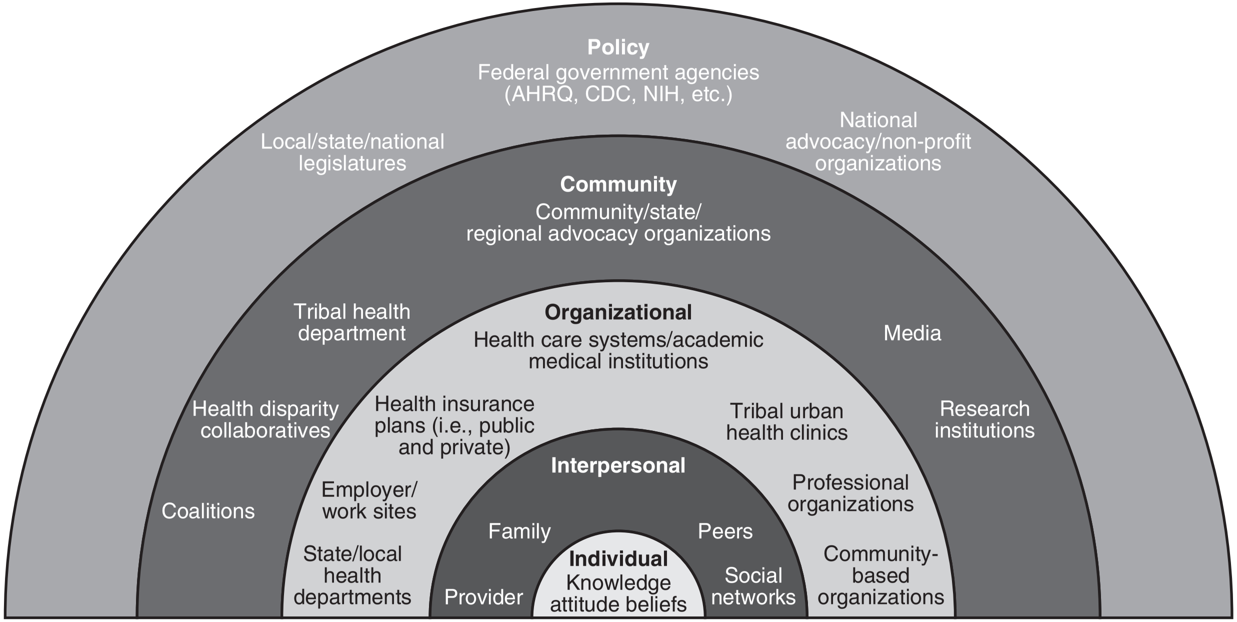


Figure 2-1 Socioecological Model of Health

Reproduced from Division of Cancer Prevention and Control, National Center for Chronic Disease Prevention and Health Promotion. (2011). *Social Ecological Model*. Retrieved from: https://www.ahrq.gov/prevention/resources/chronic-care/clinical-community-relationships-measures-atlas/ccrm-atlas3.html behaviors. Emancipatory knowing intends to uncover and resolve social, political, economic, and gender injustices to empower people to seek and obtain their authentic well-being (Chinn, 2018). Nursing research and practice involve discovering and ameliorating inequities and injustices (Chinn & Kramer, 2014).

Person-centered care is increasingly central in nursing research, practice, and health and social policy (Bolster & Manias, 2010; McCance et al., 2009; B. McCormack et al., 2020, 2021). Conceptually, person-centered care is receptive and tailored to the person's needs, based on developing respectful and dignified therapeutic relationships (NAM, 2001). Person-centered care upholds the person's desires, needs, and principles to guide care decisions, thereby improving the power imbalances inherent in the current healthcare system. Person-centeredness advocates that all individuals are on a journey of health and healing. Person-centered care must be discernible and received as caring by the recipient (Bolster & Manias, 2010; Sharp et al., 2016). Often, clinicians respect the person, but they do not recognize the need to acknowledge and ameliorate discriminatory influences on health as part of the person-centered care approach (Chinn, 2018). It is, therefore, necessary to integrate the theory of emancipatory knowing to critically reflect on the multidimensional influences that affect health equity (Chinn, 2018).

Background of Person-Centered Care (PCC)

Historical Perspectives of Person-Centered Care in Medicine, Health Policy, and Nursing

In Nightingale's (1859) *Notes on Nursing*, she instructs nurses to "always sit down when a sick person is talking business with you, show no signs of hurry, give complete attention and full consideration if your advice is wanted, and go away the moment the subject is ended" (pp. 23–24). These simple instructions laid the foundation for the next 150 years of discourse on the professional interactions between nurses and patients. Other professions joined the epistemology much later. Medicine's PCC roots began when Engel (1977) called into question the centuries-old practice of dualism, the separation of mind and body in physician practice. Health policy makers came to the conversation still decades later, as they acknowledged the disparity in health outcomes and cited PCC as a potential solution (NAM, 2001). During this evolutionary process, scholars used different terms (*individualized care*; *patient-, client-, and resident-centered care*; and *patient-, client-,* and *person-focused care*) with subtle contextual variances to describe the phenomenon (Hobbs, 2009; Kitson et al., 2012; Morgan & Yoder, 2012; Zhao et al., 2016). Some authors proposed that the discordant language and definitions stymied the understanding of the phenomenon (Hobbs, 2009; Mead & Bower, 2001; Robinson et al., 2008). The following brief history of PCC in medicine, health policy, and nursing highlights sentinel texts from each discipline and their influence on the philosophical posits of PCC.

History of Person-Centered Care in Medicine

The origins of medicine's Biomedical Model can be traced to the early 1500s. Two paradigms were active: Descartes' analytical philosophy, where the whole body may be understood by examining its parts, and the Christian Church which supported that the mind held the soul in its domain. The mind-body dualism prevailed until Engel (1977) disputed the separation of biological-psychological-social influences of health. Engel (1977) denounced, "The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in the psychological, social, and cultural as well as the anatomical, physiological, or biochemical terms" (p. 132). This call to rebuke the Biomedical Model laid the groundwork for PCC in medicine.

Stewart (1995) authored the foundational PCC reference in medicine. The systematic review of the literature reported six domains of patient-centered care: (a) exploring the experience and expectation of the disease; (b) understanding the entire patient; (c) the physician and the patient finding common ground regarding management; (d) incorporating health promotion and self-management in the consultation; (e) attending to the quality of the physician–patient relationship; and (f) setting realistic expectations of outcomes. In a later text, Stewart et al. (2000) clarified that within patient-centered care, a physician does not relinquish control to the patient; instead, the patient and physician come to a mutual understanding of the patient's needs and respond accordingly. Although the element of "control" retained by the physician appears contradictory to the ontology of PCC, Stewart and collaborators (2000) were among the first to associate improved health status and efficacy of care with patient-centered practice.

A decade later, a team of physicians published a definition of patient-centered care much closer to that of the nursing discipline. Levinson, Lesser, and Epstein's (2010) definition of patient-centered care is from the perspective of physician communication skills. Patient-centered care is "characterized by continuous healing relationships, shared understanding, emotional support, trust, patient enablement, activation, and informed choices" (p. 1311).

History of Person-Centered Care in Health Policy

The seminal work in promoting change in health policy is attributed to the National Academy of Medicine's (2001) book *Closing the Quality Chasm*. In this publication, patient-centered care "encompasses qualities of compassion, empathy, and responsiveness to the needs, values, and expressed preferences of the individual patient" (p. 48). The World Health Organization's (WHO, 2007) policy framework affirmed the NAM's definition and provided an antecedent perspective to patient-centered care. A person-centered approach recognizes the imperative to educate and empower people to foster and safeguard their health before they become patients (WHO, 2007). The WHO's (2007) policy framework outlines four domains to promote person-centered health care: (a) individuals, families, and communities; (b) health practitioners; (c) healthcare organizations; and (d) healthcare systems. Each domain includes a strategic plan to promote the ideals.

History of Person-Centered Care in Nursing

PCC's ontology originates in nursing. Florence Nightingale (1859) described the work of medicine as removing obstructions, and nature does the work of healing. The work of nursing "is to put the patient in the best condition for nature to act upon [them]" (Nightingale, 1859, p. 82). This premise underpins PCC. To know the best condition for each patient is to know the person, understanding their perspectives, values, beliefs, and experiences and honoring how the collective influences health and behaviors.

Person. In the PCC literature, authors rarely define *person*, but scholars may glean characteristics of personhood in nursing and health policy works. A person is a relational, multidimensional human being with the potential to change and develop through and with others at all stages of life (McCormack, 2003a; Peplau, 1997; World Health Organization [WHO], 2007). This composite definition respects personhood in the young and old when traditional societal views may negate a person at these life stages as an autonomous individual. It also affirms that humans are communal beings who develop as social exchanges occur.

Environment. The environment concerning PCC is the healthcare system. The location may be community based, in a primary care clinic, in a school, and/or an acute care setting. Ideally, the values, mission, and actors in a person-centered healthcare system regard and respond to individual preferences, needs, and beliefs in humane and holistic ways that are in harmony and balance with people and the environment (IOM, 2001; WHO, 2007).

Nursing. The nursing profession's definitions in the context of PCC have advanced over the last 150 years. Florence Nightingale (1859) laid the foundation when she adeptly defined nursing as "the proper use of fresh air, light, warmth, cleanliness, quiet and the proper selection and administration of diet—all at the least expense of vital power to the patient" (preface). Peplau added the dimension of bonding between the nurse and the patient. According to Peplau (1997), nursing is a practice-based science founded on an interpersonal relationship between nurse and patient to promote the individual's well-being. Lauver and colleagues (2002) expanded beyond the nurse–patient dyad. They wrote that "nursing recognizes the uniqueness of individuals and the multidimensionality of human experience" (p. 246). Nursing is a profession that respects and works with persons, families, and communities through services and interactions that support persons, families, and communities "in regaining, maintaining, and attaining the fullest health possible in biopsychosocial-spiritual dimensions" (Lauver et al., 2002, p. 247).

Health. The PCC literature is nearly silent on the construct of health. Nursing authors speak to health with the other metaparadigm concepts of nursing, person, and care environment. Drawing from these paradigms, Lauver and team (2002) provide a comprehensive definition of the nursing profession that embeds health. Health is the fullest possible biopsychosocial and spiritual dimensions one may achieve (Lauver et al., 2002). McCormack (2003a & 2003b) contributed to the nursing discipline and PCC when he identified gaps in nursing theory, research, and practice in the epistemology of PCC. McCormack's (2003a & 2003b) sentinel works astutely recognize *that context in which the person-centered exchange* has the greatest potential to enrich or constrain the relationship. The context includes the professional's practice, which transpires within the confines of norms, values, milieu, power differentials, and organizational structure tolerance for innovation.

Person-Centered Nursing Framework. In subsequent years, McCormack and McCance (2006) published a middle-range theory, a person-centered nursing framework, which is the first to evaluate outcomes of person-centered nursing. Morgan and Yoder (2012), similar to McCormack and McCance's (2006) four constructs of person-centered nursing, delineate three domains of person-centered care, identified as antecedents, attributes, and consequences. Morgan and Yoder's (2012) contribution to epistemology includes empirical referents used in international acute care settings that aim to measure the "phenomena that demonstrate the occurrence of the concept" (p. 11). They urge U.S.-based researchers and practitioners to test the utility of the instruments across healthcare settings to develop and refine the implementation and practice of PCC.

Kitson and colleagues (2012) narrative review of the core elements of PCC synthesized 60 texts from nursing, medicine, and health policy. Contrary to other reports, the recognized seminal PCC texts had similar epistemology across disciplines. Health policy makers, nursing, and medicine included foundational themes of (a) patient participation and involvement, (b) the relationship between the patient and health professional, and (c) the context where PCC is delivered. Differentiation between professions developed with an emphasis on broader systems-level and contextual aspects of provider–patient relationships in nursing and health policy literature and circumscribed physician–patient therapeutic relationships in medicine articles. More discreetly described in the nursing literature was adhering to patient beliefs and values, where medicine devoted more exploration to understanding informed decision making (Kitson et al., 2002).

Contemporary Definitions of PCC

Building on the historical perspectives of PCC, several tenets guide current conceptualizations of person-centeredness: treating patients as individuals; respecting personhood; creating mutual trust and knowledge; and developing therapeutic relationships (McCance et al., 2021). Person-centered practice begins with humanistic caring and empathic listening to understand and facilitate care that aligns with an individual's context, roles, experiences, concerns, values, and aspirations (Morris et al., 2022).

