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Making health a shared value: Lessons from nurse-designed models of care

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ABSTRACT

Background: Nurse-designed models of community-based care reflect a broad definition of health; family- and community-centricity; relationships; and group and public health approaches.

Purpose: To examine how nurse-designed models of care have addressed "making health a shared value" based on the framework of the Culture of Health.

Method: A mixed-methods design included an online survey completed by 37 of 41 of "Edge Runners" (American Academy of Nursing-designated nurse innovators) and telephone interviews with 13 of the 37. Data were analyzed using descriptive statistics and standard content analysis.

Findings: Two main areas of "making health a shared value" were increasing the perceptions that individual health is interdependent with the health of the community and community health promotion. Themes were the value of social support (interventions that engage an individual's inner circle and a group environment to reveal shared experiences); messaging (a holistic definition of health, the value of both culturally- and medically-accurate information, and the business case); and building trust (expertise sits locally and trust takes time).

Discussion: Refinement of the COH framework may be warranted and can provide strategies for making health a shared value within a community. Shifting the orientation of healthcare organizations must be a long-term, deliberate goal.

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Reducing health care costs and improving population health require building healthy communities where individuals and families can thrive. Doing so will not be easy. The United States has a history of investing far more in acute care services than in the social determinants of health (such as education, economic stability, housing, and food security) that are

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Figure 1 – Culture of Health (COH) Action framework. Source: Policies for Action; **https://www.policiesforaction.org/what-culture-health**.

key to promoting health and improving people's ability to access care.

The Culture of Health (COH) initiative is a major long-term focus of the Robert Wood Johnson Foundation that aims to contribute to the shift from investing in medical care to improving population health, wellness, and equity. The Robert Wood Johnson Foundation developed a framework to undergird the initiative and direct programmatic activities (Figure 1). It includes four areas for action by individuals, groups, and communities (action areas): (a) making health a shared value; (b) fostering cross-sector collaboration to improve health; (c) creating healthier, more equitable communities; and (d) strengthening the integration of health services and systems (Acosta et al, 2017).

The first area, making health a shared value, undergirds the model. Unless people and communities share a belief in the value of health, collaborative work to promote community health is unlikely.

Shared values mean that individuals and whole communities prioritize health and that health informs and drives local decision-making; that communities have high expectations for their environment, health system, and supporting services; and that people understand that their health

influences and affects others, and vice versa. (Chandra et al., 2016a, p. 48).

Building an awareness among individuals and organizations within a community that health and well-being are essential for all is foundational for the social cohesion and collaborative action that will foster healthy communities (Chandra et al., 2016b). Promoting a shared value of health, however, may prove to be difficult. Our society is growing more atomized as the bonds among community members weaken and neighbors are less involved with each other (Putnam, 2001; Taylor, 2007).

Prior research (Martsolf, Sloan, Mason, Sullivan, & Villarruel, 2017) showed that the models of care designed by nurses who have been designated as "Edge Runners" by the American Academy of Nursing can inform an understanding of the health sector's role in building a COH. The work recommended further research on how health care providers and communities can understand and direct their work in ways that are consistent with the COH's first action area—making health a shared value. Most of the Edge Runner models were developed at least a decade before the COH framework was developed but they have been shown to have commonalities (Mason, Jones, Roy, Sullivan, & Wood, 2015) that are consistent with the concept of building a COH.

The present study examines ways in which the Edge Runner models promote making health a shared value. We hypothesized that Edge Runner models would yield lessons in this area because they display a commitment to improving their patients' health self-efficacy—the belief in one's ability to succeed in a given situation—and support the philosophy that engaging people, families, and communities in addressing their own health needs and enabling them to be self-advocates are essential components of making health a shared value.[1]

COH: Making Health a Shared Value

The COH Framework (Figure 1) guided this study. It has three key concepts—domains, drivers, and measures. The domains are the action areas described earlier. Drivers are areas where change needs to accelerate; they serve as priorities for investment in COH work. In the action area "Making health a shared value," three drivers have been identified—mindset and expectations; sense of community; and civic engagement.

Mindset and Expectation

This driver includes "the perceptions and views that individuals, families, and organizations hold about health" (Chandra et al., 2016b, p. 49). This does not mean that people in a community or in organizations must hold the same views about health. Rather, health must be viewed as important enough to find common ground and synergies among diverse viewpoints. Of course, cultural differences within a community are likely to be accompanied by different views of health.

