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Afterword by Dr. David L. Katz, MD, MPH

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HealthCARING



A Reset for Health and Healthcare

B. HELTON

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Introduction: Why "Healthcaring"? Why Now?

What if healthcare providers and our loved ones chose to care only as much about our health as we do, not a solitary ounce more? For many, the answer is "that's a terrible idea." While nothing separates caring from health and healthcare, our everyday routines and common patterns of behavior have measurably diluted its influence and that needs to change.

When we purposely care for something, we want to tend to it and improve it. Caring is both an inborn and ingrained human behavior. To be caring describes a trait, an action, an attitude or, at times, a common inclination in the spirit of being a good person.

At its essence, caring is the voice of our genes drawn from the deep wellspring of generation upon generation of people living together in settings where cooperation was essential to human survival. It's an expression used to characterize an act of kindness or compassion and an emotion to describe the positive makeup of being human.

Everyone cares to varying degrees about different things, ideas and other people. Being caring is how we demonstrate this concern. Whether this is in families, communities, organizations or societies, caring is more than a unit of language; as are its companions, empathy and self-interest.

When it comes to healthcare, we all want the best. What if I don't know what is the best? Well then, shouldn't I want the most? "Caring" healthcare that includes lifestyle choices will guide our understanding of what is, in fact, best.

Our response, **healthcaring**, meshes with a desirable goal—wellbeing—to reset behavior and lessen competing interests.

Just as the phrase (and movement) *going green* created a mindset that changed people's behavior and guided the world's approach to improving the environment, the term *healthcaring* wipes the slate clean for improving health and healthcare. And it does this in a proven way.

How health is defined determines what gets done and how. If resistance to change is locked in a culture, it takes a new way of thinking, seeing and doing to break through to fresh ideas and achieve what everyone wants: good health, wellbeing, and of course, more caring, accessible and affordable healthcare.

The language of *healthcaring* appeals to strength of character and personal virtue. It creates a pathway to guide individual, institutional and organizational health and healthcare decisions and actions. *Healthcaring* reframes the seemingly intractable problem—healthcare delivery reform—by defining a shortcut to reshape societal behavior and overcome unchecked self-interest. Like *going green*, *healthcaring* will also lead to a cascade of other behavioral cues in a way similar to *sustainability*, *renewable energy*, *carbon footprint* and *organic*, all while providing a social counterbalance to the money-centered U.S. healthcare model.

Equally important, *healthcaring* will provide a behavioral code that sets the tone for individual health improvement. As in self-help, this will make it easier to develop a positive and healthy attitude about our physical and mental wellbeing. *Healthcaring* will raise people's commitment to this, as it encourages self-respect and individual responsibility.

The result will be a personal daily health management routine and, when necessary, more judgment-based medical treatment decisions. Because the accent is put on caring, *healthcaring* will over time also temper what are socially acceptable healthcare entitlements and eligibility

requirements for government-provided support like U.S. Social Security disability, Medicare and Medicaid.

Above all, this will simplify change, rewire behavior and enable providers, patients and payers to better agree on what is necessary in healthcare delivery, what is wasteful and what to focus improvement efforts on most—for our health, general wellbeing and the overall U.S. and world economies. This begins with a language that builds consensus and common purpose across divergent healthcare interests. Once commonplace, the emphasis on “caring” will help redefine the value every segment of society brings and form a smoother path to the desired outcome: a truly *healthcaring* America and world.

• 1 •

Everybody accepts that change can be really hard, so we resist it. What we haven’t paid much attention to is that subconscious change is much easier to swallow than conscious change. We respond when other people around us take positive health steps, and the greater the number of those who adopt a healthier lifestyle, the more likely we are to be cued by *healthcaring* to do the same. Nevertheless, just saying that *healthcaring* will transform American health and healthcare won’t make it happen.

One key for simplifying change lies in language itself and that’s supported by our research into *how to reset the behavior of millions, simply*. This revolves around **behavioral definitions**—a tool ordinary people have used to trigger extraordinary results, for example, *open source* or *designated driver*.

Behavioral definitions form the shorthand of life. They frame an under-recognized pattern as distilled and potent for behavior as mathematics is for science and biology is for

This preview of **HealthCARING: A Reset for Health and Healthcare** continues and includes excerpts from two chapters, the Afterword, an Appendix, and the complete index. To order a copy or two for yourself or to gift to someone else, order online at:

www.open4definition.org/healthcaring.php?v=1

1

Reset the Behavior of Millions, Simply

One person changed the way an entire society behaves.