Selected Concepts for Nursing Practice Represented in the Domain

Communication

The AACN *Essentials* concept of communication is most clearly present in the PCC domain through the subcompetencies included for engagement to establish a caring relationship and communicating effectively with individuals. In their sentinel paper, Street and colleagues (2009) ask, *How does communication heal?* They describe the communication functions and pathways that lead to proximal, intermediate, and health outcomes. They identified six communication functions: information sharing, acknowledging emotions, managing uncertainty, nurturing therapeutic relationships, decision making, and fostering self-management. Although not stated in the paper, information sharing goes beyond facts about the individual in person-centered communication. It must include the sharing of individualized information, such as genetic/genomic, environmental exposure information, social and fiscal resources, values, goals, and beliefs. One study invited individuals to identify preferences, values, goals, and barriers to care before their primary care visit using a digital tool linked to their electronic health record (Holt et al., 2020). They found that the digital tool users indicated notable increases in specific Communication Assessment Tool (Makoul et al., 2007) items rated as excellent: treated me with respect, showed interest in my ideas, showed care and concern, and spent about the right amount of time with me (Holt et al., 2020) versus nondigital tool users. These findings align with the proximal outcomes Street and colleagues (2009) identified.

Intermediate outcomes of person-centered communication may include trust in the healthcare system, consistent engagement in self-management activities, emotional regulation, and commitment to the co-designed care plan (Street et al., 2009). Notably, mistrust of healthcare providers and healthcare systems stems from egregious historical trauma and research misconduct (Bowen et al., 2022). In a nationally representative sample of 1,003 U.S. Black and Hispanic households, over one-third of households who received health care within the last year reported experiencing racism in care. Underscoring the importance of person-centered communication, only one-third of Black and Hispanic individuals who experienced racism reported satisfaction with care and care quality.

Health outcomes of person-centered communication patterns may lead to health equity and justice. Street and colleagues (2009) propose that health, well-being, functional capacity, and vitality restoration stem from person-centered communication. The therapeutic relationship must support culturally affirming agency and self-efficacy to manage health and access resources, leading to enhanced capability and motivation to solve health-related problems, manage complications, and consistently engage with treatment.

Social Determinants of Health

Social determinants of health (SDOH) are the conditions in which "people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (Healthy People 2030, 2020). There is growing evidence that supports the remarkable sensitivity of health to the social and physical environment and political structures (WHO: Europe, 2003). Dagher and Linares (2022) recognize that the foundations of health begin before conception and are attenuated by early childhood experiences (Felitti et al., 1998), socioeconomic status, discrimination, working conditions, educational attainment, food access, and housing security (WHO: Europe, 2003). The environment and structures shape behavior, such as self-management practices, nutrition, physical activity, and substance use. Indeed, there is tremendous evidence that indicates that susceptibility to risk, healthcare choices, and health outcomes must be viewed with a systems-level lens and conditions within which people live, work, pray, and play (Prather et al., 2016). Furthermore, clinicians must acknowledge and reframe health inequities from race-based to racism-based disparities (Hardeman et al., 2020). For example, moving from a race-based statement, *Black pregnant people are at higher risk of preterm birth*, to a racism-based statement, the *lived experience of being Black in the United States puts Black pregnant people at higher risk of preterm birth* (Hardeman et al., 2020).

The healthcare system can prolong life and improve health in some conditions; however, the most impactful drivers of health stem from social and economic factors that make people ill in the first place (WHO: Europe, 2003). As nurses, we need to be cognizant of how people are affected by the context of their lived experiences. How is a person's living, working, and social conditions affecting their choices, behaviors, and health? Further, within the lived (and healthcare) experience, does the person feel heard, valued, and appreciated? How are we assessing them, and from whose perspective?

The AACN *Essentials* subcompetencies surrounding effective communication with individuals are imperative competencies in evaluating SDOH. Bourgois and colleagues (2017) challenge medicine to expand their assessment of social history beyond risk behaviors to acknowledge the impact of poverty, discrimination, and inequality on health. They highlight the overlapping and reinforcing power hierarchies (e.g., race, class, and gender), and institutional and political factors that inhibit healthcare access and the pursuit of healthy lifestyles (Bourgois et al., 2017). They developed a structural vulnerability assessment tool that assesses an individual's or a population's susceptibility to negative health outcomes by identifying eight domains of structural vulnerability, that is, financial security, residence, risk environments, food access, social network, legal status, education, and discrimination. In the healthcare environment, the structural vulnerability tool may lead to identifying susceptibilities and referring to mitigating resources. Although not explicit in their publication, personal agency must be included in a person-centered care environment to identify the desired intervention.

Risk Assessment Framework (2.9i)

The WHO's (2021) risk assessment framework defines *Risk* as the complex function of the probability of suffering harm or loss (adverse outcome) from exposure and susceptibility to some hazard. Applying this framework to the high rate of infant mortality in Milwaukee, WI (Capp, 2022), the risk is the scientific process of estimating the threat that hazards pose to adverse infant outcomes.

APNs/DNPs can use risk assessment to engage in risk management. First, identify what factors can be mitigated or managed. Second, focus on identifying predictors to address in the clinical and community settings. Third, share the assessment with community members and listen to their lived experiences. How do the patterns detected and health and risk factors identified align with their experience and goals for realigning or sustaining resources? See **Figure 2-2** regarding the complexity of

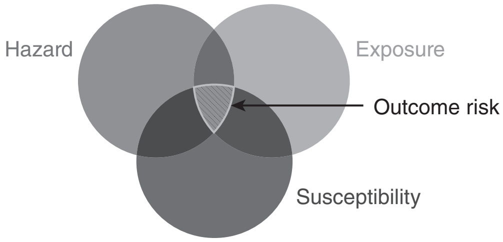


Figure 2-2 Risk = Complex Function of p[hazard] * p[exposure] * p[susceptibility]

Data from World Health Organization. (2021). Strategic toolkit for assessing risks: a comprehensive toolkit for all-hazards health emergency risk assessment. https://www.who.int/publications/i/item/9789240036086; Saulnier, D. D., Dixit, A. M., Nunes, A. R., & Murray, V. (n.d.). 3.2 Disaster risk factors – hazards, exposure and vulnerability. Retrieved March 20, 2023, from https://extranet.who.int/kobe_centre/sites/default/files/pdf/WHO%20Guidance_Research%20Methods_Health-EDRM_3.2.pdf risk assessment. The community-engaged participatory research method can build consensus for community-identified health and risk factor prioritization for intervention development (McFarlane et al., 2022; Parker et al., 2020).

The AACN *Essentials* concept of SDOH is also prominent in the competencies surrounding development of a plan of care and evaluation of care outcomes. How the SDOH concept impacts subcompetencies within these competencies is described with more detail in the following paragraphs.

Strengths-Based Person-Centered Care

Person-centered health approaches, including explicitly naming how social, environmental, and political structures impact the community's health (Bowen et al., 2022) and resilience, are needed to enable a holistic picture of health. A holistic perspective may advance health equity by focusing on how individuals and communities thrive despite historical and contemporary health challenges (Chae et al., 2021). A person's strengths and resilience must be a part of a person-centered health approach. Strengths include individual, family, and community assets, talents, and capabilities (L. N. Gottlieb, 2014; L. N. Gottlieb & Gottlieb, 2017). Resilience is a learned and adaptable skill that can reduce an individual, family, or community's susceptibility to risk experiences and achieve a relatively good outcome despite adversities, traumas, challenges, or setbacks (Rashid et al., 2014). Person-reported strengths and clinician support promote resilience and prepare individuals to encounter challenges adaptively (Rashid et al., 2014). However, surveys and research rarely gather these data (Chae et al., 2021).

We can draw on the tenets of the Person-centered Practice Framework (B. McCormack & McCance, 2006) when screening for the SDOH. To begin, ask permission to complete the screening using culturally affirming communication, (i.e., communicating in the most respectful and effective ways to the individual). Also, ensure the healthcare system completes universal screening using a validated instrument to avoid bias in practice (NAM, 2020). If the person discloses a need, discuss potential and desired interventions, including resource and referral options. The discourse should be held within a compassionate, caring, and honest therapeutic relationship (Johnson et al., 2022). Steeves-Reece and colleagues (2022) systematically reviewed the literature to identify facilitators and barriers to resource connections. The facilitators included relevancy of the referral to social needs and context, simple to navigate and prompt connection, and inclusive of multiple social needs. Barriers to resource connections were referrals that were inaccessible, irrelevant, or restrictive; fears surrounding stigma, discrimination, and immigration status; impersonal or disrespectful interactions; inadequate knowledge about or capacity to connect to the resource; and language, culture, or literacy barriers (Steeves-Reece et al., 2022).

Driven by the critical need to advance health equity, researchers are rapidly developing instruments to survey health influences and connect people to needed resources. In 2016, the University of California–San Francisco (UCSF) established the Social Interventions Research and Evaluation Network (SIREN) to curate, mobilize, and disseminate rigorous research and inform the use of SDOH instruments (L. Gottlieb et al., 2017). Clinicians and researchers can submit a SDOH instrument for consideration of inclusion on the SIREN website. SIREN displays the instruments' number of social and nonsocial needs items, language availability, readability level, time to complete, and cost information. Further, they identify if an instrument contains the item(s) that assess any SIREN-identified 32 SDOH domains (e.g., discrimination, financial strain, and interpersonal violence). These instruments enable the various collections of SDOH; however, they are not standardized and are rarely harmonized to provide comparable and shareable data across information systems (Freij et al., 2019). The EHR needs better methods to incorporate whole-person health, including SDOH and strengths.

A strengths-based assessment tool option is MyStrengths+MyHealth (MSMH), a person-centered HIPAA-compliant web-based health assessment application designed for individuals to self-identify health and healthcare strengths, challenges, and needs. It includes Simplified Omaha System Terms (SOST), which are community-validated plain language versions of the Omaha System (Austin et al., 2022). MSMH aligns with national initiatives prioritizing social determinants measures for EHRs as it is mapped within SNOMED-CT and LOINC to enable interoperability within existing electronic health system platforms (Dzau et al., 2021; Rasanathan, 2018). MSMH was developed by employing user-centered design principles and validated among a diverse population (Austin et al., 2021). Participants or their proxy complete the MSMH app on their devices such as smartphones, iPad, or tablets.

Participants answer health assessment questions to identify strengths, challenges, and needs based on 42 health concepts in the Omaha System (Martin, 2005). Within MSMH, Strengths are defined as a rating of 4 or 5 on a 5-point Likert-type scale for each concept (e.g., "how would you describe your income"). Challenges are defined as binary signs/symptoms for each concept (yes if selected, no if not selected). Needs are defined as binary interventions for each concept (e.g., hard to buy the things I need; yes, if selected, no if not selected). MSMH app can be tailored to the health concepts relevant to a population (Austin et al., 2021). Participants receive a unique identifier when they complete the application to facilitate the retrieval and revision of their data. Participants can print or save their responses as a PDF at the end of the survey.

Some healthcare systems have been challenged by the implementation of SDOH screening (Imran et al., 2022). Chagin and colleagues (2021) developed a sequential six-step process to screen for SDOH and referral to a service organization when necessary. Developed for the primary care setting, all individuals are screened, it is determined if they have social needs, and they are asked for consent for a referral to a service organization. The healthcare team places the referral, monitors if the service organization accepts the referral, and documents the outcomes of the referral (e.g., did the individual accept the referral?).

Health Policy

The AACN *Essentials* concept of health policy is most clearly present in the competencies associated with communicating effectively, evaluating outcomes of care, and provision of care coordination. Each of these competencies has subcompetencies closely related to creation and/or development of policy.

When Does Policy Inhibit or Create Barriers to PCC?

Inequities experienced by non-White and non-heteronormative populations are largely due to systematic and structural racism in policy (Nickitas et al., 2022; Prather et al., 2016; Williams & Collins, 2001; Williams & Mohammed, 2013;

Yearby et al., 2022). Systematic and structural racism are "forms of racism that are pervasively and deeply embedded in systems, laws, written or unwritten policies, and entrenched practices and beliefs that produce, condone, and perpetuate widespread unfair treatment and oppression of people of color, with adverse health consequences" (Braveman et al., 2022, p. 171). Racially based socioeconomic and health inequities persist due to well-entrenched, unequal systems that uphold the legacy of overtly discriminatory practices, policies, laws, and beliefs (Yearby et al., 2022). These discriminatory legacies deny certain groups access to living wage jobs with benefits; safe neighborhoods; home ownership; high-quality education; accessible and acceptable health care; and fair treatment by the criminal justice system (Bailey et al., 2017; Gee & Ford, 2011; Williams et al., 2019; Yearby et al., 2022). There are many examples. Gee and Ford (2011) and Yearby and colleagues (2022) discuss over 30 racial and ethnic policies and actions, beginning in the 1700s, whose legacies maintain health inequities.

