CarePhysics

Bringing Out the Best in Care

Advance review draft 3.7
October 2026

Joe Gleason

Human wisdom. Purposeful assistance. More room for one another.

About This Review Edition

Advance review draft 3.7 · October 2026

Thank you for helping us bring out the best in this book.

This complete manuscript is shared for discussion and reader feedback before publication. It retains the ten CarePhysics principles, the continuing family story, the Reference Companion, and the practical tools. This edition makes limited editorial and layout refinements to version 3.6; it does not add a new research review.

What would help most

Tell us where an explanation is unclear, a scene does not feel true to care, a practical step needs more support, or a claim needs a better source or qualification. Tell us what is useful and worth preserving, too. You do not need to review every chapter to make a valuable contribution.

How to return feedback

Use Word comments or Track Changes, or send a short note with the chapter, heading, and a few words from the passage. Include the page number from this edition where helpful; pagination may change in later versions. Keep private patient, participant, family, and staff details out of review comments.

A guide to examine and adapt

The book distinguishes published research, professional guidance, proposed applications, fictional examples, and dated organizational records. Use it alongside the professional guidance and responsibilities that apply in your setting. Its family scenes are teaching illustrations, not testimonials or evidence of results.

Release information

This is an advance review draft, not the final publication edition. Publication and reuse information, illustration credits, and final author approval will accompany the release edition.

Read what is useful. Bring one question. Help the next version become better.

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Introduction

What If We Could Bring Out the Best in Care?

Meaningful change can begin with a good question.

What if we could bring love, compassion, and purpose more fully into everyday care—while giving the people who provide it more time, better support, and less unnecessary work?

What if a family could feel more connected and better prepared without someone having to spend every evening coordinating the next day? What if a nurse, social worker, or care team member could spend less time reconstructing information and more time understanding the person in front of them?

What if technology and artificial intelligence could help us carry the best of one encounter into the next: a thoughtful explanation, a useful question, a practical solution, or something a family taught us that another family should not have to discover alone?

And what if we could pursue those possibilities through principles people can understand—drawing on established research, care practices, and human experience rather than starting over with every new tool?

These are the questions at the heart of CarePhysics.

The ambition is to connect things that belong together: the humanity of care, the knowledge of the people providing and receiving it, and practical ways to make that knowledge useful.

Love gives us a reason to pay attention. Compassion asks us to understand what someone is carrying. Purpose helps us recognize what care should protect or make possible. Research helps us examine our assumptions. Thoughtful design gives those intentions a place in the everyday work.

Technology should serve that work. The future worth building is one in which a more capable system makes more room for a human being.

Where These Questions Became Personal

I lost both of my parents to dementia.

The idea for Genus began taking shape during that journey, while our family was still learning what care would ask of us. My children were nine, eleven, and thirteen when it began. They came with me to visit their grandparents in hospitals, Day Centers, rehabilitation centers, assisted-living communities, and dementia-care settings. I was there as a son and a father, trying to support one generation while raising the next.

There were medical questions, but there were also questions about ordinary life. How could we make a visit meaningful? How could we share responsibilities? What help was

available? What should we ask next?

I saw worry follow families into their work and relationships. I saw care teams responding to difficult situations while needing more time, preparation, and support themselves. I also encountered remarkable knowledge and generosity. People had found thoughtful ways to welcome, explain, listen, and help. They were willing to share what experience had taught them.

That combination—real strain alongside real wisdom—became the starting point. The question was how to make more of that wisdom available, and how to give people better conditions in which to use it.

Conversations became interviews, focus groups, and a wider inquiry. Families, patients, participants, volunteers, nurses, social workers, doctors, researchers, and organizational leaders contributed perspectives that changed the work. The questions grew beyond my own family.

The “I” became “we.” And that “we” continues to make room for “us.”

Throughout the book, “we” acknowledges that wider circle of contributors. Their perspectives need not be identical. When we describe company practice, we say “we at Genus,” keeping that responsibility distinct from the broader community.

Dementia brought this work into focus, but it does not define its limits. These questions belong in hospitals, homes, rehabilitation, independent and assisted living, Day Centers, workplaces, and communities. They matter to someone surrounded by relatives and to someone living alone.

Carry the Best Forward

Consider what we might learn from one ordinary encounter. A team member finds a clearer way to explain a confusing instruction. A family member points out that an apparently simple task requires three telephone calls. A participant suggests offering activity choices earlier, before the day becomes tiring. A volunteer notices that a photograph of the entrance would answer a question the welcome booklet leaves unresolved.

Each observation could improve the next experience.

CarePhysics asks us to give that knowledge a dependable route forward. Invite the contribution. Understand the situation in which it arose. Review it alongside relevant evidence and professional guidance. Try an appropriate change. Ask the people involved what happened. Credit the contribution and share what others can responsibly use.

The lesson may become a better conversation, a short demonstration, a revised article, a staff practice exercise, or a change in how a service is arranged. Sometimes the useful result is removing an unnecessary step. Sometimes it is recognizing that more resources are needed. Learning means allowing what people discover to change what we do.

This is the opportunity we see in technology and AI: assistance that helps people find, prepare, connect, and carry forward useful knowledge.

Imagine a care team preparing for a family conversation. An appropriately configured assistant could assemble relevant guidance, organize questions already raised, and prepare a draft for review. During an agreed, supported interaction, it might bring an unanswered question to the facilitator's attention. Afterward, it could help prepare the follow-up and preserve a useful suggestion for review. These are proposed tasks to configure and evaluate, with people retaining judgment, relationships, and responsibility.[1]

The goal is less time rebuilding what we already know, and more opportunity to use what we know well.

We should ask what happens to any time returned. Does it create room for a question, a break, preparation, or a more personal interaction? Does it make the day more workable for staff and families? Evaluate the complete experience, including the work of checking and following through.

Efficiency has a human purpose when it changes what people have time and energy to do.

A Strong Foundation for Better Questions

We do not have to invent the foundations of good care. CarePhysics brings together research and practice from healthcare, behavioral science, social learning, communication, education, design, and organizational improvement. Its contribution is to organize that knowledge around choices people can recognize and put to work.