Empowerment is a key component of this driver, both in enabling people and organizations to change their views about health and to demand the changes that can lead to healthier communities. It is essential for local participation in actions that promote health. This driver is influenced by actions at three levels—individuals valuing their own health and engaging in healthy behaviors, organizations prioritizing and advocating for health, and communities developing policies supportive of health.

The framework identifies several measures for each driver. For mindset and expectations, three measures were proposed: the proportion of Tweets on health promotion vs. acute medical care; the "percentage of adults in strong agreement that health is influenced by peers, neighborhood, and the broader community"; and the percentage who are interested in how their community invests in "well-being" (Chandra et al., 2016a, p. 55).

Sense of Community

When individuals and organizations understand their interconnectedness, collaboration and a sense of shared purpose among community members can help align diverse interests and perspectives into common goals and strategies for health. This collaboration includes individuals engaged in their communities through personal and professional relationships; organizations that work with others to advance community development and health; and policies that foster community engagement (Chandra et al., 2016a, p. 53).

But as our society has moved from communities to atomized "lifestyle enclaves" (Bellah, Madsen, Sullivan, Swidler, & Tipton, 1985), creating this sense of community can be challenging. There are two measures of sense of community—"percentage of adults noting that they had adequate social support from their partner, family, and friends" and "emotional connection to and membership in the community."

Civic Engagement

Civic engagement occurs when individuals and organizations actively participate in processes to bring about positive change in their communities. Equity depends on all parts of the community being involved in advancing changes. And it suggests a "health assets" perspective that seeks to identify and build upon a community's strengths, including developing social connectedness among residents and full participation of community-based organizations in actions that will advance the health of the community.

Civic engagement is advanced when individuals value their participation in promoting a healthy community, organizations support civic engagement, and a community has policies and governance structures that stimulate and support civic engagement. Measures of civic engagement include the percentage of adults who vote in a general election and the percentage of adults and youth who volunteer in their communities.

Methodology

Setting

The setting for this study is the American Academy of Nursing's Edge Runner program, developed in 2006 to recognize nurses who have designed and/or are leading care models that have demonstrated good clinical and financial outcomes. There are 66 Edge Runners whose 50 models of care and outcomes are highlighted on the Academy's website (http://www.aannet.org). The models include a child birthing center, nurse-managed health centers, programs for improving how parents and teachers manage child behavior problems, group or "centering" approaches to care, integration of behavioral

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[1] Not all Edge Runner models focus on people in a healthcare setting. We use the term "patient" to refer to individuals who are the target of a program's intervention regardless of setting.

health into primary care, complex care management, and others. This program has provided an opportunity to better understand the contributions of nurses in developing models of care that often serve underserved and vulnerable populations (Mason et al., 2015).

Procedure

The study used an online survey and telephone interviews to gather information from participants. The study was approved by the Institutional Review Board at the Rand Corporation.

Data

First, from December 2015 to March 2016, we conducted an online survey of the 41 Edge Runners that were active at the time of survey fielding. We sent an email to all nurses who were the designers or key contacts for these models, inviting them to participate in the study; and 37 of 41 Edge Runners completed the online survey between December 2015 to March 2016. The survey (available in Martsolf et al., 2017) examined various aspects of the models of care (e.g., primary setting of the model; population of focus); the presence of model components that are consistent with the four action areas of the COH framework; barriers and facilitators to the model's success; key community collaborations; and measurement of model outcomes.

Thirteen respondents were invited to participate in follow-up telephone interviews that asked them to elaborate on their responses to the survey. We used purposive sampling to select models that would reflect diversity of settings, populations, origins (practice- vs. research-driven), dissemination, and congruence with the COH framework. The interview guide was developed by the investigators (available in Martsolf et al., 2017). The interviews were conducted by members of the research team with qualitative research experience. Interviews were between 60 and 90 min long via telephone, recorded, and transcribed.

Quantitative Analysis

Using the survey data, we described the Edge Runner models in terms of each model's primary setting and population served. Respondents rated each setting based on whether it was a primary setting, secondary setting, or not a setting at all for the model. We calculated the proportion of Edge Runners who indicated that the specified setting was the primary setting of their program. Respondents also reported on the extent to which various populations were the focus of the Edge Runner model using a four-point Likert scale (i.e., 0 = not at all, 1 = to some extent, 2 = to a moderate extent, and 3 = to a great extent). We report the proportion of Edge Runners who indicated that the population listed was the population that they served "to a great extent." We then calculated the extent to which models focused on making health a shared value using a four-

point Likert scale (i.e., 0 = not at all, 1 = to some extent, 2 = to a moderate extent, and 3 = to a great extent).