The path forward requires interventions at the individual, systems, and societal levels. The social ecological model (Bronfenbrenner, 1977) indicates that multilevel interventions yield greater and more sustainable benefits than interventions aimed at one level of influence (L. McCormack et al., 2017). Devine and colleagues (2012) reported on the success of a multifaceted program designed to decrease individual implicit biases by introducing multiple strategies to increase awareness of individual and societal biases. Results indicated that non-Black undergraduate student program participants sustained a reduction in implicit biases for at least three months after the program started (Devine et al., 2012). Additional implicit bias tests and training for healthcare providers are discussed later in this chapter.

Healthcare systems can review their policies and procedures to evaluate if they disenfranchise certain groups. Consider RC, who uses public transportation to travel to their clinic appointment from their place of employment. How could a late policy that states a person needs to reschedule if they are 15 minutes late to an appointment disadvantage people who use public transportation? Another example is the use of clear language principles across written and digital materials (Baur & Prue, 2014; L. McCormack et al., 2017). One principle is to prepare written materials at a seventh-grade reading level or less (National Institutes of Health, 2015). A 20-year review of patient education materials published in high-impact journals found the mean range of materials was approximately 11th to 14th grade (Rooney et al., 2021). The inability to understand written health materials has been linked with decreased self-management, reduced health engagement activities, and increased health disparities (Landis, 2021; Monsen et al., 2015; Rush et al., 2021).

Health policies at the state and national level also impact health outcomes. The Kaiser Family Foundation maintains a postpartum Medicaid extension coverage website (Medicaid Postpartum Coverage Extension Tracker, 2022) that illustrates states' postpartum Medicaid coverage. Twenty-seven states (as of 12/06/2022) have extended Medicaid coverage, and seven plan to implement extended coverage to one year postpartum. Wisconsin's Medicaid policy extends postpartum coverage to 60 days after birth, with an extension to 90 days under review in the legislature.

National organizations (e.g., American Association of Colleges of Nursing, 2021; NAM, 2021) call upon nurses to lead and advocate for policy changes. To do so, APNs/DNPs can review policies with a critical lens to evaluate how they impact the health of the people within their practice and organization (e.g., housing policies, and institutional policies). DNP-prepared nurses can also advocate for change by assuming leadership positions on boards at the local, state, and national levels (Ellenbecker et al., 2017). Nurses must take an ecological and holistic perspective toward policy change, including advocating for improving the quality of housing, food access, and neighborhood environments, access to financial opportunities, quality education, and accessible health care (Yearby et al., 2022). Remember that multilevel policy changes make the most impact on improving health outcomes (L. McCormack et al., 2017). Refer to Nethers and Milstead (2022) for a comprehensive review of the political process for nurses.

Level II Competencies of the Domain

Engage With the Individual in Establishing a Caring Relationship

Promote and Foster a Caring Relationship Through Empathy and Compassion and Facilitate Difficult Conversations

Empathy is a requisite of person-centered care and communication (Levett-Jones & Cant, 2020). It is a multidimensional construct that includes cognitive, affective, and behavioral elements (Everson et al., 2015). Levett-Jones and Cant (2020) describe a three-stage process of the empathy continuum used to establish a caring relationship. In the perceiving stage, the nurse senses the individual's emotional state. Then, using past and current reflections of personal biases, prejudices, and judgments, they must suspend these thoughts to be present unconditionally. During the processing stage, the nurse is respectfully curious about the person's experience and how the experience shapes the person's story. Finally, the responding phase is an altruistic expression of concern and offer of assistance to ameliorate suffering. The expression of concern includes active listening, being present, reflective listening, summarizing what was heard, and engaging in actions supporting the alleviation of suffering and promoting health and well-being. In other models, the responding stage is defined as compassionate care (Sinclair et al., 2017). Also, during the responding phase, the nurse engages in self-reflection to learn and improve empathetic skills going forward (Levett-Jones & Cant, 2020).

Sinclair and colleagues (2017) interviewed 53 individuals in advanced stages of cancer. The study compared and contrasted individuals' palliative care experiences of sympathy, empathy, and compassion. Participants described sympathy as receiving pity about regrettable circumstances and a shallow and superficial emotional response by the observer. Sympathy was always viewed as a negative care experience. Examples of sympathetic responses included, "I am so sorry" and "That must be so awful for you." Palliative care recipients positively viewed empathetic conversation, characterized by an affective response that recognizes and tries to comprehend an individual's experience through emotional resonance (Sinclair et al., 2017). Examples of empathetic responses included, "Help me understand your experience" and "I get the feeling that you are frustrated with your situation." Compassionate care builds on an empathetic response in an attempt to relieve suffering through actions (see **Figure 2-3**). Individuals receiving palliative care lauded compassionate care as

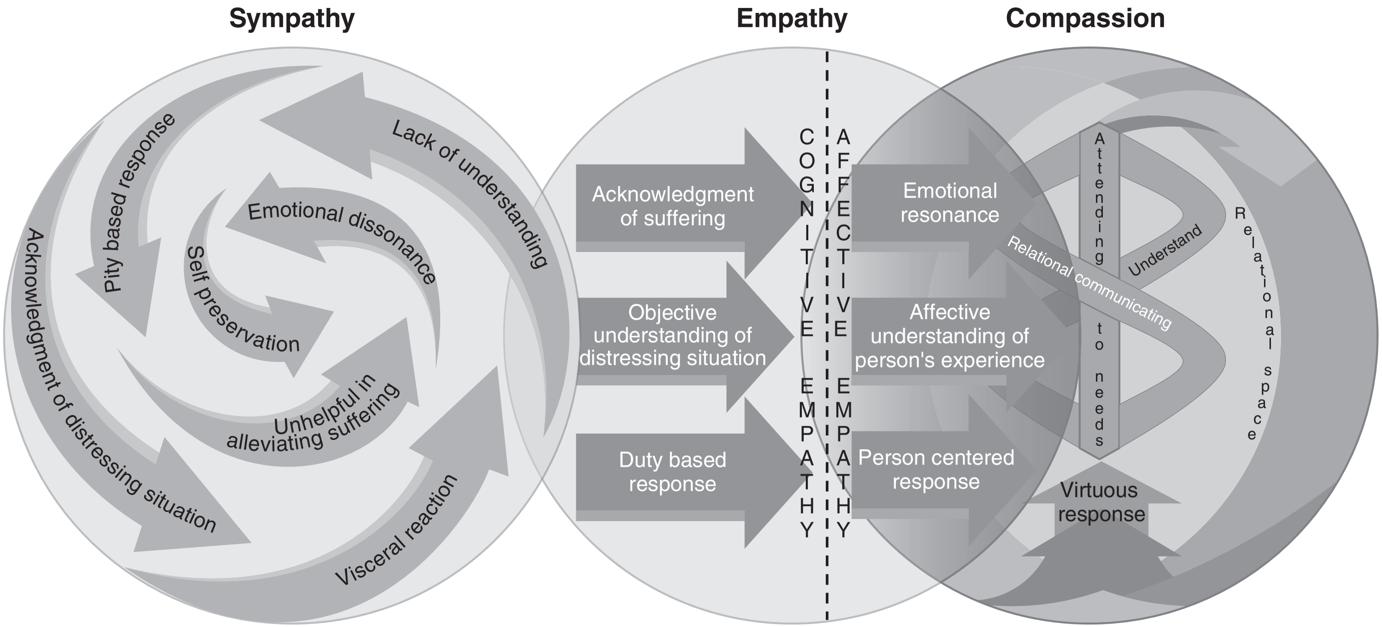


Figure 2-3 Sympathy, Empathy, and Compassion

Reproduced from Sinclair, et al., (2017). Sympathy, empathy, and compassion: A grounded theory study of palliative care patients' understandings, experiences, and preferences. *Palliative Medicine, 31*(5), 437–447. https://doi.org/10.1177/0269216316663499 the highest level of care. Examples of compassionate statements included, "I hear you saying . . . Would you be open to . . . ?" "I see that you are uncomfortable. How can I help you to feel more at ease?" (Sinclair et al., 2017).

To gain competency in establishing caring relationships with individuals, consider how you feel, engage, and react with interacting with others. A sympathetic reaction may be a coping mechanism used when the clinician feels inadequately prepared to address situational suffering (Sinclair et al., 2017). Empathy and compassion are a continuum of care valued by most individuals. In an empathic relationship, the clinician can share feelings of joy or suffering with an individual without losing perspective between self and individual (Singer & Klimecki, 2014). Singer and Klimecki (2014) propose that compassion is a protective action when a clinician feels concerned for another and is motivated to help. Clinicians can also practice being compassionate through meditation and other wellness activities.

In Fredrickson and colleagues' (2008) sentinel randomized control trial, they trained adults to become more compassionate using loving-kindness meditation. The one-hour per week for seven-week intervention consisted of 15 minutes of group meditation, 20 minutes of group sharing, and 20 minutes of education on how to apply mediation principles in daily life. The group meditation is built from directing love and compassion toward oneself to loved ones, acquaintances, strangers, and all living beings. The researchers predicted that as participants became skilled in loving-kindness meditation, they would experience more positive emotions, improving mental health and life satisfaction. The results indicated that the one-hour a week of loving-kindness meditation improved various positive emotions and interactions with others (Fredrickson et al., 2008). Refer to the Greater Good Science Center at the University of California Berkeley website to listen to the audio and read the loving-kindness meditation script (University of California Berkeley, 2022).

Communicate Effectively With Individuals

Create Cultural Safety Through Demonstration of Advanced Communication Skills and Techniques and Designing Evidence-Based, Person-Centered Engagement Materials

Recall when you were a "patient" in the healthcare system. Did the provider give you time to explain your priorities, values, or goals? Did they ask you about your agenda for the visit? Unfortunately, research results inform us that only 36% of clinical encounters include elicitation of the patient's agenda (Singh Ospina et al., 2019). When clinicians asked, the patient was interrupted 70% of the time, with a median time to interruption of 11 seconds. Furthermore, when the patient was uninterrupted, they completed their statements in a median of 6 seconds (Singh Ospina et al., 2019). Remember these startling statistics the next time you communicate with a person who is sharing their priorities, values, or experiences with you.

Actively listening to people is one step in establishing cultural safety. Cultural safety is when a person enters a health service, developed by someone of a different age, culture, race, ethnicity, gender, sexual orientation, (dis)ability, and/or belief structure, without the person losing their self in the process (Papps & Ramsden, 1996; Ramsden, n.d.). The person feels safe to authentically and fully engage in the therapeutic relationship to promote or restore their health. An outcome of cultural safety is clinician recognition and valuing of an individual's historical and personal narratives (Mukerjee et al., 2021).

Consider this clinical scenario adapted from The Fenway Institute (2015). Oscar is a 22-year-old Salvadorian female-to-male transgender person. Oscar has not had gender-affirming surgery or hormone therapy. Since arriving in the United States about 4 years ago, he has been a bartender in a nightclub. He has been with the same sexual partner for the past 6 months. Today he is visiting the clinic after taking a home pregnancy test, which was positive. Oscar is uninsured and an undocumented immigrant.

Take a moment to reflect on your assumptions or thoughts when you read this scenario. What mental imagines come to mind? How would you introduce yourself to Oscar? How would you ask Oscar to introduce himself? How can your (re)actions and words establish a culturally safe encounter? Clinician language and communication can support or hinder cultural safety. At the beginning of an encounter, a clinician may introduce themself using the following model: "Hi, my name is Dr. Jeana Holt; I am a family nurse practitioner. I use she/her pronouns. Please call me Jeana. What name and pronouns would you like me to use today?" (Mukerjee et al., 2021; Roe & Galvin, 2021).

Use Person-First Language by Applying Individualized Information in Delivery of Personalized Health Care

Creating a safety culture through language extends to using people-first language.