The behavioral foundations ask different questions. COM-B examines capability, opportunity, and motivation. Self-Determination Theory directs attention to autonomy, competence, and relatedness. Fogg's model considers motivation, ability, and a prompt coming together at the moment of action. They help us investigate what makes a chosen step possible rather than assume that every difficulty calls for another reminder.[2,3,4]

Alex Pentland's Social Physics brings attention to how ideas move through relationships and become part of collective action. Health-communication practice adds plain language, attentive listening, demonstrations, and opportunities to check understanding. Together, these perspectives help us ask how useful knowledge reaches a person and becomes something they can work with.[5,6]

The Age-Friendly 4Ms—What Matters, Medication, Mentation, and Mobility—offer a complementary framework for older-adult care. The initiative led by The John A. Hartford Foundation and the Institute for Healthcare Improvement, with their partners, connects assessment with action across the four elements.[7]

RUSH University Medical Center's Caring for Caregivers model makes another need explicit: the person doing the caring needs support in their own right. Its approach to identifying, understanding, and assisting caregivers informs the separate caregiver-support pathway in this book.[8]

Eliyahu Goldratt's Theory of Constraints contributes a practical improvement question:

what is currently limiting the result we are trying to achieve? A family may understand a service and want it, yet still be waiting because responsibility is unclear or capacity is unavailable. Improving the invitation alone will not resolve that situation. We need to examine the arrangement and direct the next improvement where it can help the whole process.[9]

These approaches do different jobs. The person's life gives those jobs a common purpose.

CarePhysics is an evidence-informed framework. Some foundations have a substantial research history; others offer promising methods or emerging applications. We distinguish published findings, professional guidance, our proposed applications, and local experience. Evidence supporting one component does not validate the whole combination or a particular product. R1 presents the research and its limits; R2 explains the models.

Make the Human Purpose Practical

Love and compassion become visible in how care is organized. For a person receiving care, that may mean being addressed directly, understanding a choice, or finding that something important to them has changed the plan. For a caregiver, it may mean a private conversation about their own needs or dependable support that leaves time they can genuinely use. For a team member, it may mean the right information, workable preparation time, and a clear route to help.

Seeing the whole person also means making room for worries about cost, work, transportation, housing, and future decisions. A concern deserves an appropriate response and a connection to people qualified to help. A kind explanation is valuable; a practical question also needs an answer.[10]

Communication design belongs here too. Think of the television remote in your own home. You know where the controls are. At someone else's house, the same simple task can become unfamiliar. Care information can create that experience repeatedly: a different format, different terminology, and another way to find the next step.

We can give people more familiar ways through. A video can show what an article explains. A message can make the next action clear. A question can invite a response from someone prepared to answer. Keep the structure recognizable while adapting language, examples, depth, and assistance to the person and setting.

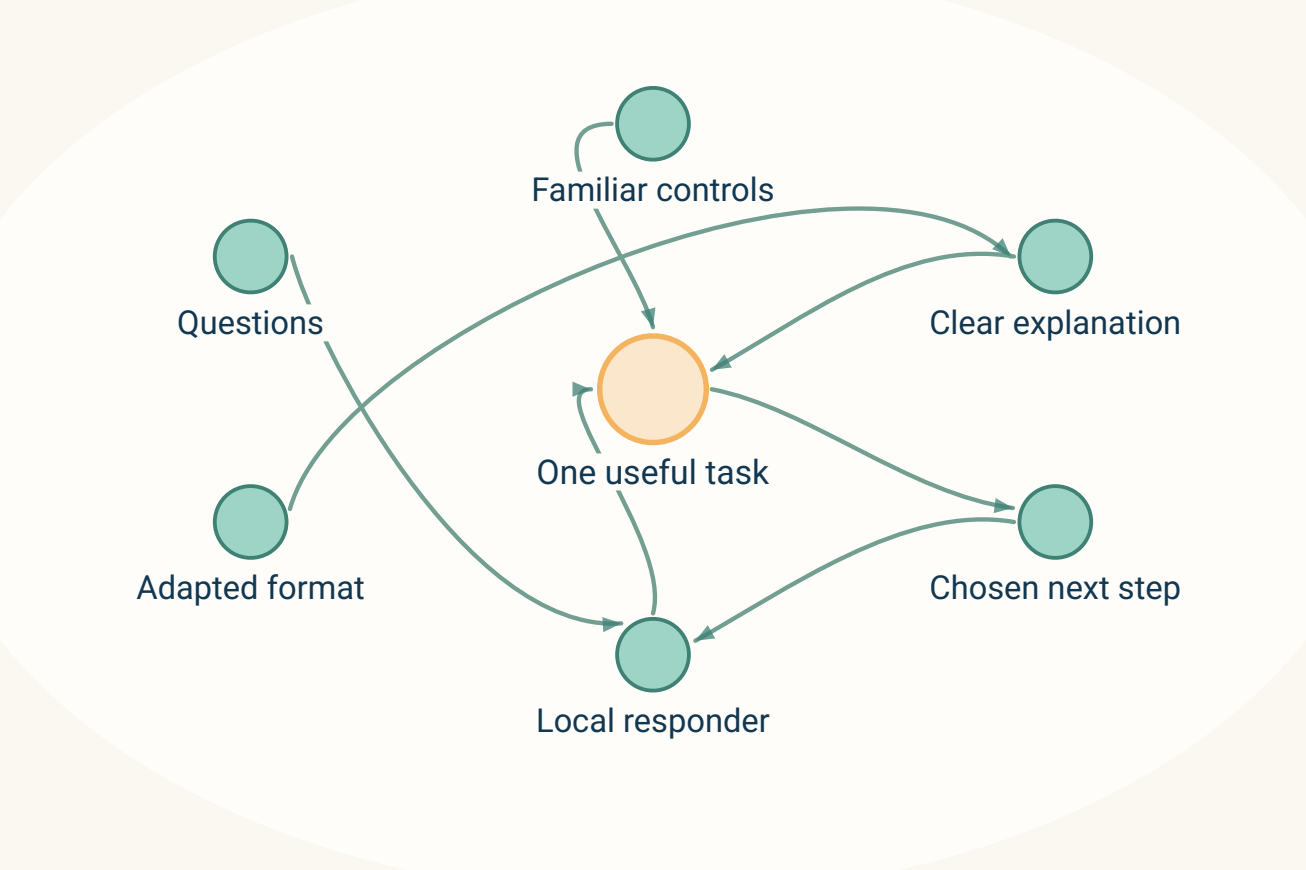


Figure 01 · Familiar controls, clearer help. Concept illustration; contact details must come from the local service.