Qualitative Analysis

We used standard content analysis to draw themes from the data (Hsieh & Shannon, 2005). To do this, we loaded the transcripts into Dedoose (qualitative analysis software). We created a code book which included 10 a priori codes which were based on various sections of the interview protocol. Two of the investigators then applied these codes to the transcripts in Dedoose. For this manuscript, we extracted all sections of the interviews that were coded as related to "making health a shared value." The same two authors read those sections separately, identified key themes, and wrote memos on each theme. These memos were compared and the list of themes was refined. When the authors reached agreement on the themes, one author summarized the themes and shared them with co-authors for validation and further refinement.

Findings

Quantitative Survey Data

In Table 1, we describe the models in terms of the primary setting and the population served. Edge Runner models had very diverse settings, and few of the models occurred in any one primary setting. The most common setting was inpatient (33.3%), followed by primary care (25.0%), and community alone (22.1%). The most common populations of focus were women (80.6%), low income people (61.1%), and racial/ethnic minorities (61.1%).

Table 2 shows survey respondents' answers to questions about how much they focus on certain activities that represent "Making health a Shared Value," such as volunteering, community health promotion, and fostering community social support. The two activities with the most focus among Edge Runners are (a) increasing the perceptions that health is interdependent (53.8% indicated that they focus on this activity to a great extent) and (b) community health promotion (61.5% indicated that they focus on this activity to a great extent). More than half of participants (54%) indicated they focus on volunteering "not at all."

Qualitative Interview Data

Three major themes emerged from the qualitative analysis: the value of social support, the importance of messaging, and building trust. Each of these themes is central to actions that contribute to making health a shared value. For example, building trust is essential for convincing people to volunteer, or for them to trust the information at community health promotion events. Each theme had two to three subthemes, discussed below.

Table 1 – Primary Setting and Population Served Among Survey Respondents (*n* = 36)	
	Survey Respondents (%)
Primary Setting*	
Inpatient	33.3
Primary care	25.0
Community alone	22.2
Community co-located	16.7
School	16.7
Home	16.7
Other outpatient	11.1
Long-term care	8.3
Childcare	5.6
Other	5.6
Population served to a great extent†	
Women	80.6
Low-income	61.1
Racial/ethnic minorities	61.1
Infant	41.7
Elderly	52.8
Adolescents	33.3
All members of a specific geographic region	22.2
A population with a specific disease or condition	27.8
Other (rural, homeless, part of a health plan or system)	80.6

  * Calculated using the percent of Edge Runners who indicated that the setting listed was the primary setting of their program. Respondents could check as many primary settings as apply.

  † Calculated using the percent of Edge Runners who indicated that the population listed was the population that they served "to a great extent." Respondents could check as many populations served to a great extent as applied.

The Value of Social Support

The importance of fostering social support within the populations served was a key theme throughout the interviews and case studies. We found that there were two common ways that Edge Runner programs did this: creating interventions that recognize the importance of an individual's inner circle, and creating a group environment to reveal shared experiences.

Targeting the Individual's Inner Circle

While all of the Edge Runner programs seek to reach a certain population and improve health outcomes, many have expanded their interventions to target not only those individuals, but their immediate social circles, as well, to maximize outcomes. For example, a representative from one group that works with pregnant mothers emphasized *"talking to the moms and their family members—because it's not just the moms.*

She doesn't sit in isolation." Including the family members in these conversations recognizes the role families can have in improving health. Another program focuses on family caregiving issues, again recognizing the role of close social ties in improving health outcomes. Yet another example is engaging parents in schools. One Edge Runner stated, in reference to the high percentage of children in a city's schools who are not meeting benchmarks for social behavioral readiness:

> This is a huge problem. And so it's not an illness problem. It really is creating a culture of health. And you can't fix it without engaging parents. And so what I've been trying to do with schools is to help them to understand that parent engagement in early childhood isn't like going on the field trips. It isn't helping out in the classroom. Because those are things that middle class parents with leisure

Table 2 – Participants' Engagement in Activities Representing Making Health a Shared Value (%)				
	Not at All	To Some Extent	To a Moderate Extent	To a Great Extent
Volunteer efforts related to socioeconomic issues, physical or environmental health or general well-being, such as civic engagement, advocacy and other volunteering	54.1	29.7	2.7	13.5
Community-wide well-being and public health discussions	27	27	13.5	32.4
Community-wide health promotion activities	13.5	13.5	8.1	40.5
Participation in activities related to development of youth leadership in health	21.6	21.6	8.1	8.1
Assessing or fostering community social support	18.9	18.9	24.3	29.7
Increasing community members' perceptions that their health is interdependent	21.6	21.6	5.4	40.5

time can do. But what that really means is providing things to parents that builds their capacities to be the parents that they want to be.