Compare these descriptors:

- Diabetic vs. A person with diabetes
- Schizophrenic vs. A person with schizophrenia or a person with a mental health illness
- Nonadherent/Noncompliant vs. acknowledging the social and structural barriers to health
- Disabled vs. A person with dwarfism

Person-first language is founded on the principle that people are more than a condition, disease, (dis)ability, social class, race/ethnicity, or other characteristic (Dawkins & Daum, 2022). Acknowledging the holism of a person is critical for building and maintaining a culturally safe and therapeutic relationship. Using identify-first language has resulted in medical mistrust, decreased patient satisfaction, decreased engagement in care, and increased healthcare costs (Dawkins & Daum, 2022). Therefore, the words APNs/DNPs use must convey respect, cultural safety, and inclusion. Person-first language also aligns with the recommendations of trauma-informed care (Ravi & Little, 2017; Schimmels & Cunningham, 2021; Substance Abuse and Mental Health Services Administration, 2014).

Trauma-Informed Care as Part of Demonstration of Advanced Communication Skills and Techniques

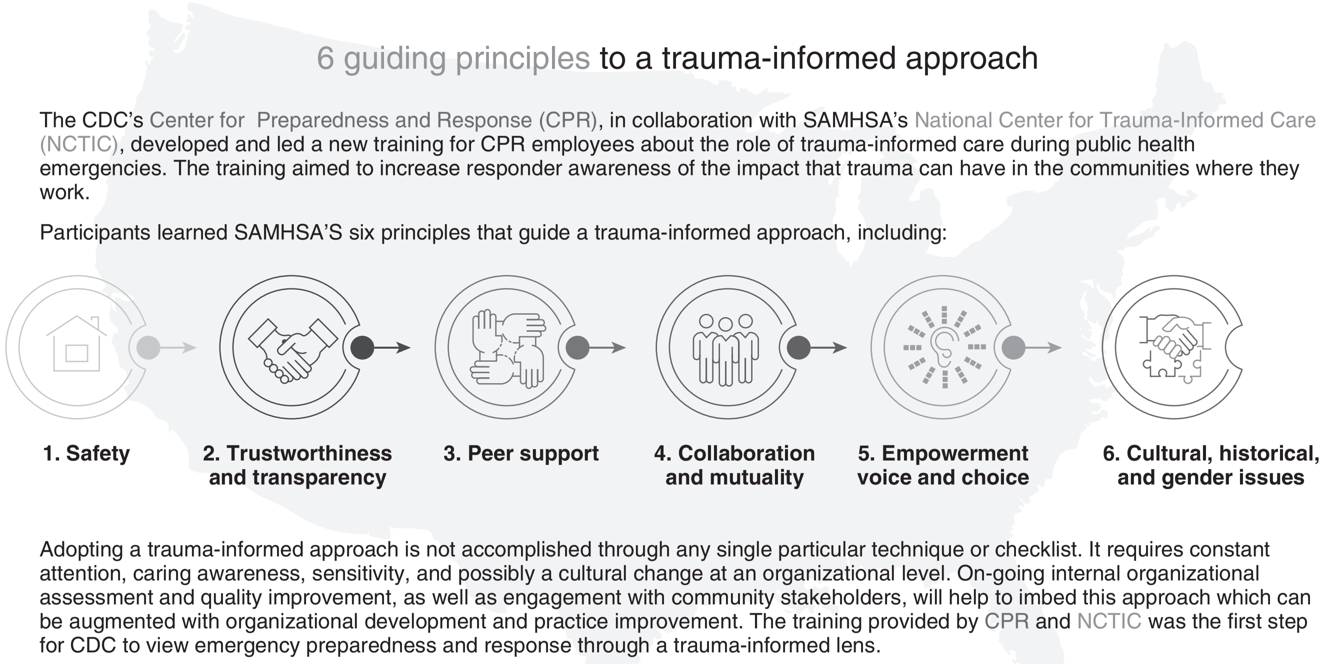
Substance Abuse and Mental Health Services Administration (SAMHSA) provides healthcare organizations and clinicians with a trauma-informed approach to care that can be applied to all clinical encounters (SAMHSA, 2014). The framework consists of four pillars and six key principles. A trauma-informed organization *realizes* the insidious impact of trauma and various paths for recovery; *recognizes* the diverse signs and symptoms of trauma in individuals, families, clinicians, and others involved with the system; and *responds* by developing policies, procedures, and practices that acknowledge the widespread impact of trauma and *resists* retraumatizing those involved in the system (SAMHSA, 2014). Six key principles are fundamental to a trauma-informed approach, including establishing and maintaining safety, trustworthiness, and transparency; peer support; collaboration and mutuality; empowerment of voice and choice; and recognizing and validating cultural, historical, and gender experiences. In this context, establishing and maintaining safety and trustworthiness is the sense of physiological and psychological security (SAMHSA, 2014).

In a trauma-informed and culturally safe healthcare system, the organization and clinicians are transparent in building and maintaining trust with the person. Using a trauma-informed approach, clinicians validate past and current cultural, historical, and gender experiences and avoid retraumatizing the individual (Ravi & Little, 2017; Schimmels & Cunningham, 2021; SAMHSA, 2014). Empathizing and validating a person's experience with the healthcare system can also build trust. If someone discloses a negative healthcare experience, a clinician may respond, *I hear that you are angry and frustrated with how the clinicians treated you during your recent hospital stay*.

Clinicians recognize that trauma and chronic stress may present as alterations in sleep, appetite, libido, mood, and energy. Somatic symptoms may also occur such as nausea, headaches, and chest tightness. People may self-manage their symptoms by overexercising, restricting food or types of foods, or using alcohol, tobacco, or other substances (Ravi & Little, 2017).

A trauma-informed approach also recognizes the power relationships among the individual and clinician, the individual and health system, and the clinician and the health system. Please see **Figure 2-4** for principles of a trauma-informed approach. Clinician's actions can minimize the power differential, for example, sitting down, maintaining eye contact, and actively listening to the individual. Clinicians can also offer options during the interview and exam. For example, being alone or with a support person, using an interpreter, and ensuring that the individual knows their agency to decline to answer questions or decline portions of the exam (Ravi & Little, 2017). Clinicians can also be transparent about why they ask certain questions during the interview process. Mukerjee et al. (2021) offer the following phrasing when taking a sexual health history, "I ask all of my patients about their sexual activity so that I can make better recommendations about each person's sexual health" (p. 76).

Healthcare systems can offer peer support from trauma survivors to assist with establishing safety, hope, trust, collaboration, and healing (SAMHSA, 2014). Collaboration and mutuality begin with asking about priorities, values, and goals of care. *What would you like to discuss during this visit? What are your health goals? Which one is your priority? Who or what can support you to achieve and maintain that goal? Let's discuss the best ways that I can assist you.* The organization and staff practice a strengths-based resilience approach to empower and elevate the individual's voice and choices to engage in healing. The organization and clinician acknowledge their biases and actively work to move past their cultural, historical, and gendered assumptions to provide cultural and gender-affirming services that recognize and address historical trauma.



6 guiding principles to a trauma-informed approach

The CDC's Center for Preparedness and Response (CPR), in collaboration with SAMHSA's National Center for Trauma-Informed Care (NCTIC), developed and led a new training for CPR employees about the role of trauma-informed care during public health emergencies. The training aimed to increase responder awareness of the impact that trauma can have in the communities where they work.

Participants learned SAMHSA'S six principles that guide a trauma-informed approach, including:

1. Safety

2. Trustworthiness and transparency

3. Peer support

4. Collaboration and mutuality

5. Empowerment voice and choice

6. Cultural, historical, and gender issues

Adopting a trauma-informed approach is not accomplished through any single particular technique or checklist. It requires constant attention, caring awareness, sensitivity, and possibly a cultural change at an organizational level. On-going internal organizational assessment and quality improvement, as well as engagement with community stakeholders, will help to imbed this approach which can be augmented with organizational development and practice improvement. The training provided by CPR and NCTIC was the first step for CDC to view emergency preparedness and response through a trauma-informed lens.

Figure 2-4 Six Guiding Principles to a Trauma-Informed Approach

Reproduced from CDC (2022). *Office of Readiness and Response Infographic Six Guiding Principles to a Trauma-Informed Approach* https://www.cdc.gov/cpr/infographics/6_principles_trauma_info.htm

Originally published in 2004, the Primary Care Post-Traumatic Stress Disorder (PC-PTSD) screen was developed and tested with 188 U.S. Veterans to detect PTSD in primary care clinics with limited time and resources (Prins et al., 2004). The screener includes four items with yes/no response options beginning with the following statement,

> In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:
>
> 1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?
> 2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?
> 3. Been constantly on guard, watchful, or easily startled?
> 4. Felt numb or detached from people, activities, or your surroundings?
>
> (Prins et al., 2016) and colleagues updated the screener in 2016 to align with the DSM-5 (PC-PTSD-5). They added an introductory item,
>
> Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:
>
> - a serious accident or fire
> - a physical or sexual assault or abuse
> - an earthquake or flood
> - a war
> - seeing someone be killed or seriously injured
> - having a loved one die through homicide or suicide.
>
> Have you ever experienced this kind of event? YES / NO
> If no, screen total = 0. Please stop here.
>
> If the respondent answers “Yes” they answer five items. Four of the items are consistent with the PC-PTSD, with the fifth item being,
>
> **In the past month, have you . . .** Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

If a respondent endorses a trauma exposure in the initial statement, they can score a 0–5 on the PC-PTSD-5, which is one point for each of the affirmative responses to the five subsequent items. Tested in a sample of approximately 400 primary care–seeking veterans, a cut-point of four balanced false negatives and false positives for the overall sample and for men (Bovin et al., 2021). However, for women, a cut-point of three resulted in a better fit. The researchers advised clinicians to adjust the cut-point depending on the sample characteristics and screening purposes (Bovin et al., 2021). For people who meet the cut-point, a referral to a mental health professional trained in trauma-informed care is warranted.

The PC-PTSD and PC-PTSD-5 have been tested in non-veteran populations. The PC-PTSD-5 maintained strong and similar diagnostic accuracy within a middle-aged (M=40.97 +/− 17.03 years) civilian primary care sample (Williamson et al., 2022).

However, the PC-PTSD had poor diagnostic accuracy among college-age students (Hawn et al., 2022). All people who have experiences trauma should be screened for suicidal ideation. Panagioti and colleagues (2009), in their narrative review explain the relationship between PTSD and suicidal thoughts and behaviors, cautioning clinicians to note that comorbid depression increases the effect of PTSD on ideation and behaviors.

The staff at the U.S. Department of Veteran's Affairs developed the tool, which is in the public domain and not copyrighted. You may access it and publications at the PTSD: National Center for PTSD (n.d.) website.

Implicit Bias as Related to Advanced Communication Skills and Person-Centered Engagement Materials

Implicit bias is a human condition where people unconsciously assign judgments to a person or group based on their overt or perceived characteristics and past experiences (Narayan, 2019). It occurs across professions, but when healthcare professionals hold negative implicit biases, they contribute to healthcare disparities (FitzGerald & Hurst, 2017). Care recipients also notice. Blair and colleagues (2013) evaluated providers' level of implicit ethnic/racial bias and patients' perceptions receiving person-centered care. Individuals who rated their provider lower on "person-centeredness" (e.g., interpersonal communication, trust, knowledge, and treatment) received care from providers who had more implicit bias. Bias may be experienced by members of the nondominant race, ethnic groups, or religious minorities (Narayan, 2019). Other populations may also experience discrimination based on sexual orientation, gender identification, (dis)ability, social class, level of education, or stigmatized diagnoses (e.g., obesity or mental illness) (Narayan, 2019). To fulfill the goal of providing person-centered care, nurses must be conscious of thoughts and actions that impart a negative evaluation of an individual who is connected to membership of a group or to a certain characteristic (FitzGerald & Hurst, 2017).

The first step is to recognize implicit bias and acknowledge the harms that arise when implicit bias occurs within the healthcare system. To recognize implicit bias, Project Implicit (n.d.) offers 15 Implicit Association Tests (IAT) that measure the strength of associations between concepts (e.g., dark skin, gender-career, young-old) and evaluations (e.g., good, bad, neutral) or stereotypes (e.g., athletic, smart, frail). The results may reveal unconscious biases that the participant holds. Once known, individuals can begin to resolve implicit biases by taking implicit bias training, mandated in some states for healthcare professionals (Cooper et al., 2022). There are many free implicit bias training opportunities for healthcare professionals. One example is the UnBIASED Project, which is funded by the National Library of Medicine (NLMR01LM013301) to help reduce health disparities by improving patient–clinician communication for low-income, racially diverse patients in primary care (Hartzler, 2019). The Think Cultural Health website from the National Institutes of Health provides a free 2-hour online training for healthcare providers and students to increase their skills and knowledge for cultural humility, person-centered care, and combating implicit bias across the care continuum of maternal health (Maternal Health Care, n.d.). The Kirwan Institute has a free online five-module course that assists participants with understanding the origins of implicit associations (The Ohio

State University, n.d.). The University of California–Los Angeles has an implicit bias video series (University of California Los Angeles, n.d.) and Project READY: Reimagining Equity & Access for Diverse Youth hosts a series of free, online professional development modules for people interested in improving their knowledge about race and racism, racial equity, and culturally sustaining pedagogy (Project READY: Reimagining Equity & Access for Diverse Youth – A Free Online Professional Development Curriculum, n.d.). APNs/DNPs can also develop evidence-based materials with diverse groups to ensure the person-centered materials are culturally affirming.