He wasn't a President, billionaire entrepreneur or even widely known beyond his professional circles. And he still isn't. However, his efforts paid off in a big way: a keystone behavioral definition has become a ubiquitous and accepted practice whenever friends go out drinking on the town.

Jay Winsten, a Harvard Public Health professor, introduced the idea of a designated driver to America in the 1980's. He cherry-picked this behavioral definition from the Scandinavian countries where it had already become a cultural lodestone. If a group was going out, one person would not drink any alcohol the entire evening. This person became *the* designated driver.

Winsten's team made it their goal to create a safety routine across America. They did not have a formula or other examples to follow. "Winsten's inspiration was that you could make the behavior contagious by repeatedly exposing people to it, in many different contexts, even if those contexts were fictional."¹

They collaborated with writers and producers of more than 160 prime-time television programs before the internet and cable splintered America's attention. Shows would sprinkle designated-driver moments into their scripts. These moments appeared on **The Cosby Show**, **Who's the Boss**, **Hunter** and many others. A *designated driver* poster was displayed on the wall of the bar set for **Cheers**. In an especially memorable episode of another big hit show, **L.A. Law**, actor Harry Hamlin, playing the heart-throb lawyer, asked the bartender to please call his *designated driver*.

A 1988 **Los Angeles Times** interview about Winsten reads:

“Jay’s crusade was one that we could do something about fairly easily, unlike a lot of other worthwhile causes,” said Grant Tinker, then a vice president of NBC, who introduced Winsten to dozens of writers at all the major networks. Winsten always requested just “five seconds” of dialogue featuring the designated-driver idea, not a whole episode or even a whole scene. “Considering the simplicity of it all,” said Tinker, “it was very hard for us to feel our independence was being challenged.”

Three years after the campaign launched, nine out of ten people were familiar with the behavioral definition *designated driver*. And in 1991, people were behaving differently. Thirty-seven percent of American adults reported they had served as a designated driver. Fifty-four percent of those who drank frequently had also been driven home by a designated driver.²

This behavioral definition was not just life changing—it created “life saving” behavior. By 1992, alcohol-linked road fatalities had declined by at least twenty-five percent since 1988. This decline from nearly 24,000 to less than 18,000 lives lost was significant, and this happened at a time when more vehicles were on the highways and more miles were driven. It is likely the number of lives saved by the wide use of designated drivers was understated. By now, the cumulative total far exceeds 100,000 deaths avoided on America’s roads.

Jay Winsten used the power and reach of television to stimulate a desired behavior and Americans responded. They first saw it and then mimicked it. *Designated driver* became a societal norm. What began as pure fiction became tangible, quantifiable and, from a behavioral definition and change implementation perspective, highly instructive.

4

Am I Going to Live Through This?

“All under one roof” sounds like a pitch for a shopping mall rather than a process design and operating definition for a Breast Cancer Care Center. Coupled with the companion behavioral definition *patient-centered*, it is easy to see what surgeon and *healthcarer* extraordinaire Laura Esserman had in mind. *All-under-one-roof* and *patient-centered* guided the development of what became one of America’s leading medical treatment centers. Esserman practiced at the University of California at San Francisco (UCSF).⁶²

A warm and empathetic person, Esserman decided there was a more caring way to treat women with breast cancer. Of course, it didn’t hurt her popularity with patients when she gave them her personal cell phone number and often even sang them a lullaby as they drifted off under anesthesia before surgery.

This human touch is in sharp contrast to what most breast cancer candidates usually experience. A typical progression in the U.S., as described by a Stanford University Case Study⁶³, follows in a condensed description, where we use a Jane Doe as the patient:

Jane discovers a lump in her breast. She calls for a doctor appointment and awaits her scheduled examination. The doctor confirms she needs to be further examined, so Jane is referred to another facility with a radiologist for a mammogram(s). It takes a few anxiety-filled days to get the results and they are suspicious, so she is given an appointment to see a busy surgeon like Dr. Esserman. Unfortunately, the mammogram images don’t arrive in time for her

examination, so there is a further delay of hours or days while they're located. Nevertheless, the surgeon does a biopsy, which is then sent to (or out for) pathology to determine if the lump has cancerous cells. Jane goes home to—again— anxiously await a phone call. When cancer is detected, she returns to see the surgeon and surgery is scheduled. After surgery, Jane is referred to another specialist for radiology and to an oncologist for chemotherapy. This sequence might take several weeks to unfold, and all the while, Jane can't help but wonder: **"Am I going to live through this?"**

Laura Esserman was appalled by the process and she decided it could be and should be dramatically improved. "What if there were a breast care clinic where a woman worried about a lump in her breast could walk in at the beginning of the day and walk out at the end of the day with an answer—either knowing the lump was no problem, or if it were a problem, having a treatment plan already in hand?" Esserman next set out to design an integrated process around the patient and, ideally, all-under-one-roof, which at UCSF, as in most large organizations, meant there were "turf" issues, as well as institutional politics and bureaucracy, to overcome.