This statement exemplifies a recognition that helping children succeed in school must involve the children's parents. Recognizing and endorsing the value of engaging with participants in the context of their daily lives by including their families or closest social ties is key to creating a shared value and experience.

Creating a Group Environment

Many Edge Runners use group environments to foster and operationalize social support, establish a sense of community, create a shared understanding of health and what affects it, and empower people to make informed choices about their health. For some programs, there is a value in having participants realize they are not alone. One Edge Runner stated a goal of their group sessions as *"creating an awareness of a shared health experience."* Another Edge Runner provided a strong example of the value of groups in helping participants realize their shared experiences:

> And in the context of the group, parents connect with other parents... especially low-income parents who are very isolated from one another... They don't go outside their home if they can help it, because it's not safe.... So even in the first session when parents find out that other parents have kids that don't do what they tell them to do the first time, they're like, "You're kidding me! Really?!" [It's a] normalizing aspect... And they start building networks of other parents in the school.

In addition to connecting previously isolated individuals who have shared experiences, Edge Runners emphasized the importance of fostering relationships and creating a sense of community. For example, one Edge Runner representative stated, *"we know the research tells us that peer-to-peer support matters for breastfeeding outcomes. And so, for example, at [name of institution] we have a support group... And so we bring the families together once a week to really talk about the process and create a sense of community."* Other Edge Runners created a space for relationship-building through group sessions and also encouraged participants to foster and use these relationships outside of the group. For example, one Edge Runner stated *"people participated in the program in groups of 10 to 15 and social support was encouraged. We encouraged people to exchange phone numbers, to go out together outside of the program, to email each other, to stay in touch."*

Other Edge Runners with community health centers build relationships and community in creative ways:

> We have murals and we engage the patients in helping us design them. So at [one center], they have a beautiful mosaic mural...the community is engaged in helping to design it. And we have a painted mural at one of our other health centers

and, again, community people and staff were involved. We still have a few people including our staff help to design the mural to represent what the community looks like and what the services are we provide and what their idea of health is. And we're doing that, once again, at one of our other health centers right now. So that would be one other example of how we engage.

Connecting individuals, providing a venue for fostering relationships and social support, and building community are core building blocks of making health a shared value, a main pillar of the COH action framework.

The Importance of Messaging

Creating a shared value relies on people's understanding of health and how it is prioritized, which is heavily shaped by how information is defined, messaged and disseminated. Within this theme of messaging, Edge Runners emphasized a holistic definition of health, underscored the value of both culturally accurate and medically accurate information—and when there might be tension between the two—and stressed the importance of getting people (target populations, stakeholders and funders) to believe in the "cause."

Expanding the Definition of Health. One consideration in messaging is seeking to redefine health and the role of the health care provider more broadly. For example, many of the programs aim to de-medicalize wellness through the integration of physical, mental, emotional, social, and mind/body care, and by empowering the participants to monitor their own health outcomes. One participant stressed social behavioral health as critical to a child's success:

> The social behavior skills are the things that enable children to sit still, to listen, to follow instructions, to remember what they're being taught, to problem solve, to manage their feelings, to manage their frustration, to sit still and learn, all of these things. And so if a teacher can't get a child to sit still they can't teach them to read. I mean, teachers will say, "I can teach them to read if I can just get them to listen." And so these social behavioral skills undergird everything.

In addition to expanding the definition of health, participants emphasized the need for everyone to come together around a shared definition of health. For example, one Edge Runner who develops and implements workplace wellness programs, stated *"You know, how a provider defines health and...how employees define health are two different things and so one of the things we work on is to try to figure out how to blend those two things."*

Another participant who works with the elderly, discussed understanding depression and the importance

of getting both providers and clients on the same page: "*And many people believe that—and this is including physicians and nurses think that—depression is a normative aspect of growing older. But it's not. It's a medical condition that's treatable. But many older adults don't know the difference between grieving and depression, particularly if they've experienced a number of losses recently.*"

Redefining health to be more inclusive and holistic and ensuring that providers and communities share in their definition of health is an important part of people's mindset and expectations, one of the drivers of making health a shared value in the COH action framework.