Implicit Bias Activity

Directions: Read the following five clinical scenarios and answer the reflection questions.

Scenario 1. Anita is a 30-year-old working single mother of a 3-year-old son and is expecting a second child (36 weeks pregnant). She needs to be screened for group B streptococcus (GBS) during this prenatal visit. Anita discloses that she has not felt the baby move in the last 24 hours. Anita is worried that there is something wrong with the baby.

Scenario 2. Jan, a 22-year-old, married woman, is 24 weeks pregnant, and presenting to the clinic today for a routine prenatal visit. She is 5 feet, 2 inches tall, and weighs 260 pounds. Her BMI is 48. Upon review of her electronic health record, you note her blood pressure was 150/111 mm Hg (normal <130/80) at her last visit 4 weeks ago and is 163/105 mm Hg today. You are concerned about a new diagnosis of pre-eclampsia and/or the potential to develop HELLP. Jan has difficulty transitioning from the chair to the exam table due to joint pain and lower extremity edema.

Scenario 3. Hailey, who is 29 weeks pregnant, received blunt-force trauma to her abdomen during an argument with her boyfriend. She has no obvious injuries and denies pain and vaginal bleeding. Hailey has two other children present at the visit, ages, 2 and 4 years. She is not currently working and receives food supplements from the Women, Infants, and Children (WIC) program.

Scenario 4. Shafaq Zahra, a 24-year-old woman, presents to a mobile clinic for a postpartum visit six weeks after the birth of her third child. Her children are 24 months, 12 months, and 6 weeks. She immigrated to the United States four years ago from Iran and identifies as a devout woman of the Shia tradition. She is wearing a hijab and requests only female clinicians and an interpreter.

Scenario 5. Jenny (she/her/hers), a 25-year-old male-to-female transgender person, wants to investigate the services that you provide. She has not legally changed her name, so her documents display her birth name, James. She is new in transition, dressed in t-shirts and jeans, and still produces facial hair (which is exposed). She appears to be shy, jittery, and very nervous, and does not look anyone in the eyes. Jenny had unprotected sex one week prior and is concerned about her HIV status.

Implicit Bias Self-Reflection Questions

- What are my mental models and assumptions that I employed when reading the scenarios?
- Where do I derive my assumptions (previous healthcare interactions, social/political influences, parental/familial norms, media portrayals)?
- How can I view an individual as a "whole person"?

Integrate Assessment Skills in Practice

Patient-Centered Assessment Method to Demonstrate That One's Practice Is Informed by a Method Appropriate to Function in Advanced Nursing Practice

The Patient-Centered Assessment Method (PCAM) identifies an individual's biopsychosocial complexities to facilitate referral to the appropriate services (Pratt et al., 2015; Scored, n.d.; Yoshida et al., 2017). It includes four domains: health and well-being, social environment, health literacy and communication, and service coordination. PCAM has good reliability and validity, tested internationally (Yoshida et al., 2017) and in primary and acute care settings (Pratt et al., 2015; Yoshida et al., 2017). In a Japan-based study, higher levels of biopsychosocial complexity were positively correlated to longer hospital lengths of stay. The researchers advised that addressing the biopsychosocial concerns early in the acute care stay may assist in a timely discharge (Yoshida et al., 2017). In primary care–based studies in Scotland, the implementation of the PCAM correlated with decreases in medical referrals and increases in psychological, social, and lifestyle referrals (Pratt et al., 2015). However, the researchers noted that the referral increases did not overburden the system. Nurses involved in the study reported feeling supported by a network of health systems and community-based organizations. People were forthright and willing to discuss their challenges and accepted referrals to organizations that may assist with their needs (Pratt et al., 2015).

Clinical Scenario. Rolonda is a 22-year-old who identifies as a Black woman. She presents to the clinic six days after giving birth via cesarean section. She reports feeling tired and warm and has little to no appetite. She brings her 6-day-old son with her, whom she is breastfeeding. Rolonda is concerned that he is not latching well. The APN notes that his birth weight was 8 lbs., 0 oz, and today he weighs 7 lbs., 1 oz. Rolonda does not have any help at home and is feeling overwhelmed and exhausted.

Using the four domains of PCAM—health and well-being, social environment, health literacy and communication, and service coordination—how should the APN begin the visit? It is essential that the clinician create a caring environment that provides privacy and builds trust. The APN should sit down and actively listen while acknowledging and validating Rolonda's feelings and concerns. As part of the therapeutic discourse, the clinician can ask how they may assist Rolonda to alleviate some of her sufferings. The APN can further explore Rolonda's social environment using the principles of SAMSHA's Trauma-Informed Care (TIC) framework (SAMSHA, 2014). Using a validated instrument, the care team can assess service coordination needs and referral to resources. During the physical exam, the APN can exemplify actions in the Person-Centered Nursing Index (McCance et al., 2009) by listening to Rolonda's questions and requests, explaining assessment techniques, involving Rolonda in the assessment, and respecting Rolonda's agency if she declines care.

Diagnose Actual or Potential Health Problems and Needs

Clinical Reasoning as Context-Driven Diagnostic Integration of Advanced Scientific Knowledge

Clinical reasoning is a process of thinking through various aspects of a clinical encounter, (e.g., presentation, clinical data, and diagnostic test results) to arrive at a reasonable decision regarding the prevention, diagnosis, or care plan for a given patient (Hawkins et al., 2019; Reinoso et al., 2018). Hawkins et al. (2019) delineated an eight-step clinical reasoning process. The following questions guide the clinician through the process:

1. What is the purpose of the clinical reasoning?
2. What clinical problem are you trying to solve?
3. Are the assumptions that you are making justified?
4. What are the strengths and weaknesses of your point of view?
5. Is there enough relevant data to support a conclusion?
6. How are you applying concepts and theories correctly to guide your clinical reasoning?
7. What inferences are you and should you be considering?
8. What are the implications of your conclusions?

Clinical Scenario. Consider the following clinical scenario. Allie, a 15-year-old Latina, presents to the mobile clinic with concerns of persistent fatigue. Her history reveals a 24-hour diet recall of a granola bar, chips, a box of corn starch, ice chips from the gas station, and a 20 oz. cup of soda. She also disclosed compulsive consumption of ice. She denies gastrointestinal (GI) symptoms, epistaxis, menorrhagia, melena, hematuria, hematemesis, surgical history, and a family history of GI malignancy. Her physical examination reveals a well-developed, slightly undernourished, pale female. During the exam, Allie shared that she slept on a friend's couch because her home was unsafe. She does not know how long she will be able to stay there. Her laboratory test results reveal a low mean corpuscular volume, low ferritin, increased total iron binding capacity, low serum iron level, and low transferrin saturation.

Use the clinical reasoning process to arrive at a reasonable care plan for Allie.

1. Purpose: To address Allie's chief complaints of fatigue.
2. Clinical problem: What is the most effective way to address the likely diagnosis of iron deficiency anemia?
3. Assumptions: Lab tests indicate iron deficiency anemia. The most effective treatment will be iron replacement therapy. The underlying cause of the anemia is a lack of nutritional intake of iron.
4. Point-of-view: A conservative approach would be to initiate a trial of iron therapy and educate Allie on iron-rich foods.

5. Relevant data: Lab results, patient history, and physical exam.
6. Concepts: Iron deficiency anemia is the most common nutritional disorder worldwide, characterized by decreased red blood cell production due to low iron stores.
7. Inferences: The laboratory data indicate a positive diagnosis of iron deficiency anemia. Since Allie has clinical symptoms and laboratory data indicative of iron deficiency anemia, iron replacement therapy should be initiated.
8. Conclusions: Failure to treat iron deficiency anemia may result in fatigue, headaches, restless legs syndrome, heart problems, and pregnancy complications. (Short & Domagalski, 2013)

Clinical Decision Making as Context-Driven Integration of Advanced Scientific Knowledge to Guide Decision Making

Clinical decision making, as defined by Reinoso and colleagues (2018), has the elements of clinical reasoning PLUS the person's unique circumstances, including social support, cultural beliefs, financial support, health beliefs, and practices. Using the clinical decision-making definition, how would Allie's plan of care be adjusted?

Raising awareness of and avoiding potential errors of diagnostic reasoning will increase an APN student's competency in diagnosing actual or potential health problems and needs (LaManna et al., 2019). During the data gathering phase, engage in empathetic listening to understand the concern from the individual and/or family's perspective. Also, systematically collect and interpret data to gain situational awareness of the concern. Generate a succinct but comprehensive list of the obvious hypotheses, not to be missed hypotheses, and hypotheses not influenced by the age or gender of the individual. As the APN evaluates the list of hypotheses, continue to use a systematic approach to gather more data to rule out or confirm a hypothesis. Self-reflect, *what else could this be?* Throughout the process, communicate with the healthcare team, engaging in consultation and referring the individual to specialty clinicians as needed. Furthermore, engage with the individual and/or family about the process, goals, priorities, capacity, and resources. Finally, evaluate care from the individual's and/or family's perspective.

Develop a Plan of Care

Cumulative Complexity Model to Prioritize Risk Mitigation Strategies for Prevention or Reduction of Adverse Outcomes

In 2012, Shippee and colleagues presented the Cumulative Complexity Model that illustrated the complicating factors that individuals may face when managing multiple chronic conditions (MCC). The model purports that an *individual's workload of demands* (e.g., employment, caretaker responsibilities, self-care, and healthcare system navigation) and an *individual's capacity* (e.g., physical and mental wellness, social connectedness, financial resources, and health literacy) to meet those demands may directly or indirectly influence outcomes.

Burden of Treatment Theory to Lead and Collaborate With an Interprofessional Team Considering Risk Mitigation as Well as Evidence-Based Interventions to Improve Outcomes and Safety

Similar to the Cumulative Complexity Model is the Burden of Treatment Theory (May et al., 2014) developed for individuals who seek to manage health rather than cure a condition. The model recognizes that plans of care may demand complex self-management regimens that assume a high level of individual knowledge, motivation, resources, and behaviors. People may struggle to balance the treatment regimens with daily life, leading to structurally induced non-adherence and/or over- or under-utilization of healthcare services. As self-care complexity increases (i.e., burden of treatment), some individuals and families become overwhelmed, leading to poor health outcomes, caregiver strain, healthcare services over-utilization, and rising healthcare costs (Boehmer et al., 2016; May et al., 2014).

Clinicians can lessen the burden of treatment by recognizing the plan of care demands and asking about treatment burden to address or prevent workload–capacity imbalances (Shippee et al., 2012). APNs can lead and collaborate with interprofessional teams to review and develop a comprehensive plan of care that reduces the burden of treatment. Articles from several authors (i.e., May et al., 2014; Shippee et al., 2012; Tinetti et al., 2019) informed the following clinical example.

Vanessa, a 42-year-old, married, working mother of five, presents to the clinic with concerns about not having a period for the last three months. She usually menstruates every 28-days. Her past medical history reveals type 2 diabetes, hypertension, and obesity. She ate lunch 1 hour ago and her glucose at the clinic today was 211 mg/dL (normal <180 mg/dL), BP 150/99 (normal <130/80), Ht 5 ft, 11 in., 275 pounds, BMI 38. She states that she is very stressed by the recent loss of her job and insurance. She requests a pregnancy test and help with her medications and glucose testing strips that she cannot afford to pay for out of pocket.

The Cumulative Complexity Model informs us that Vanessa's recent job loss may have simultaneous direct and indirect influences on care and outcomes (e.g., inability to pay and chronic stress), reflecting the amplification of structural vulnerabilities (Bourgois et al., 2017; Shippee et al., 2012). Additionally, capacity-limiting circumstances (e.g., physical and mental functioning, symptoms, and social support) may sensitize her, leaving her especially susceptible to a complex plan of care (Shippee et al., 2012).