Familiar controls help someone find their way through one useful task. A clear explanation says what the task is and why it matters. The task offers a visible, feasible next step the person can choose. The next step includes a verified local responder and contact route where help is needed. Language, format, depth and assistance adapt the explanation to the person. Questions need a route to someone prepared to answer. The responder provides the human help behind the task. Conceptual design relationships; local services must verify their own contacts and response commitments.

A familiar way to find help

What this is: One clear explanation of the resource and why it matters.

What happens next: A visible, feasible step the person can choose.

Who can help: The verified local responder, contact route, and response expectation.

Keep the wayfinding familiar; adapt the help.

There is room for creativity as well as clarity. A story, a shared photograph, appropriate humor, or a thoughtful analogy may offer another way into a conversation. Sometimes the purpose is learning. Sometimes it is simply enjoying time together. We should design for both.

Ten Principles. Nine Areas of Improvement. One Human Purpose.

The first five principles—Holistic Care, Awareness, Behavioral Influence, Communications, and Community—help us understand people, support their choices, make information usable, and connect them with relationships and resources.

The next five—Engagements, Pathways, Technology, Care AI, and Scoring—turn that understanding into worthwhile interactions, connected support, useful tools, and continuing learning.

TEN PRINCIPLES	NINE AREAS WHERE WE SEEK IMPROVEMENT
1 Holistic Care	1 Culture of care
2 Awareness	2 Social needs and resources (SDOH)
3 Behavioral Influence	3 Care equity
4 Communications	4 Community connections
5 Community	5 Stronger relationships
6 Engagements	6 Quality of life
7 Pathways	7 Staff well-being and caregiver strain
8 Technology	8 Relevant health and care outcomes
9 Care AI	9 Organizational sustainability
10 Scoring	

The nine areas are improvements to pursue and examine, not nine guaranteed results or a one-to-one match with principles. Chapter 10 turns them into evaluation questions. Better care should be meaningful to the person receiving it, workable for the people providing it, and sustainable for the organizations supporting it.

Bring out the best in care—and make it easier for people to bring their best to one another.

A Book to Read, Revisit, and Put to Work

We at Genus use CarePhysics as one of our operational guides for content, training, development, and the experiences we help organizations prepare. We are sharing that foundation so others can examine it, adapt it, and contribute to it. Applying the principles does not require adopting Genus technology.

The main book has three parts. Human Foundations develops Principles 1–5. Putting Care into Practice develops Principles 6–10. Better Care, Learning Together applies the ten principles to supporting caregivers and teams, working across organizations, sharing knowledge, and beginning with one meaningful pathway. Its five chapters are applications, not additional principles.

The Reference Companion provides research summaries, model explanations, culture and care, related books, Social Physics, public and frontline voices, and shared terminology. The practical appendices supply working tools. You do not need every page or every tool for every task. Begin with a question and return for the depth your

situation needs.

Meet Pat and Ellen

We follow Pat, a 79-year-old retired teacher, and Ellen, his 76-year-old wife. Their daughter, Maya, lives away; their son, Daniel, lives nearby. Emma and Noah are their grandchildren. Casey coordinates discharge, Sam is the social worker, and Lena leads the Day Center team. Jordan joins later when we examine learning across organizations.

Their story is fictional, separate from the family experience that began this introduction. Throughout the book, family scenes and teaching examples illustrate choices; they are not testimonials, reports of deployed services, or evidence of outcomes.

A fall brings Pat to the hospital. Clinical concerns remain with the healthcare team while the family begins to discuss changes it has noticed but does not yet understand. The story follows the choices, support, and relationships around them. Pat has humor, interests, and knowledge to contribute. Ellen has needs and hopes of her own. Their grandchildren remain grandchildren.

Bring your experience alongside theirs. You may recognize a difficult handoff, a confusing explanation, an overworked colleague, or a family trying to find its way. You may also recognize something your team already does beautifully—something worth understanding, protecting, and sharing.

From “What If” to What Happens Next

The opportunity before us is not only to build more capable tools. It is to become more deliberate about what we ask those tools to help us do. We can ask for less repetition and better preparation, clearer communication and dependable support. We can give people’s ideas a fair hearing and show them what changed.

We can make love, compassion, and purpose part of decisions about time, training, content, services, and technology. And we can keep learning.

What if the next person could begin with the best of what we have learned—and help us make it better?

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

Return to text

2. Michie S, van Stralen MM, West R (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science. 6:42. DOI: 10.1186/1748-5908-6-42. Source

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3. Center for Self-Determination Theory. The Theory. Official account of the work of Edward L. Deci and Richard M. Ryan on autonomy, competence, and relatedness. Source

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4. Fogg BJ. Fogg Behavior Model. Stanford Behavior Design Lab. The model describes motivation, ability, and a prompt converging for behavior. Source

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5. Massachusetts Institute of Technology, Industrial Liaison Program. Social Physics: How Ideas Turn into Action. Book description of Alex Pentland's work on idea flow, exploration, and engagement. Source

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6. Agency for Healthcare Research and Quality (2024). Communicate Clearly: Tool 4. Health Literacy Universal Precautions Toolkit, 3rd edition. Source