Esserman brought Meredith Mendelsohn aboard as her chief administrative director and they moved to a modified test mode one day a week. UCSF Radiology Department presented the most difficult scheduling problems, but they prevailed. Esserman would, in the morning, tell patients to go out for a nice lunch or go shopping and then come back at 1:00, while she spent her lunch break in radiology with a radiologist examining the morning's mammogram images and deciding what needed to happen next. It worked, not seamlessly, but well enough to be expanded to two days a week.

"More surgeons started to get involved, and then nurses, and counselors, and support staff, and the snowball began." Success bred more success. Demand grew so much that UCSF

decided to dedicate an entire floor to a new Breast Care Center. The initial design didn't include radiology, so Esserman gave up a full third of the floor to achieve a core definition—*all-under-one-roof*, and of course, to be *patient-centered*.

Patients flocked to this center. Their patient count from 1997 to 2003 grew from a base of 175 to 1,300 per month. The UCSF Breast Cancer Center became recognized as a national leader and research center. From a business perspective, the gains were equally impressive: great cash flow and profit coupled with raving customer satisfaction.⁶⁴ "For the first time," said Esserman, "we put the woman at the center."

All-under-one-roof was another umbrella vision and keystone behavioral definition that aligned the efforts of disparate and often competing intra-organizational silos, including radiology and nursing, at the UCSF Medical Complex. This was no small feat. A self-organizing behavioral definition, *patient-centered*, spurred an improvement effort driven by Laura Esserman.

Resistance was overcome by connecting these behavioral definitions. This wasn't an abstract, high-level visionary goal created by a Hospital Administrator or board. Rather, the definitions were developed by a practicing surgeon and connected to the fears and trepidations of the very patients the center served. These patients who, in common medical practice, are told to wait for the next phone call days and sometimes weeks later for the results of their mammograms, biopsies or other tests, discovered a timing-and-care-sensitive surgery center. The process was also accepted and followed explicitly by the center's staff, practicing surgeons, radiologists and nurses. It appealed equally to their emotions and intellect.

As with the *designated driver* behavioral definition, UCSF's Breast Care Center had a "why," "how" and "when." Prospective patients, more importantly, now knew where to

Afterword:
More Care, More Health, Less Healthcare
by Dr. David L. Katz

My field—health promotion—and no doubt many others just as well, handily illustrates the gap between knowledge and the true power of its effective application. We have known for the past two decades at a minimum how to eliminate fully 80% of all chronic disease⁹⁸, and just look around to see the use to which that knowledge has been put. During those same two decades, chronic disease rates and their public health toll have only escalated⁹⁹, and dramatically at that, globally, and especially in the U.S.¹⁰⁰

Knowledge, alas, is not power.¹⁰¹ Knowledge may be necessary for power. Knowledge may be prerequisite to power. But knowledge is not sufficient for power. The gap between what we know, and what we do with what we know, belies the wishful thinking the expression espouses.

It was in 1993 that we were first, most clearly told in no uncertain terms of the opportunity to eradicate 80% of all chronic disease. For it was in that year that McGinnis and Foege published their seminal paper in **JAMA: Actual Causes of Death in the United States**.¹⁰² We learned then what perhaps should have been obvious all along: diseases were not really causes. Diseases were effects.

McGinnis and Foege asked, and answered: effects of what? What was causing the diseases—heart disease, cancer, stroke, diabetes, dementia—that were in turn causing premature deaths? What was causing the diseases that were taking years from life, and life from years?

The answer was a list of ten factors, most of which are under our potential personal control. But for our purposes here, the salient finding was that fully 80% of the action was just the first three items on that list: physical activity, dietary pattern, and tobacco use. I have long summarized this as use of feet, forks, and fingers.

Since 1993, a whole series of publications^{103,104,105,106,107,108,109} has served to reaffirm the link between those same few behaviors and the epidemiology of premature death and chronic illness—and even control over the expression of our genes. And perhaps more importantly, to establish the reverse connection as well: we could, with good use of feet (routine physical activity), forks (optimal dietary patterns), and fingers (no cigarettes) eliminate fully 80% of all chronic disease. That is incredible—but certifiably true.