A strengths-based approach may guide a plan of care that lessens Vanessa's workload demands and builds her capacity. Completing a social health screening tool may assist with identifying additional areas of need and lead to connecting Vanessa to resources. The tool may also identify areas of strength that must continue to be supported. Redesigning her care plan may include identifying goals, prioritizing care demands, integrating healthcare and community resources to support capacity, and engaging social support to lessen burdens (Shippee et al., 2012). For example, engaging Vanessa's social support in her care may assist with negotiating and navigating the healthcare system (May et al., 2014). It is important to document Vanessa's goals, values, and preferences in the EHR for the healthcare team.

A nonrandomized clinical trial that compared patients who identified care priorities and those who did not indicated that care priority identification increased patients' perceptions of goal-directed and less burdensome care. Results also indicate that care priority identification yielded fewer medications, self-management tasks, and diagnostic tests ordered when compared to usual care (Tinetti et al., 2019). Individuals and clinicians found the intervention feasible and acceptable with minimal implementation time or impact on the workflow.

Innovation and Design Thinking for Incorporation When Evidence Is Not Available

Central to developing a plan of care is the recognition that some care systems need to be redesigned to prevent or reduce adverse outcomes. The nursing profession holds in high esteem evidence-based practice (EBP) and clinical guidelines (Melnyk & Fineout-Overholt, 2019), yet current technologies, supplies, and processes may not serve nurses' practice needs and thus lead to inefficient and at times unsafe care (Debono et al., 2013; M. E. S. Glasgow et al., 2018; Risling & Risling, 2020; Westphal et al., 2014). In practice, this translates to nurses needing to adapt, adopt, and modify their workflow to "workaround" poorly designed technologies, products, or processes (Debono et al., 2013; Risling & Risling, 2020). Instead of circumventing current protocols and creating makeshift solutions, nurses need the innovation and design thinking skills to develop solutions to challenges in their daily practice.

Design thinking is a methodology that focuses on creating empathy for stakeholders (e.g., patients, families, nurses), working in collaborative teams, and employing an action-oriented approach to prototype and test solutions (Altman et al., 2018; MacFadyen, 2014; Roberts et al., 2016; Rowe, 1991). It is an iterative process that uses analytical, creative, critical, divergent, and convergent thinking to find effective, acceptable, and sustainable solutions, that is, *an innovation* (Rahemi et al., 2018). The goal of the design-thinking process is to foster innovation. Unlike the traditional linear approach to health intervention design, which is often led by healthcare leadership (Lyon & Koerner, 2016; MacFadyen, 2014; Roberts et al., 2016), in the design-thinking process, stakeholders are the experts, and innovation emerges from several cycles of ideation, prototyping, and testing. Holt and colleagues (2022b) described a pilot study that showed the feasibility and acceptability of graduate nursing students' participation in a 150-minute innovation and design thinking workshop as part of their curriculum. Reflections from students provided preliminary evidence that creative self-efficacy, design-thinking traits, and psychological empowerment may increase after engaging in innovation and design thinking experiential learning. The National Academy of Medicine (NAM, 2021) affirms that I&DT are competencies needed in nursing education so nurses can lead the redesign of safe, effective, and efficient person-centered care systems.

Demonstrate Accountability for Care Delivery

Nurse-Managed Health Centers as a Model of Best Care Practice and to Promote Care Delivery at Full Scope of Education

Silver Spring Neighborhood Center is in one of Wisconsin's largest housing developments (Westlawn Gardens) and has been in operation since 1958. The Silver Spring Community Nursing Center (SS CNC), now the Silver Spring Health and Wellness center, was opened in 1986 by Sally Lundeen, PhD, RN, FAAN, who intentionally sought a community partner who valued whole-person health. In her

1993 publication, Dr. Lundeen (Lundeen, 1993) referred to the SS CNC within the neighborhood center as a one-stop shop for food, education, recreation, health, childcare, and more. The Capuchin Community Services-House of Peace is in and has served the poorest population in the City of Milwaukee since 1968. Sandra Underwood, PhD, RN, FAAN, and a House of Peace founder, Br. Booker Ashe, noticed the need for health education for community members. The House of Peace Community Nursing Center (HOP CNC), now the House of Peace Health and Wellness center, began in 1992, when undergraduate nursing students provided health education to community residents. In these centers, health professions students, baccalaureate prepared, and APNs deliver continuous, comprehensive, coordinated, collaborative, community-based, and culturally relevant health and wellness care to individuals, families, and communities (Lundeen, 1999). They deliver care at the full scope of their education, practice, and expertise. However, to demonstrate success of these innovative healthcare delivery models, a standardized, systematic, and comprehensive documentation method was needed.

Dr. Lundeen and colleagues found what they were looking for in the Omaha System (Martin, 2005). The Omaha System is a standardized nursing taxonomy encompassing diagnoses, interventions, and outcomes that can be analyzed to produce practice-based evidence (Martin, 2005). The practice-based evidence may improve communication, healthcare quality, safety and outcomes, and interoperability among healthcare systems (Fennelly et al., 2021).

Omaha System for Monitoring Aggregate Metrics for Accountability of Care Outcomes, Applying Current and Emerging Evidence in Development of Care Guidelines/Tools, and Ensuring Accountability Throughout Transitions of Care

The Omaha System (Martin, 2005) is a healthcare taxonomy developed by nurses to capture systematically and comprehensively all of health and health care. In 1992, the American Nurses Association endorsed the Omaha System as a taxonomy to identify, support, and represent nursing practice across settings (Rutherford, 2008). The Omaha System is a comprehensive set of health concepts, interventions, and outcomes supporting person-centered care, critical thinking, best practices, and safe and effective health care (American Nurses Association, 2018). Please see **Figure 2-5**. Tested and revised from 1978 to 1993, nurses developed it to track care and outcomes in a methodical and complete manner.

The Omaha System consists of three interrelated elements: the Problem Classification Scheme, Intervention Scheme, and Problem Rating Scale for Outcomes (Martin, 2005).

The Omaha System is available in the public domain and used across healthcare professions (Jurkovich et al., 2014; Kang et al., 2022; Kates, 2020), settings (Hobensack et al., 2022; Martin et al., 2011), and internationally (Ardic & Turan, 2021; Monsen et al., 2011, 2019). Clinicians can aggregate Omaha System data to account for care quality and outcomes among adults receiving nurse-led healthcare services (Holt et al., 2014), evaluate the integration of behavioral health services into nurse-led primary health care (Holt et al., 2022a), and develop strengths-based population health metrics to inform person-centered care, risk and protective factors, and improve health outcomes and value (Gao et al., 2018).

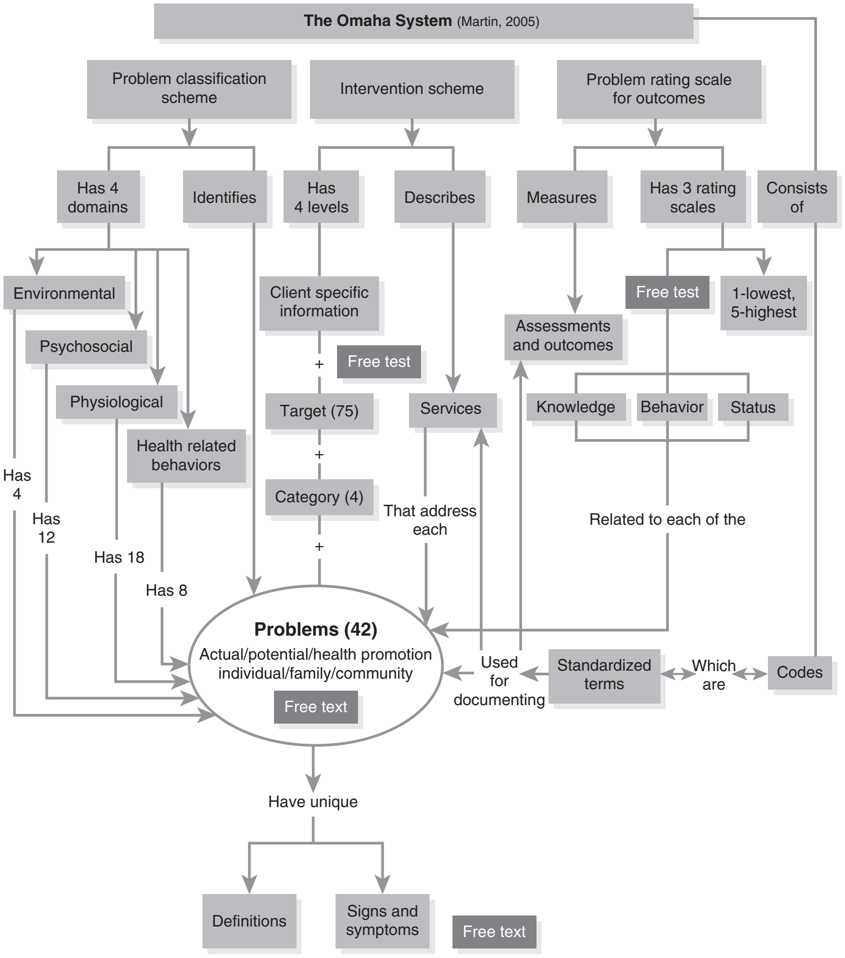


Figure 2-5 Omaha System Concept Map

Reproduced from Monsen, et al. (2011). Evidence-based Standardized Care Plans for Use Internationally to Improve Home Care Practice and Population Health. *Applied Clinical Informatics, 2*(3), 373–383. https://doi.org/10.4338/ACI-2011-03-RA-0023

The Omaha System has been used to assess changes in care delivery and scope of interventions of care. Recently, Kang et al. (2022) compared changes in interventions that RNs and Licensed interventions Nurses (LPNs)/Licensed Vocational Nurses (LVNs) employed from pre-pandemic to interventions used in response to COVID-19 (WHO, 2020). There was a 75% increase in the types of interventions used in response to the pandemic with a shift in intervention focus to infection precautions and sickness/illness care (Kang et al., 2022).

The Omaha System Guidelines website provides evidence-based practice guidelines and standardized care plans in coded, open access format, for clinicians and consumers. An international transdisciplinary group of scholars, clinical experts, and Omaha System experts have translated 31 evidence-based guidelines (e.g., sexual assault nurse examiner, transgender care management) to the Omaha

System, LOINC, and Sno-Med CT. The open access format allows for sharing and comparable data across settings and systems to improve the continuity of care (Omaha System Guidelines, n.d.).

Person-Centered Practice Framework to Model Best Care Practice, Promote Care Delivery at Full Scope of Education, and Contribute to Development of Transparency and Accountability in Policies and Practices

McCormack and McCance (2006) developed the Person-Centered Practice Framework (PCPF) to operationalize PCC in healthcare environments. Initially developed by nurses for nurses, the authors expanded the framework to encompass all healthcare workers (McCance et al., 2021). The PCPF embodies a systems-level approach to create an accountable person-centered healthcare system. Please see **Figure 2-6**. The PCPF figure depicts a flower surrounded by two concentric circles. At the center of the flower are person-centered outcomes, for example, satisfaction

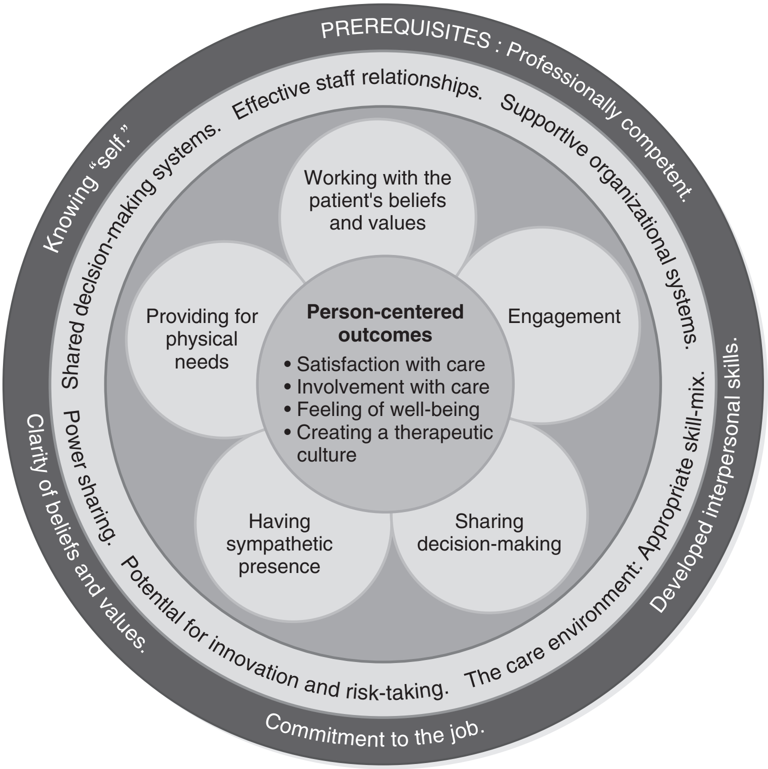


Figure 2-6 Person-Centered Practice Framework

Reproduced from McCormack, B., & McCance, T. V. (2006). Development of a framework for person-centred nursing. *Journal of Advanced Nursing, 56*(5), 472–479. https://doi.org/10.1111/j.1365-2648.2006.04042.x and involvement with care, well-being, and therapeutic culture. The five petals depict the person-centered processes, various activities that actualize person-centered nursing engagement, shared decision-making, empathetic presence, providing for physical needs, and working with the patient's beliefs and values. The inner circle is the care environment, comprised of the appropriate skill mix, shared decision-making systems, effective staff relationships, supportive organizational systems, power sharing, and potential for innovation and risk-taking. The outer circle includes prerequisites of the healthcare worker: professional competence, interpersonal skills, job commitment, clarity of beliefs and values, and self-knowing (McCormack & McCance, 2006). APNs can use the PCPF to assess and model best practices and to deliver care using the full scope of their education and experience. The PCPF also supports the development of policies and processes that promote transparency and accountability of the person-centered healthcare system.