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7. Institute for Healthcare Improvement (2026), Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals. Public IHI 2026 hospital guide (PDF) [R1 source CG4]. The John A. Hartford Foundation (2024), Age-Friendly Health Systems Updated Guides: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices and Guide to the Care of Older Adults in Nursing Homes. Public Hartford Foundation guide announcement [R1 source CG14]. Source 1 · Source 2

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8. RUSH Center for Excellence in Aging. Caring for Caregivers Across U.S. Public implementation resource for the C4C model. Source

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9. Goldratt Research Labs. Introduction to Theory of Constraints (TOC). Description of the Five Focusing Steps. Source

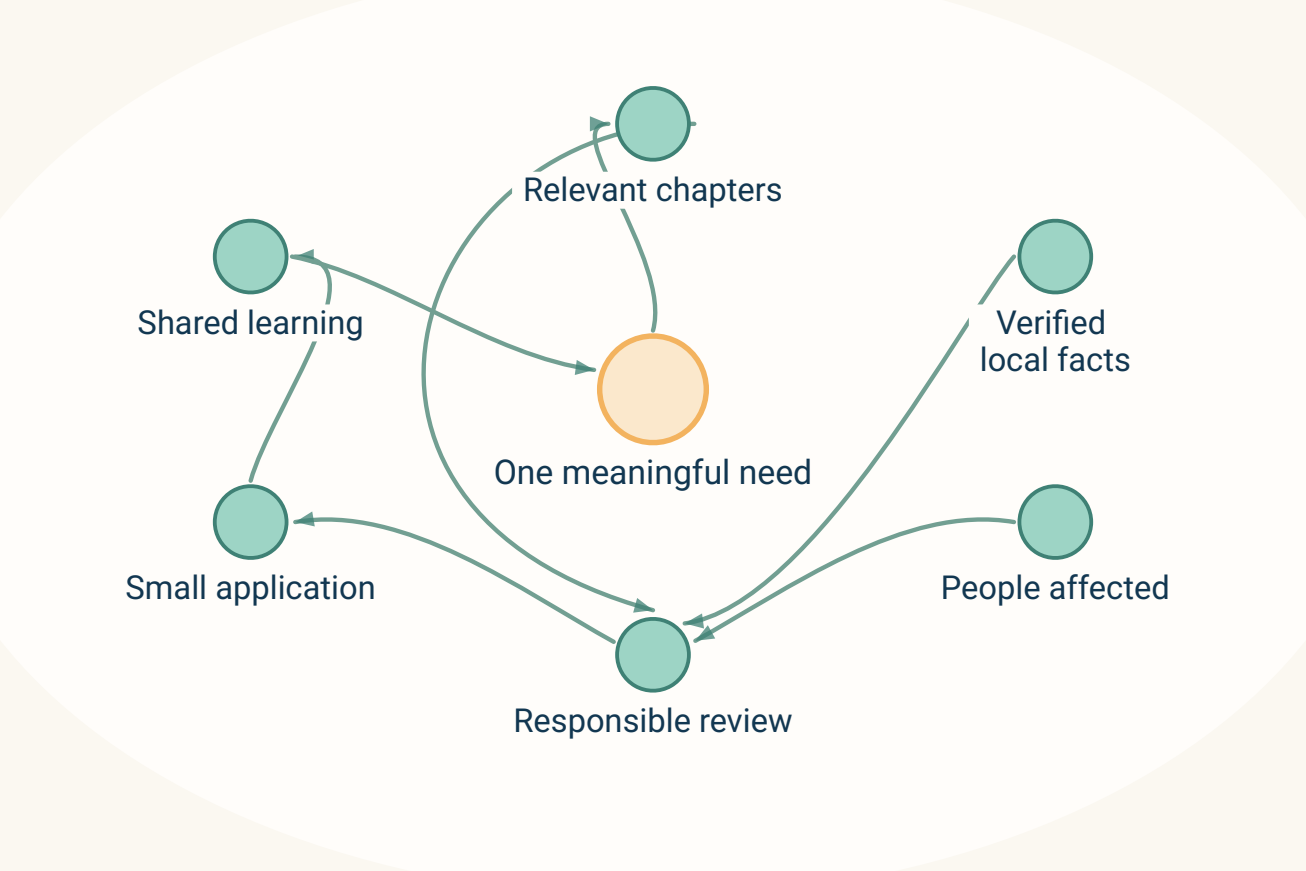
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10. Agency for Healthcare Research and Quality (2024). Attend to Social Needs: Tool 18. Health Literacy Universal Precautions Toolkit, 3rd edition. Source

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Using This Book

Start with one meaningful need



Connection map — Begin with one meaningful need

Choose relevant chapters for one meaningful need. Bring the relevant book guidance into responsible review. Add verified local guidance, service facts and capacity to the review. People receiving and providing support help review the proposed response. Responsible review prepares an appropriate small application. Trying the application produces experience to discuss and examine. Return the learning to the original need and revise the response. An application needs an owner, resources and a review point; completing a form is not the aim.

Your organization brings knowledge this book cannot supply: its mission, professional guidance, services, staff expertise, community relationships, and current capacity. The people you serve bring their own account of what matters and what it is like to use the support.

Choose one situation before choosing tools. It may be an unanswered question, an introductory visit, a handoff, or a recurring task that creates avoidable work. Read the relevant chapters with the people receiving and providing that support. Notice what already helps; identify what needs to change.

Keep research, local service facts, professional instructions, fictional examples, and private personal information distinguishable. When sources conflict, the responsible reviewer resolves the conflict. Select only the material and personal context needed for the task.