Valuing Both Culturally and Medically Correct Information. We found a tension between ensuring the community is informed with accurate medical information, and respecting and endorsing community and cultural norms around certain issues. As health care providers, Edge Runners emphasized the medically appropriate information they gave their population, viewing this as a way to empower people to make informed decisions. For example, one stated "*the first step of my model is about informed decisions. And so women often make the decision not to breastfeed or provide milk because they lack research-based information.*" However, Edge Runners also noted the importance of understanding cultural norms that inform decision-making. Another Edge Runner told the story of one participant, who was "*buying milk out of the case and taking it home and heating it and putting in bottles and feeding the baby with it. But babies can't digest cow's milk protein so that's why the baby was in such distress. And so I was able to talk to her about that and I learned that she had been taught, it was part of her culture, that you never give babies anything from a can.*" Understanding this cultural information allowed the Edge Runner to address the issue sensitively and effectively.

Across Edge Runner programs, a common theme was valuing the cultural norms and information accepted by the community of interest and establishing a strong understanding of them because these norms shape behavior. Having a shared understanding of health and the cultural beliefs that shape health is key to making health a shared value.

Making the Business Case Central to the Cause of Building a COH. Another key component of messaging that many Edge Runners discussed is the importance of having community members and stakeholders believe in the cause in order for it to be successful. One Edge Runner mentioned the good fortune of having others on board: "*One of the things that's very lucky for me is that we have entered an environment right now nationally where it seems to be consensus among the business community, researchers, economists and schools, everybody, that early childhood has got to be the primary…is a really important investment time for us.*" Making a strong business case, or value proposition, in order to get people to care seemed central. Another Edge Runner stated, "*I think the stronger the business case is built around if you don't invest in changing the root cause…it's continuing to build that business*

case around things broader than just the immediate problem that's in front of leadership in the organization." Another, who works with workplace wellness programs, shared those sentiments despite serving a different population. She stated, "*it's not just a matter of controlling disease and claims, which is what a lot of the CFOs and CEOs are most interested in, but it's how if you have a healthier work force, it's going to impact multiple aspects of your business and so health becomes a real business strategy for our clients.*"

Making sure everyone, from community members to community partners to the larger social and business communities, understands the financial impact of moving upstream is key to creating a shared value.

Building Trust

The third theme was that of building trust. This starts with recognizing that community expertise sits locally. It also requires an acknowledgement of differences, and of the systemic systems of social oppression. Lastly, building trust and being successful take time.

Expertise Sits Locally. Part of the process of building trust is being able to recognize and give credit to experts. In a community, the community members or residents are the experts. One Edge Runner stated simply, "*you have to have the perspective that they are the experts of their world, we are not.*" Other Edge Runners use lay community members to run their programming—a recognition of the importance of their expertise—or as community health workers, peer-to-peer breastfeeding counselors, or volunteers to help patients with navigating services in a community health center. Others have assembled community advisory boards to ensure that the local expertise is heard and is informing programmatic and strategic decisions for the Edge Runner model. One Edge Runner captured the importance of valuing this local expertise when she stated: "*I mean, everything is local. Those old adages…, 'Making a national change requires local engagement.' If you don't work as if everything is local… Top-down just doesn't work. I've seen it bottom-up. I've seen it top-down. And people who try to just do something top-down, you've got to bring everybody else along. And, I'm sorry; you've got to really engage everybody's mind. And it's all about local.*"

While this notion of community members holding the expertise on their communities is not new, it is central to the success of these Edge Runner programs and a common theme throughout.

Acknowledging Differences. According to Edge Runners, a key component of gaining and building trust is acknowledging differences. For example, one Edge Runner acknowledged the systemic oppression her community has faced. "*When White people go into Black neighborhoods, why are they there? Usually it's for population control, right? And they want to do abortions and so forth and so on. Well, we were very different from them but*

we had to fight that impression that there was in the neighborhood." Another Edge Runner describes acknowledging differences to start breaking down barriers between herself and her community. She stated, "And so when I walked in I would say, "Now, I know I'm the wrong color and I'm from the wrong place, New York." Everybody knows New Yorkers are crazy, right? And so that would sort of break the ice." Acknowledging differences and systemic issues is another stepping stone to making health a shared value.