Archimedes famously said: give me a lever long enough, and I can move the whole world! Feet, forks, and fingers are levers long enough to move the whole world of modern epidemiology to a dramatically better place. And they are accountable, and in principle accessible, to each of us.

But just as knowledge is not commensurate with power, will is not tantamount to way—despite cultural platitudes to the contrary. We may have the will to be healthy, but in a world of willfully addictive junk foods¹¹⁰, ingenious labor-saving technologies, and cultural ambivalence¹¹¹—we may not have, or know, or find, the way.

Where there's a will, there may or may not be a way. And so that way must be paved. One approach, accessible to us as individuals, is to align will-power with skill-power. There is a path to the summit of Mt. Everest—but only those with genuine mountaineering skills can take it. The climb to eating well and being active is, fortunately, not nearly that arduous—but in our obesigenic environment, it's no walk in the park, either. Taking the path to health in our culture requires skill.¹¹² Will-power alone will not suffice. Will-power plus skill-power certainly can.

Caring about health is where it all begins. And because we don't, in general, care nearly enough about health, we wind up with way too much healthcare.

Over 20 years of patient care, I have seen—far too many times, painful to recall—people reach retirement age with nicely gilded nest eggs, and disastrously scrambled health. I have never met anyone seriously willing to trade their capacity to get out of bed for a large bundle of cash. I have

Appendices

Appendix NO. 1 **Worldwide Wellbeing Models**

A guide on well-doing, leadership shortcuts and five gauges of wellbeing, including the European Union-wide and Gallup national measurement systems.

Appendix NO. 2 **Birthing a Behavioral Definition**

The design process including six key tenets and four common traits of a behavioral definition, along with an example design: *WHOlistic*.

Appendix NO. 3 **Primer on *Healthcaring*: A Keystone Reset**

The backstory on *healthcaring* along with a Q & A on behavioral definitions plus the central argument for their systematic creation and use.

Appendix NO. 4 **Subtle Yet Jarring Inflections of Language**

Thoughts and insights on the interplay of language and behavior featuring the distinction between *humane nature* and human nature

Appendix 3

Primer on *Healthcaring*: A Keystone Reset

Healthcaring provides a simple, broad, flexible, adaptable and, above all, causal mechanism for change. It's defined as *many, together* in **caring health and healthcare**.

In the spirit of Open4Definition—our organization's name—*healthcaring* will also remain open for definition even as we further refine and make it more personal for you in this book. The individual aim is: to transform the health and wellbeing of the whole person; to blossom physically, emotionally, mentally, socially and spiritually; to improve a person's state of health as exemplified by WHO's definition of complete physical, mental and social well-being and is not merely the absence of disease or infirmity (see **Appendix 2** for this stated in a definition form). We need to do this with as few negative distortions to the economic engine and the social culture of America and elsewhere in the world as possible.

The goal for *healthcaring* in organizations, institutions and government is equally broad. The idea is to take self-absorbed individuals, whether as patients, employees or officials, and rewire minds around *caring* health and healthcare. Our view is every bit as utopian, altruistic and value-laden as WHO's definition of health, but with two important distinctions.

First, we've taken what already exists for a subgroup of committed individuals, an intense *caring* about health and healthcare, and amplified it to make it understandable and a usable, causal reset in America and elsewhere.

Second, *healthcaring* organizes the system and our health behavior without controlling it. Unlike the WHO definition, this isn't a black-and-white definition that is so specific as to keep

About the Author: Personal Experience Colors a Nonfiction Book



Growing up in the hills of Eastern Kentucky in what is now ranked as the unhealthiest U.S. Congressional District was, perhaps counter-intuitively, a wonderful experience for B. Helton. His family's health history was equally as abysmal as the rest of the district's. As an only child, B. spent hundreds of hours in hospitals or in close-by motels while a parent was "receiving care" or undergoing treatment. B. watched as his parents tried to avoid hospitals and institutions, especially on weekends, and he became convinced that there just had to be a better way. He knew early on that he didn't want a medical career, but that didn't stop B. from wondering why American healthcare delivery was so prone to inconsistency, errors and oversights.