> **In Context — A new partner prepares its first family introduction**
>
> *This is a hypothetical example of applying the guide, not a report of a particular deployment.*
>
> A Day Center team is preparing to introduce its program to participants and families. The team knows its staffing, activities, eligibility, fees, and transport arrangements. Families have questions about what an ordinary day involves and how to decide whether the program fits.
>
> The partner and implementation team begin with that situation—not a tour of every feature.
>
> An approved assistant helps draw together relevant CarePhysics material, the partner's guidance, and its verified service facts. It prepares a planning brief, a staff practice exercise, a video outline, a companion article, and an optional question for the family.
>
> People with the relevant responsibilities review the work. The program lead checks the offer. Appropriate professionals review clinical material. Intended users help examine language, accessibility, and practical fit. The team confirms who answers requests and what happens if the usual responder is unavailable.
>
> The software has a defined job: make the approved information and chosen response route easy to find. A request for a callback is recorded as a request until the receiving person accepts it. A referral is not described as completed care merely because information was sent.
>
> The material lets someone ask a question, involve a chosen supporter, or explore an alternative without being pressed to enroll. A telephone or printed route is part of the plan where needed.
>
> **The same human purpose is recognizable in the planning, the training, the content, and the experience.**
>
> That is what it means to use the book operationally. A health-system department, home-care provider, or community organization could begin with a different need and use the same discipline to develop its own response.

Make the next version a shared piece of work

A useful working sequence is: retrieve relevant material, add verified local context, prepare options, review with responsible people, try an appropriate application, and revise from what is learned. Give the change an owner, resources, and a review point.

Credit contributors and return with the result, including when an idea could not be used or did not help.

A configured assistant may help prepare resources or explain approved routine information between conversations. Its task, access, review requirements, and route to human help must be defined. Uploading the book does not train the underlying model or prove that the assistant will apply it reliably. Availability of information is not continuous professional coverage.[1]

Use Appendix D to plan a pathway, F to examine benefits and burdens, and H to review content. The other tools are available when the task calls for them. A completed worksheet is not the purpose; a more understandable choice or dependable piece of support is.

Continue the conversation

The CarePhysics website is an entry point to the framework and related resources.[11]

Our companion vision includes podcast conversations, appropriately scoped assistants, and downloadable knowledge resources for use alongside an organization's own guidance. Check the website for what has been released and its intended use. Share what helped, what did not, and what the next version should understand. Participation is an invitation, not a condition of receiving support.

Read what is useful. Bring one question to the people involved. Then change something because of what you learn.

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

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11. Genus. CarePhysics: Bringing Out the Best in Care. Public framework resource. Source

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About the digital edition

This digital edition preserves the complete CarePhysics 3.7 advance review manuscript. Its examples, research qualifications, and dated organizational records retain their original status.

Choose a chapter or section from Contents. Search covers the complete book; following a result opens its place in the full chapter. Larger text changes this reading session only.

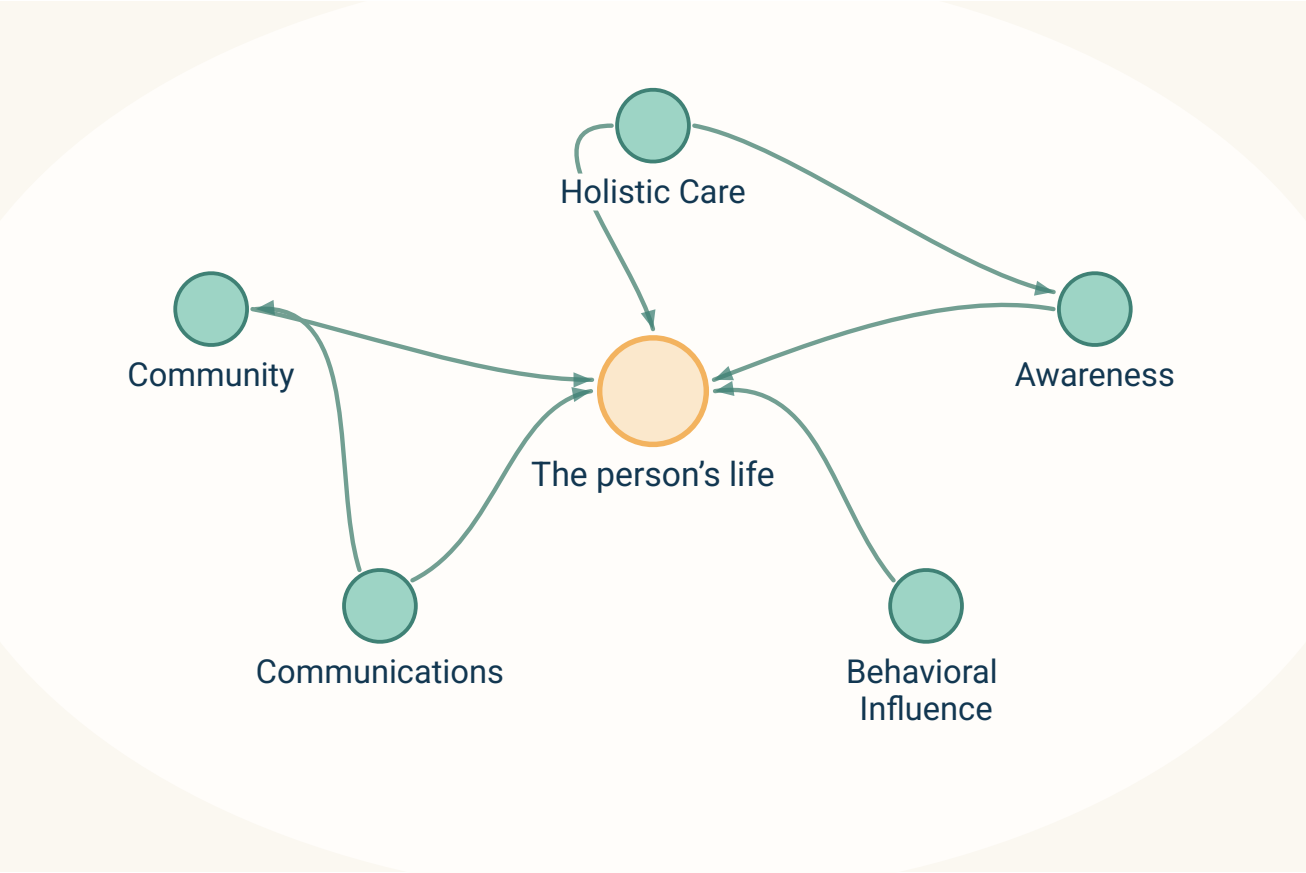
Example scenes stay in the reading flow. The author’s recollections remain distinct from fictional teaching examples. Connection maps illustrate the ideas in each chapter and major section, with one shared map for the appendices. Each map has a text description; the manuscript’s original captions and explanatory text remain in place.