Evaluate Outcomes of Care

APN Quality of Care

Dr. Loretta Ford and Dr. Henry Silver developed the nurse practitioner role in 1965 to increase access to pediatric care (Ford, 2015). The role has expanded to four advanced practice registered nurse roles (Nurse Practitioner, Certified Nurse Midwife, Certified Nurse Anesthetists, and Clinical Nurse Specialist) and continues to address healthcare access limitations across the country (Brennan, 2020). As early as 1979, the U.S. Congress Congressional Budget Office recognized the value of APNs. Congress cited research demonstrating improved patient outcomes, appropriate diagnosis and management of medical conditions, patient satisfaction, and preliminary evidence of more cost-effective care comparable to physicians (U.S. Congressional Budget Office & Smith, 1979). Over the next four decades numerous original research studies (e.g., DesRoches et al., 2017; Kippenbrock et al., 2019), systematic reviews (e.g., Newhouse et al., 2011; Stanik-Hutt et al., 2013), meta-analyses (e.g., Brown & Grimes, 1995; Naylor & Kurtzman, 2010), and a Cochrane review (Laurant et al., 2005) came to the same conclusions. APNs provide care that is comparable or superior to physicians and physician assistants. A sentinel example is a randomized control trial conducted by Mundinger et al. (2000). The results indicated no statistically significant differences at 6 months in patient satisfaction, health status, physiological tests, and health service utilization of people who received primary care by nurse practitioners (NPs) or physicians after an emergency department or urgent care visit. Individuals randomly assigned to NPs had statistically significant lower diastolic blood pressure values at 6 months. Two years after the initial visit, study participants were contacted again. There continued to be no statistically significant differences found in patient satisfaction, self-reported health status, disease-specific physiologic measures, or use of specialist, emergency department, or acute care between NP or physician providers. However, individuals who received primary care from physicians had a higher primary care utilization when compared to individuals who received primary care from NPs (Lenz et al., 2004). The American Association of Nurse Practitioners (*Quality of Nurse Practitioner Practice*, n.d.) maintains a comprehensive list of quality nurse practitioner practice publications on their website.

Structure-Process-Outcome Model as Approach to Analyze Data for Identification of Gaps, Inequities, and Trends in Care and Monitoring Epidemiological and Systems-Level Aggregate Data for Outcomes and Trends and Synthesizing to Inform Evidence-Based Practice, Guidelines, and Policies

Santana and colleagues (2018) present practice guidance on how to implement PCC in healthcare settings using the Donabedian (1988) Structure, Process, and Outcomes model. At the healthcare system and organizational level, creating a PCC culture involves co-designing, implementing, and evaluating PCC education for clinicians, staff, and employees. Additionally, designing interoperable health information technology facilitates care across settings and organizations. Finally, create a feedback system for individuals and families to share their experiences in the system or organization. PCC processes occur at the individual and healthcare clinician level including creating culturally safe environments, providing compassionate care, empowering individuals to be active in achieving their health goals, and integrating care across the healthcare continuum. PCC outcomes are measured at the individual, clinician, and healthcare system/organization levels. Individuals provide outcome data through patient-reported outcome and patient experience measures. Systems can measure timely access to and cost-effective care and health outcomes at the population level (Santana et al., 2018).

Patient-Centered Outcomes Research Institute and Analysis of Data for Gaps and Inequities as Well as Monitoring Outcome Trends

The Patient-Centered Outcomes Research Institute (PCORI) began in 2011 as a governmentally supported, independent, nonprofit research institute. PCORI is dedicated to supporting comparative clinical effectiveness research (CER) to evaluate the outcomes of two or more treatments, interventions, or other therapeutic methods to improve health and health care and inform healthcare policy (Fischer & Asch, 2019; Patient-Centered Outcomes Research Institute, 2021). The U.S. Congress reauthorized the Institute in 2019 for another decade of funding. Published in June 2022, PCORI's strategic plan focuses on patient-centered CER; engagement with the community to ensure evidence is applicable, relevant, and trustworthy; disseminating results and implementation of proven treatments, interventions, or other therapeutic methods to improve health or health care; and developing and maintaining a CER research infrastructure (Greene et al., 2021). APNs/DNPs can use PCORI resources to measure outcomes in their setting.

Patient Experience as a Measure to Synthesize Outcome Data to Inform Evidence-Based Practice, Guidelines, and Policies

Another way to measure outcomes in care is from the care recipient. In a systematic review of the literature and concept analysis of patient experience, patient experience is "any process discernible by patients who receive healthcare, including subjective experiences, objective experiences, and observations of provider or staff behavior within the healthcare system" (Holt, 2018, p. 560). How the care recipient perceived the level of trust, communication, shared decision making, expectations, values, beliefs, knowledge, power, and acceptance mediated patient engagement (Holt, 2018). Therefore, this underlines the importance of critical tenets of person-centered care. Also noteworthy, patient experience is not the same as patient satisfaction, which only reflects if the healthcare exchange meets the patient's expectations (Cleary, 2016; Holt, 2018).

Patient engagement is "the desire and capability to actively choose to participate in care in a way uniquely appropriate to the individual" (Higgins, Larson, & Schnall, 2017, p. 33). Patient engagement includes the contextual, relational, organizational, and structural aspects that facilitate or hinder an individual's ability to drive health and interactions with healthcare systems (Barello et al., 2015). Engaged patients are more likely to collaborate with a healthcare provider or institution (Salgado et al., 2017), optimize outcomes (Sacks et al., 2017), and report improved care experiences (Higgins et al., 2017). Although researchers have proposed that increasing patient activation may be a critical link to lessening health disparities in populations who historically experience health disparities (Hibbard et al., 2008), there is a dearth of research to date testing interventions designed to improve patient engagement in these populations.

Reporting of Outcomes in Relationship to Analysis and Synthesis of Outcome Data

It is important to note how researchers, clinicians, and administrators report population-level outcomes. Researchers, clinicians, and administrators contribute to health disparities when they describe population-level outcomes that perpetuate biases or stereotypes. For example, *the majority of patients have uncontrolled hypertension because they are noncompliant with their medications, eat fried foods, and do not exercise*, instead of *the majority of patients have uncontrolled hypertension because the built environment lacks access to fruits and vegetables, safe places to exercise, and a pharmacy to pick up prescriptions*. One approach blames individuals, and the other acknowledges how social, economic, racialized, and political structures impact health (Bowen et al., 2022).

Promote Self-Care Management

Individual and Family Self-Management Theory as a Strategy to Promote Self-Care Management

Self-management is a multidimensional, complex phenomenon that includes condition-specific risk and protective factors, the built and social environment, and characteristics of individuals and family members (Ryan & Sawin, 2009). Self-management is influenced by knowledge, beliefs, priorities, goals, self-regulation skills and abilities, and social support (Ryan & Sawin, 2009). The degree to which individuals self-manage their health (i.e., chronic condition and health promotion activities) affects short- and long-term outcomes (Ryan & Sawin, 2009). Ryan and Sawin (2009) described how a nursing research team applied and modified (Schilling et al., 2002) a definition of self-management in a family-centered clinical example of juveniles with spina bifida. In their example, self-management is an active, daily process in which juveniles and their guardians share accountability and decision making for achieving optimal outcomes of their condition, health, and well-being using various knowledge, behaviors, and skills (Ryan & Sawin, 2009). Ryan and Sawin (2009) noted in their example that as the juveniles aged, they assumed more accountability and decision making regarding their daily health practices (Ryan & Sawin, 2009).

Shared Decision Making as a Strategy for Self-Care Management in Incorporating Current and Emerging Technologies, Counseling Techniques, Evaluation of Adequacy of Resources, and Fostering Community Partnerships

RJ, a 41-year-old man, presents to the clinic for help with his recently diagnosed type 2 diabetes (A1c 8.7%) when hospitalized for pneumonia. He is adamant that he does not want to take "shots" for his diabetes. An angiotensin-converting enzyme (ACE) inhibitor controls his blood pressure, and he is on statin therapy. He does not have renal insufficiency. He was treated with insulin while in the hospital and was discharged on monotherapy with metformin 1,000 mg twice daily. He was also given nutrition and exercise instructions and is trying to incorporate lifestyle modifications into his routine. He asks if you think the metformin will sufficiently treat his diabetes. You discuss with him that metformin would only be expected to reduce his A1c by 1% to 1.5%. Therefore, he wants to know what other treatment options can help him.

In this clinical scenario, RJ invites you to engage in a shared decision making (SDM) conversation. SDM is a collaborative way to make health decisions between a person and their health team, where pertinent and valid information is accessible to the individual, and the decision incorporates the person's circumstances, beliefs, and preferences (Elwyn et al., 2017).

There are over 40 SDM models comprising 53 elements (Bomhof-Roordink et al., 2019). Some SDM models can be applied across care settings (e.g., three-talk model [Elwyn et al., 2017]), while others were created for specific settings (e.g., primary care (Lenzen et al., 2018); emergency departments (Probst et al., 2017); and clinical situations, for example, lung cancer screening (Dobler et al., 2017). In a systematic review of SDM models, Bomhof-Roordink et al. (2019) found that most SDM models include decision making (75%), patient preferences (65%), individualized information (65%), deliberation (58%), overview of options (55%), and learning about the patient (53%). Interestingly, a third of SDMs did not identify the healthcare professional and patient as actors.

SDM models continue to evolve. As an exemplar, first published in 2012 (Elwyn et al., 2012), the three-talk model of shared decision making was critiqued for the omission of the coproduction of goals, patient preferences, and context (Elwyn et al., 2017). The revised model incorporates those concepts during the three phases: team talk, options talk, and decision talk (Elwyn et al., 2017). Team talk includes discussing choices and patient goals and offering support. Options talk focuses on weighing the potential benefits and drawbacks of the options. Decision talk moves the discussion to understand the person's values and priorities in the decision (Elwyn et al., 2017).

Motivational Interviewing as a Counseling Technique Strategy to Incorporate New and Emerging Technologies for Self-Care

Motivational interviewing is a collaborative, person-centered discourse method used in clinical practice to elicit and promote an individual's motivation for change (Miller & Rollnick, 2009). It honors autonomy and recognizes that only the individual has the agency to change. Clinicians can use motivational interviewing as part of a communication method that involves informing, asking, and reflective listening to guide the individual to resolve uncertainty about behavior change (Miller & Rollnick, 2009). Motivational interviewing can be delivered during traditional or telehealth clinical encounters and mHealth applications (Nurmi et al., 2020). It differs from the Transtheoretical Model (also known as the Stages of Change Model), a comprehensive conceptual model of how health behavior progresses through six stages of change (Prochaska & Velicer, 1997). In accordance with the Stages of Change Model, clinicians recognize which stage of change (i.e., precontemplation, contemplation, preparation, action, and maintenance) an individual is in and employ different intervention strategies to assist the person to the next stage (Prochaska et al., 1992; Prochaska & DiClemente, 1982, 1984).

The University of Connecticut's Rudd Center for Food Policy and Health's Toolkit for health professionals guided the following clinical exemplar to illustrate identifying a person's stage of change and tailoring discourse accordingly (University of Connecticut, 2020).