He left Appalachia and, as a freshman at Georgia Tech in Atlanta, was indoctrinated to an oft-repeated phrase: "What's the good word?" This cue had only one acceptable reply: "To Hell with Georgia!" The University of Georgia was the cross-state athletic arch-rival with more than twice as many students. This response wasn't a word; it was a phrase. But Tech's engineering students, more accustomed to electrical or mechanical signals, didn't ponder the distinction. It was, and remains to this day, a natural mimic for every student and alumnus worldwide.

This was a practiced cue and reply. Yet years later, whenever B. now hears someone ask, "What's the good word?" *healthcaring* has become his auto-reply. He asks you to also take up this response. The good word *healthcaring* is a conversation starter and, for some people, the beginning of a behavioral health reset.

B. spent a decade defining knowledge work and organizing productivity and service quality improvement overseas,

followed by years of self-employment stateside that made individual health insurance coverage a necessity for his family. The arrival of a second child in 1989, Kelly, who unlike her older brother Ben, was born on U.S. soil without the benefit of maternity insurance coverage, was paid for out-of-pocket in a hard-to-negotiate yet customized time payment prearrangement. This marked B.'s complicated and costly re-indoctrination into the U.S. healthcare system and he has since spent countless hours dealing with issues in health, self-insurance and healthcare. Frustration and the continuing belief that there had to be a better way led him to start up a dot-com business touting the predecessor to today's U.S. Health Savings Accounts, and led as well to B.'s conclusion that "lifestyle health" was the only practical answer in the face of such deeply entrenched healthcare definitions.

Then in a slow-motion awakening that began in the last week of 2007, B. was unexpectedly "called" to figure out and ultimately champion behavioral definitions. There were three key prompts, none of them health or healthcare related. These were an unfulfilled redefinition of Father's Day, an ill-defined relationship and a third prompt that began as a straightforward inventory of his life's major successes and failures. After a few days of list making and editing, B. devised a simple classification scheme to search for any common threads, and two dominated. The first was "improvement," which surprised no one, considering his background in Industrial Engineering and running a management consulting firm; however, the strand that was a close second surprised him and everyone else: "definitions."

He'd been intuitively working with definitions all of his life with constant experimentation and changes in and alterations to definitions (and their effects on others, organizational performance and his business prospects), yet hadn't consciously recognized it. For the first couple of years after this eureka moment, it still wasn't easy for B. to explain the "IT" of behavioral definitions to the man or woman on the street. This included more than a hundred generous people from around the world who were intrigued enough with definitions to volunteer hundreds of hours to the overall effort and individual projects at Open4Definition.org.

Healthcaring, *healthcarer* and *humane nature* are major launching points, test cases and opportunities for everyday people, including caring mothers and thought leaders in healthcare and elsewhere, to turn their words into action in ways that cue improved health behaviors. With the unwavering support, hard work and ownership of many, Open4Definition continues this effort as B. now thinks of himself as a lens crafter and an amateur social entrepreneur. His actual job title is Guiding Principal, but he says: "I'm really more of a reporter, curator and, from time to time, either a shepherd or improvement ambassador."

This foundational book, however, isn't an author's tale; rather, it is the story of intuitive initiators like Jay Winsten who, with his coinage of *designated driver*, independently unlocked the latent power of a behavioral definition. Without fully seeing what they were doing, their definitions became part of an overarching pattern of social improvement. This behavioral and causal mechanism, now that it has been identified and defined, will simplify change and rewire minds on a large scale, that is, as others choose to join in and support its use.

In closing, and as the book reminds us, the test of any good idea is what can be done with it. What might you do with the right behavioral definition to tackle a seemingly intractable problem in your life, health or work? What will you do to make the promise of *healthcaring* a reality for you and others? Why not begin, as B. did, by repetitiously spreading the good word among everyone you meet? Open4Definition challenges you to try it out at least for the next two or three days running. You'll be amazed, both with what you learn and with the stories surrounding health and its all too often veiled and limiting definitions.

A Guided Bibliography

In a nod to authors worldwide, the key books referenced in **HealthCARING: A Reset for Health and Healthcare** are both described and available for direct purchase in the Open4Definition online webstore at:

www.open4definition.org/bibliography.php

We share a goal with these authors of making their work more visible and readily accessible to a new audience drawn to behavioral definitions and under-recognized patterns.

For your convenience, each book's "Why Recommended" webpage includes a link to the author's website, the ISBN number and Dewey classification, and listings of key people and organizations featured in the source book's behavioral definition-based stories (including more than one hundred stories unused in the **HealthCARING** book). Select authors also share their personal insights or a co-written thumbnail story designed to broaden your understanding of behavioral definitions and their practical use.

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