The manuscript’s footnotes are presented as numbered notes at the end of each chapter or section. Repeated references keep the original note number, and each excerpt includes the notes it cites. Links return to the relevant passage.

Print PDF and Download PDF use the selected complete book or current chapter/section. Page numbers are recalculated for this edition. The review guidance about Word comments and Track Changes refers to the original manuscript.

Separate spaces are reserved for chapter narration and podcast discussions. Recordings and transcripts will be added when ready; no audio plays automatically.

PART I — Human Foundations



Connection map — Human foundations belong together

Holistic Care begins with the person and the circumstances around their life. Awareness makes relevant information understandable and usable. Behavioral Influence asks what makes a worthwhile next step possible and freely chosen. Communications makes room for concerns and dependable commitments. Community connects the person with relationships and services beyond one household. Knowing what matters helps determine what needs explaining. Listening can reveal missing support that community relationships may help address. These are the first five principles, not five guaranteed outcomes.

Before we decide what to build, what to send, or what to measure, we need to understand whose life we are entering.

A person arrives at a hospital, calls a community organization, or walks into a Day Center with more than a need for service. There are relationships, routines, responsibilities, beliefs, worries, abilities, and things worth looking forward to. Some will be easy to describe. Others will take time and trust to share.

The same is true of families and communities. We should not expect one arrangement, one explanation, or one invitation to fit them all.

The first five CarePhysics principles establish the foundation for working with those

differences.

Holistic Care begins with the person and the circumstances around them. **Awareness** turns information into something people can understand and use. **Behavioral Influence** examines what would make a worthwhile next step possible and freely chosen. **Communications** helps people listen, express concerns, and make dependable commitments. **Community** extends support beyond one person or household into relationships and services that can follow through.

These principles belong together. Knowing what matters to someone helps us choose what to explain. Understanding their circumstances helps us avoid asking for something they cannot reasonably do. Listening reveals where support is missing. Community gives some of that support a place to come from.

Design runs through all five. It shapes the questions we ask, the examples we choose, the order in which we explain things, and the way someone reaches a person when they need help.

Love becomes visible in the attention we give. Purpose helps us understand what the care is meant to protect or make possible. Trust grows through what happens after the conversation.

AI can assist with carrying that understanding forward. But before an assistant can help prepare a relevant explanation, someone must establish what is relevant. Before it can organize a useful plan, people must decide whose priorities the plan serves.

We begin there: with a person, a family, and a question that makes room for more than one answer.

CHAPTER 1

Holistic Care — See the Person

At a Glance

The central idea: Before organizing care around a condition, understand the person whose life the care is entering.

What you'll explore: How identity, relationships, beliefs, resources, and priorities shape support. Pat and Ellen's different answers show why a family needs more than one voice. Love becomes practical through attention and shared responsibility.

Design and AI: Carry stated priorities into content, timing, and involvement. Use permissioned information and human review; preserve differences and keep observations distinct from diagnoses.

Put it to work: Create a Person-and-Family Support Profile with priorities, preferences, support, open questions, and follow-up responsibility.

Evidence and evaluation: Examine person-centered care, purpose, Self-Determination Theory, and the Age-Friendly 4Ms. Ask whether the plan reflects people's priorities and makes support more workable.

> *"What mattered to him was that he mattered to me."*
>
> — Kedar Mate, MD, reflecting on a patient encounter in "Why Asking 'What Matters To You?' Matters," Institute for Healthcare Improvement, March 15, 2022.[12]