Clinical Scenario. Rosa, is a 34-year-old woman of Hispanic descent who comes to the clinic to discuss weight management. She is currently 62 inches, 265 lbs., with a BMI of 48.5. She says she always had a hard time managing her weight as a child, but she became very overweight during her college years. She has had two children in the past five years. She gained 50 lbs. with the first child and lost 30 lbs. With the second child, she gained 35 lbs. and lost 10 lbs. She has tried many diets where she initially loses weight but gains it back. She walks up to 30 minutes daily but is often limited by pain in her knees. She has thought about gastric bypass surgery but is fearful of undergoing a surgical procedure.

The APN can begin the weight management discourse with Rosa using the following questions: Would you like to talk about your weight or health today? Which words would you like me to use when talking about your weight? **Table 2-1** presents sample questions and clinician responses using intervention strategies from the Stages of Change Model (Prochaska et al., 1992; Prochaska & DiClemente, 1982, 1984).

5-A's Framework as an Evidence-Based Approach to Advance Wellness and Self-Care in Addition to Evaluating Adequacy of Resources

Another evidence-based behavior change model and person-centered way to develop a plan of care is the 5-A's Framework (i.e., Assess, Advise, Agree, Assist, Arrange) (R. E. Glasgow et al., 2006). It has been applied in various settings, behaviors, and health conditions (Friedman et al., 2017; Mateo et al., 2018; Pollak et al., 2016). First, the clinician *assesses* the individual's health behaviors, including individual-, environmental-, and structural-level risks and factors that may

Table 2-1 Stages of Change Model Applied to Weight Management

Stage of Behavior Change & Questions	Clinician Response
Precontemplation (Resistance, Reluctance, Overwhelmed, Resigned, Rationalizing)	
How ready do you feel to change your eating patterns and/or lifestyle behaviors?	I understand why you feel that way.
How does your weight affect you?	I believe that your lifestyle patterns are putting you at risk for conditions such as heart disease and type 2 diabetes. Making some lifestyle changes could help you improve your health substantially.
Are you considering/planning to make lifestyle changes soon?	It is your choice when you are ready to make lifestyle changes.
On a scale of 1–10, how ready are you to make lifestyle changes?	Everyone who's ever made lifestyle changes starts right where you are now. They start by seeing the reasons where they might want to make changes.
Contemplation (Ambivalent about change)	
For you, what is one benefit and one drawback to starting a lifestyle change?	I hear that you are thinking about making some lifestyle changes but are not ready right now.
Where are you on the scale of 1–10 as far as being ready for a change?	If "0" is not ready to make changes (in your eating habits/physical activity) and "10" is ready to make changes, what score would you give yourself? You gave yourself a score of X. Why do you think you are X, and not (a lower number)? OR You gave yourself a score of X. What would have to happen to move up to (higher #)?
How do you see me helping you in this process?	It is your decision if there are changes that you want to make now. I am here to help you and point you to other sources of support.
Arrange follow-up.	This is for you and I am here to help you. Can we talk about this at the next visit?
Preparation for and Making Changes	
Have you made some lifestyle changes?	It's great that you are taking important steps to improve your health. There are different ways that people successfully change their lifestyle behaviors. Can we spend a few moments discussing some strategies, and you can tell me what makes the most sense for you?

Stage of Behavior Change & Questions	Clinician Response
What is/are your lifestyle change priorities? What change would make the most impact on your health?	Help to set small lifestyle change goals based on priorities (e.g., nutrition, physical activity, and sleep).
Have you ever made lifestyle changes before? What makes you feel like you can continue to make progress if you decide to?	What was helpful? What kinds of problems would you expect in making those changes now? How do you think you could deal with them?
Are there people in your life who can support you in this change?	Identify support systems. How could they support you? Is there anything else I can do to help?
What do you feel about this change in lifestyle plan?	It's great that you feel good about your decision to make some lifestyle changes. It's common to feel scared/anxious/nervous about making changes.

Data from the University of Connecticut's Rudd Center for Food Policy and Health's *Toolkit for Health Providers*. Ha, E. (2020, April 20). Toolkit for Health Providers. University of Connecticut's Rudd Center for Food Policy and Health; UConn Rudd Center for Food Policy and Health. https://uconnruddcenter.org/research/weight-bias-stigma/healthcare-providers/

influence the behavior change goals and methods. Second, the clinician *advises* the individual on making a behavior change using clear, specific, and individualized information about health risks and benefits. Third, the clinician and individual *agree* on co-developed care goals and methods based on the individual's beliefs, values, resources, and motivation to change the behavior. Fourth, the clinician *assists* the individual in identifying barriers and facilitators of behavioral change. The clinician may assist the individual in acquiring new knowledge, skills, self-efficacy, and social, structural, and environmental supports for behavior change. Furthermore, the clinician may prescribe medications or refer the individual to medical treatments as appropriate. Finally, the clinician *arranges* follow-up in-person or telehealth visits to provide continued support, modify the care plan, or refer to specialty care (R. E. Glasgow et al., 2006).

Decision Aids as Technology to Support Self-Management

Decision aids are interventions designed to support individuals to make health decisions (Stacey et al., 2017). They provide information about choices and outcomes, and help to align decisions with personal values, goals, and health status (Munro et al., 2016). In a Cochrane review, the use of decision aids as part of the clinical exchange decreased decisional conflict related to feeling uninformed, reduced uncertainty about personal values, goals, and health status; increased active decision making; and positively affected patient–clinician communication when compared to usual care (Stacey et al., 2017). Moreover, people exposed to decision aids felt more informed, clearer about their goals, and equally or more satisfied with their decision compared to usual care. The use of a decision aid increased the clinical visit by a median of 2.6 minutes (Stacey et al., 2017). Research is needed to evaluate the effects of decision aids on the follow-through with the chosen option, cost-effectiveness, and use in populations with lower health literacy (Stacey et al., 2017). The Patient Decision Aids Research Group, part of the Ottawa Hospital Research Institute and affiliated with the University of Ottawa, maintains a comprehensive international list of decision aids by health condition and personal decision guide (*A to Z Inventory—Patient Decision Aids*, 2022). As APNs achieve competency in promoting self-care management, they may find decision aids a useful tool to attain goal-concordant care. Goal-concordant care has been associated with stronger medication self-management behaviors (Ellis et al., 2019).

Fostering Partnerships With Community Organizations Through Social Capital in Evaluation of Adequacy of Available Resources for Self-Care Management

Webel and colleagues (2013) researched the self-management behaviors of individuals who self-reported an HIV diagnosis, were ≥18 years, self-identified as female, and were fluent in English. They selected predictor variables of self-management behaviors of social roles, race, income, housing stability, education, individual-level social capital, and healthcare access. Webel and colleagues (2013) found that the strongest predictor of self-management behaviors was individual-level social capital measured as the level of local community participation, social agency, feelings of trust and safety, neighborhood relations, friends and family relationships, tolerance of diversity, and value of life, measured using the Social Capital Scale (Onyx & Bullen, 2000). The research reported social capital significantly predicated daily health practices ($F = 5.40$, adjusted $R2 = 0.27$, $p<0.01$), HIV social support ($F = 4.50$, adjusted $R2 = 0.22$, $p<0.01$), and accepting the chronicity of HIV ($F = 5.57$, adjusted $R2 = 0.27$, $p<0.01$). Strikingly, a one-point increase in total social capital score yielded a 13% increase in the self-management score. The authors concluded that the predictor models indicate that supporting or increasing a person with HIV's social capital may be among the most effective interventions to enhance HIV self-management (Webel et al., 2013).

Reflect on how you may assess and foster a person's level of local community participation, social agency, feelings of trust and safety, neighborhood relations, friends and family relationships, tolerance of diversity, and value of life.

Provide Care Coordination

Nurse Care Coordinators for Evaluation of Communication Pathways, Development of Strategies to Optimize Care (as Well as Transitions of Care), and Guidance of Coordination Across Health Systems as Well as Analysis of Systems-Level and Public Policy Influence on Care Coordination

The U.S. healthcare system is fragmented and difficult to navigate (NAM, 2021). The complex system often leaves consumers confused regarding how to access the right level of care for prevention, treatment, and urgent health needs. However, well-designed and targeted care coordination by a knowledgeable healthcare professional can assist the individual and family to effectively use the resources of complex health systems and multiple providers in harmony with their needs and preferences (American Nurses Association, 2021). APN and RN care coordinators may provide general care management to all individuals but often with a special focus on medium- and high-risk or high-complexity populations. Actions of APN care coordinators may include creating a care plan that lessens treatment burden; revising treatment plans in response to changes in health status; supporting self-management goals; referral to specialty providers and community resources; and working to realign resources to restore or improve individual, family, and population needs (Campagna et al., 2022). Effective care coordination is sensitive to the strengths, challenges, and needs of individuals, families, and populations. The nature of the interventions must be tailored to match the schedules, language, health literacy level, safety issues, and limited resources of these individuals and families (Anderson & Hewner, 2021).

The APN care coordinator can mobilize the appropriate interdisciplinary care team members based on individual and caregiver input and the identified social and medical needs. Nurses can coordinate interdisciplinary care and make referrals to internal or external community resources. The individual's plan of care is updated regularly to assure it addresses continuing healthcare and social needs. Follow-up care and outcomes are tracked using an electronic registry with touchpoints to affirm and revise self-management strategies (Manalili et al., 2022). Care coordination may be less burdensome to the care recipient when delivered using telehealth services, which facilitates continuity of care, eliminates the burdens of travel and transportation, and lowers the risk of disease transmission (Dhaliwal et al., 2021).

A person-centered nurse-led coordination model is a response to the call to action outlined in 2021, the NAM report titled, *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*. The report cites compelling evidence supporting the role nurses can and should play in addressing the inequities in health care resulting from uneven access to conditions needed for good health. The report's authors recognized that professional nurses have seen firsthand the inequitable impact that COVID-19 has had on those they have served and the profession itself. The report articulates a vision to leverage nurses' capacity and unique expertise across the United States to contribute more comprehensively to creating equitable health care designed to work for everyone. Innovative models fully leveraging nursing roles targeted to support health equity will be one way to realize that vision (NAM, 2021).

Participation in Person-Centered Care Coordination at Systems Level to Improve Care Coordination Across Settings

A person-centered care coordination model utilizes the unique skills of nurses to connect and coordinate a population of individuals served by a healthcare system and strategically positions nurses at different points of care. The model is person-centric and engages the individual and their identified caregivers as the center of the care team (Manalili et al., 2022). The care recipient chooses the care team members, identifies their health goals, and works with the nurse to derive strategies to accomplish those goals. The assembled team will surround the individual to educate, support, and guide them in reaching their health goals in a culturally safe manner. This coordinated, team-based approach to care is a departure from the traditional disease-oriented approach (Farre & Rapley, 2017) where a physician provider dictated the care plan. Patient engagement is essential to success as individuals activated in the self-management process are more likely to follow their care plan and participate in evidence-based preventative services (Alvarez et al., 2016).

The impact of care coordination can be evaluated using process and outcome measures. The person-centric, individualized approach is anticipated to result in improvements in these measures for all patients, but most notably for those with the greatest number of social needs and most negatively impacted by structural racism and structural and social determinants of health (e.g., people of color, LGBTQ+ community, people with disabilities, those with low income, and those living in rural areas) (Yearby et al., 2022). The overall effect will reduce health disparities for the population served. Outcomes to be measured will include but not be limited to the following:

- Increased number of new and recurring primary care visits across services because of improved access to care.
- Increased percentage of individuals who complete annual medical and dental preventative care visits.
- Increased percentage of individuals who receive recommended screenings for cancer (oral, breast, colon, cervical, prostate, etc.) and other health conditions.
- Improved self-management with recommended chronic care testing and treatments for hypertension, diabetes, heart failure, and others.
- Increased satisfaction in communication between the care team and the care recipient.
- Decreased emergency department visits and hospital readmission rates.

Summary

To achieve the domain of PCC, a nurse must co-develop person-centered interventions and evaluate those interventions at the personal level. The personal level includes the context of an individual's life including strengths, challenges, needs, and resources. The person must determine the success of the care. This may conflict with the nurse's or healthcare system's view of improving health outcomes. Slater (2006) supports this ideal, saying that "pathways of healing are designed for the individual, saluting the individual's right to not only receive care but to have choices in how it is perceived and provided" (p. 42). As nurses gain competency in PCC, the health care system needs to reconcile evaluating and valuing PCC from the perspective of the recipient, not the provider of PCC. When we recognize, value, and prioritize an individual as a holistic being, competence in PCC will be actualized (Zhao et al., 2016).

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