Success Takes Time. Building relationships and community partnerships take time. The Edge Runner for an employee wellness program noted that the program leaders appeal to the employers' concern about health care costs, but the long-term commitment to wellness programs requires creating that shared value of health: "We really work on employers' mindsets and expectations as well as the employees', and then the sense of community in that the employer cares about their employees and the employees see that the reason that the employer is putting in a wellness program is because they do truly care about them."

Building trust means sticking by partners even when success is not evident. One Edge Runner noted that it was important to support community partners on "anything that improves the community, yes. And even if it doesn't then you have to stay with them. You have to be there with them. And then they eventually can grow. You can't just leave them and isolate them."

For these Edge Runners, gaining trust and building success takes time, and so does fostering a COH across the country. But recognizing the value of the process, even when it is a long one, is part of making health a shared value.

Discussion

This mixed-method study examined how a group of health professionals, who have designed innovative models of care, have addressed one aspect of the COH framework—Making Health a Shared Value. The participants were nurses recognized as "Edge Runners" by the American Academy of Nursing for their innovative models of care. These models of care have good clinical and financial outcomes, have spread beyond their initial sites, have commonalities that include a broad definition of health, and are individual-, family-, and community-focused (Martsolf et al., 2016; Martsolf et al., 2017; Mason et al., 2015).

An earlier study of the Edge Runners found that their work reflects four themes (Figure 2)—defining health holistically; being individual-, family-, and community-centered; building relationships with patients, families, and community members; and using group and public health approaches to care (Mason et al., 2015). These are consistent with the COH framework and the findings of this study.
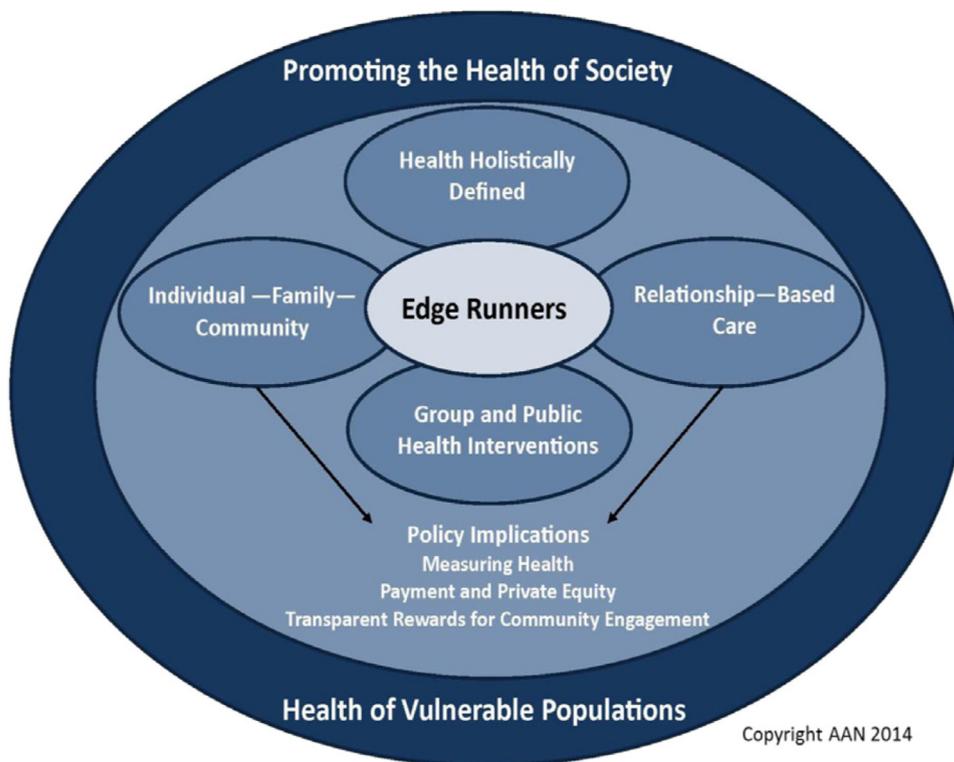
Figure 2 – Common elements of Edge Runner innovative nurse-designed models of health care.