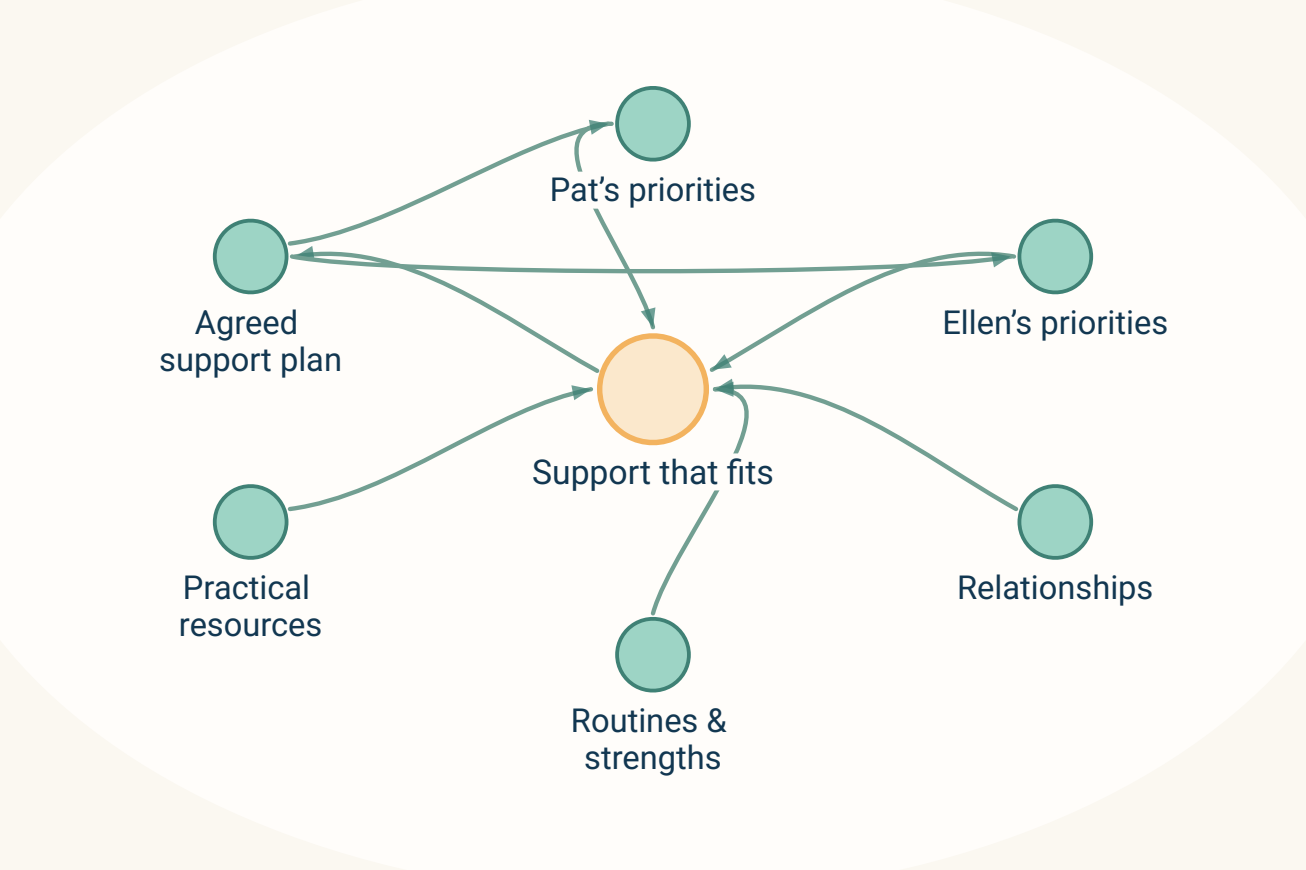


Figure 02 · The person and the life around care. Fictional voices quoted from the chapter.

Pat's own priorities help shape support that fits his life. Ellen's separate priorities help shape support that fits her life. Relationships inform how support can fit. Routines and strengths inform how support can fit. Practical resources help determine which support is workable. These perspectives and circumstances inform an agreed support plan. Review the plan against Pat's priorities. Review the plan against Ellen's priorities without treating the two accounts as one. Pat and Ellen are the book's fictional characters; this is a design summary, not an outcome report.

Pat

"Reading with the grandchildren. Seeing people. Having something to talk about besides appointments."

Ellen

"The appointments. Calls. What we need to ask. Telling the children what happened."

Relationships · Routines · Strengths · Priorities · Practical support

Ask each person. Keep different perspectives visible.

In Context — Pat and Ellen at the hospital

The fall had brought Pat to the hospital. By the time Casey pulled a chair beside his bed to discuss returning home, the family had accumulated another set of questions.

Ellen had mentioned that Pat sometimes repeated himself or became uncertain about an arrangement they had already discussed. Their daughter, Maya, had noticed things during calls. Their son, Daniel, who lived nearby, had noticed other things.

They had not put those observations together before.

Pat, 79, was a retired teacher. He had spent much of his life explaining things to other people. He was finding it uncomfortable to sit in a room where everyone seemed to have an explanation for him.

Casey began with a question.

“What are you most concerned about when you think about going home?”

“Everybody deciding what I can’t do anymore,” Pat said.

Casey waited.

“And talking about me when I’m sitting right here.”

“I’ll speak with you directly,” Casey said. “What would you particularly like us to help you keep doing?”

Pat glanced at the book beside his bed.

“Reading with the grandchildren. Seeing people. Having something to talk about besides appointments.”

Then Casey turned to Ellen.

“What has become difficult for you?”

Ellen, 76, had been keeping track of the papers. She straightened them before answering.

“I’m worried I’ll miss something important.”

“What are you keeping track of now?”

“The appointments. Calls. What we need to ask. Telling the children what happened.” She paused. “It doesn’t sound like much when I say it.”

“It sounds like several different jobs,” Casey replied.

Pat looked toward her.

“I didn’t know you were making all those calls.”

“I didn’t want you worrying.”

> **In Context — Pat and Ellen at the hospital**
>
> For a moment, neither of them spoke.
>
> Casey did not try to settle the question of Pat's memory. Those concerns belonged with the clinicians assessing him. Nor did she assume that Ellen's presence meant the family had all the support it needed.
>
> She had learned something important about each of them.
>
> Pat wanted to remain involved in his own life. Ellen wanted help carrying uncertainty without feeling that she had failed him.
>
> The care plan needed to make room for both.

The person is more than the problem

You cannot care well for someone you know only by their condition.

Holistic Care means considering the life in which care must work. In CarePhysics, that includes medical, physical, emotional, social, family, financial, and legal concerns—not as separate boxes to fill, but as connected dimensions of a person's circumstances.

Medical care addresses assessment and treatment. Physical support concerns what daily activities require and what the environment makes possible. Emotional concerns include uncertainty, frustration, grief, and the wish to feel secure. Relationships can provide companionship and practical help, while also bringing disagreements and competing responsibilities.

Financial questions may determine whether an option is usable. Legal questions may need a qualified professional. Family involvement requires understanding who is willing and able to help, what they have agreed to do, and what support they need themselves.

Culture, beliefs, identity, and personal history run through all of this.

For Pat, reading is not merely an activity that might occupy an afternoon. It connects with being a teacher and a grandfather. For Ellen, a few dependable hours for herself would mean more than time away from a task. It would restore choices that have quietly narrowed.

Neither belongs in a footnote to the medical plan.

At the same time, seeing the whole person does not mean collecting everything about them. We need enough understanding to make the next decisions well, with permission to revisit what changes. A person should not have to disclose their entire life to receive appropriate help.

The question is practical:

What do we need to understand so that the support we offer can fit this person's life?

Make practical concerns easier to bring into the conversation

Whole-person care also makes room for money, work, housing, and future decisions. Someone may hesitate to raise these concerns because they do not know who can help—or because they prefer not to discuss them in front of relatives. Offer a private beginning and ask which concern they want to address first.