As such, we had expected the online survey to demonstrate a higher percentage of participants reporting that they engaged in these indicators of "Making Health a Shared Value" than we found. Fifty-four percent said they did not engage in "volunteer efforts related to socioeconomic issues, physical or environmental health, or general well-being, such as civic engagement, advocacy, and other volunteering." Over a quarter had no involvement with "community-wide well-being and public health discussion."

There are a number of possible explanations for this. Many said they had never thought of tracking community activation around health and strategies for encouraging individuals to value and prioritize health. The idea that health is valued and that health equity is important may have been taken for granted by this particular group of health care professionals.

But another explanation may speak to the COH Framework itself. The indicators of Making Health a Shared Value, Action Area 1 of the COH Framework, do not include the one-on-one work that health professionals do with patients and family members to enhance their understanding and valuing of health and how to promote it. Building healthy communities will be challenging without empowering individuals and families to actively attend to their own health. Those hoping to develop a shared value of health would do well to recognize that there is a subsidiary or concurrent level of work here that focuses on the most local unit possible, in order to grow the shared value of health. Health professionals are key to this local level of work but must examine whether their own approaches to care foster patient and family engagement and embrace a holistic definition of health. Given that most of the Edge Runners serve underserved and vulnerable populations, perhaps the framework would benefit from measures that reflect shifts in individual community members' participation in promoting their own health and that of their families. Future research on making health a shared value should examine the extent to which a community can embrace this action area without health care providers adopting a philosophy and approach of engaging patients as active participants in their health care.

The Edge Runners have thought about how to redefine health and how to engage patients and families in their care (Martsolf et al., 2017; Mason et al., 2015). In a prior study, Edge Runners spoke of "meeting patients where they are at" and the importance of building trusting relationships over time (Mason et al., 2015). They viewed these aspects of their work as essential to engaging patients, families, and communities in advancing their own health. In the present study, Edge Runners spoke directly of valuing accurate medical information but respecting and endorsing individual, family, and community cultural norms. The present study demonstrates that nurses have the philosophical resources, knowledge, and ability to foster engagement. Participants spoke about targeting the patient's inner circle, particularly their families, and using group approaches to care and to deliberately foster a social network of support. This is done by building connectedness one individual and group at a time. Future research should examine the extent to which creating such social supports and connectedness leads to greater participation within communities.

Promoting a shared value of health will likely entail a significant philosophical shift in the problem-solving approach historically used by health care professionals. Our health care systems have long relied on centralized solutions driven by the application of remote technological expertise. Such solutions often create a disconnection between health care delivery and patients' communities and related cultural practices (Berry, 2011; Bishop, Rosemann, & Schmidt, 2008). The COH framework is implicitly attempting to reorient health care away from technological interventions and toward the promotion of cultural practices necessary to promote holistic health and wellness. These practices are likely to reflect profound local variation. The cultural practices implicit in creating a shared value of health may be realized when stakeholders outside of the health care industry and deeply embedded in the community are engaged collectively in aggressively addressing the social determinants of health.

It remains to be seen whether nurturing health as a shared value can be sustained in an environment of rapid change and consolidation in the health care industry, in conjunction with the short-term focus of funders and policymakers which often require rapid return on investment. Shifting the orientation of health care organizations must be a long-term, deliberate goal that will require extension and reinforcement of policy directions, such as value-based payments and Accountable Communities for Health, an outgrowth of the Centers for Medicare and Medicaid Innovations' State Innovations Program. As Mongeon, Levi, and Heinrich (2017) points out, "there is a body of evidence suggesting that the success of value-based payment models will be closely tied to efforts addressing the behavioral, social, economic, and environmental determinants that play a key role in health inequities and poor health outcomes." As such, Accountable Communities for Health are being tested as approaches that require cross-sector engagement in developing innovative approaches to reduce health disparities. Though an intriguing concept, challenges to moving beyond the demonstration phase include how to finance them in the long term.

While policy change is a long-term strategy, findings from the present study suggest that leaders of culturally-oriented models of care can make a business case for the value and effectiveness of the model, They can do so by engaging key stakeholders within and outside of the health care sector to embrace the broad definition of health, allowing time for building relationships, recognizing that local community members are the experts, and supporting innovative approaches to providing care.

In summary, this study suggests that nurse-designed models of care provide important lessons about making health a shared value. While these Edge Runner models may not be generalizable to all settings, they demonstrate some of the key elements to building a COH.

Supplementary materials

Supplementary material associated with this article can be found in the online version at doi:10.1016/j.outlook.2018.12.024.

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