The concern	A question to begin with	Resource and accepted follow-through
“We do not know what the service will cost.”	“Which charges or assistance options would you like someone to explain?”	A named service representative, benefits counselor, or appropriate financial-assistance contact checks actual costs, coverage, and available help. Record what is confirmed, what is unknown, and who will reply.
“We are unsure who could make a decision later.”	“What would you like to understand about future decisions, and whom do you want involved?”	Help prepare questions for the person’s clinician and a qualified local legal professional. Do not infer authority from a family relationship, screening result, or diagnosis.
“I cannot keep missing work for these arrangements.”	“Which part of the schedule or paperwork is hardest to manage?”	The service owner reviews appointment timing, response routes, and practical help with the person. Questions about employment rights or benefits go to an appropriately qualified resource; no job protection or payment is promised.

These are original navigation examples, not legal advice or statements of eligibility. AHRQ’s social-needs guidance recommends asking whether help is wanted, identifying a suitable resource, and checking whether the connection occurred. A cost question deserves an actual answer; an unanswered request remains open.[10]

> ### In Context — Care that fits a working life
>
> An original fictional illustration, separate from Pat and Ellen’s story.
>
> A working-age person managing a long-term condition has received the

> **In Context — Care that fits a working life**
>
> appointment instructions. The next visit would mean losing another shift, and the estimated charge is unclear.
>
> “I understand why I’m coming. I’m trying to work out how to get there without losing the hours I need.”
>
> The navigator checks which appointment routes the clinical team considers appropriate and which times the service can actually offer. A separate, agreed contact will explain the charge and possible assistance. The person chooses what to share about work; nobody contacts the employer without permission.
>
> The plan now identifies two practical questions and who will answer them. It does not assume that understanding the instructions removed the obstacles—or promise that an option exists before it has been checked.

Different lives need different starting points

Consider two families learning about the same community service.

In one illustrative household, the immediate question is whether the service can accommodate an important religious practice. In another, it is whether anyone can provide transportation before a working caregiver’s shift begins. A third person may want to visit alone before discussing the idea with relatives.

The service description could be accurate in every case and still fail to answer the question that matters.

Culture includes more than ethnicity or a language preference. Beliefs, family customs, professional experience, community relationships, and other parts of identity can shape how someone interprets care. AHRQ’s guidance on cultural humility emphasizes learning from the individual rather than assuming that membership in a group tells us what that person believes or prefers.[13]

For our purposes, that means asking specific, respectful questions.

“Who would you like involved in this conversation?”

“Are there beliefs or routines we should understand when we discuss these options?”

“What would make this feel comfortable—or uncomfortable—for you?”

Someone may want decisions discussed with several relatives. Another may want a private conversation first. A person may wish to involve a faith leader, a friend, or someone they consider family who is not a relative. None of these arrangements should be assigned by the organization.

The same discipline applies within a household. Ellen’s preferences do not automatically describe Pat’s. Maya’s comfort with technology does not establish what her parents will find useful. Daniel’s proximity does not tell us when he is available.

We should also separate cultural understanding from practical access. A person who cannot afford a service does not need a more persuasive explanation of its value. A family without reliable transportation does not have a communication-style problem. An unanswered message may require a different contact route rather than another reminder.

The behavioral review informing this book makes that distinction central: similar patterns of nonparticipation can arise from very different barriers, including knowledge, cost, access, exhaustion, trust, and family circumstances.

Language deserves its own questions. AHRQ recommends asking what language people prefer for conversation and for written materials, rather than inferring either from how they sound. It also calls for qualified language support rather than relying on untrained staff or relatives to interpret consequential care conversations.[14]

This is not an exercise in finding a cultural label and selecting the corresponding script. It is learning how to work with the person in front of us.

What research helps us understand

Pat and Ellen's conversation raises three questions. Should their priorities influence the plan? Does purpose deserve attention? And how do we support participation without taking over?

Different kinds of evidence help answer them.

Practice guidance: bring home life into the conversation. AHRQ's IDEAL discharge-planning approach includes patients and families as partners. It asks teams to discuss what life at home will involve, explain relevant information plainly, check understanding, and attend to people's goals, preferences, observations, and concerns. This is guidance for organizing care, not proof that asking one additional question will prevent a hospital return. It gives Casey a sound reason to look beyond completed paperwork.[15]

Observational evidence: purpose is worth taking seriously. Eric Kim and colleagues examined data from 12,998 U.S. adults older than 50 in the Health and Retirement Study. Their study, published in a 2022 journal issue, examined purpose in relation to later health and well-being. Higher purpose was associated with several favorable outcomes over four years, including less depression and loneliness, but not with every outcome studied. Because this was observational research, it does not establish that assigning a meaningful activity causes those benefits.[16]

Our application is narrower: ask what matters, and examine whether the care leaves room for it. Pat's interest in reading gives us a direction to explore with him. It is not a treatment prescription.

A foundational model: choice, capability, and connection. Self-Determination Theory draws attention to autonomy, competence, and relatedness—whether an action feels self-endorsed, whether someone feels able to participate, and whether they experience supportive connection. Autonomy does not require doing everything alone; a person can

choose to seek help or make decisions with others.[3]

A meta-analysis by Nikos Ntoumanis and colleagues combined 73 experimental studies of Self-Determination Theory–informed interventions in health promotion and disease management. It found generally small-to-medium changes in motivation and health behaviors, with smaller positive changes in health outcomes. Effects were modest and varied across studies. The author-held research review informing this book classifies the intervention evidence as Moderate, rather than treating the model as a guarantee of improvement.[17]

For Pat, the design question becomes: can he remain an active participant while receiving support? For Ellen, it becomes: can she ask for help without being judged for needing it?

These are useful questions to bring into practice. The particular approach we build around them still needs its own evaluation.

A practical companion: the Age-Friendly 4Ms

The Age-Friendly Health Systems initiative gives whole-person care a recognizable practice framework: **What Matters, Medication, Mentation, and Mobility**. Launched by The John A. Hartford Foundation and the Institute for Healthcare Improvement (IHI), with the American Hospital Association and the Catholic Health Association of the United States, it brings these elements together rather than treating them as separate projects.[7]

IHI's guidance asks teams both to assess and to act on the four elements as a set. What Matters concerns the person's health goals and care preferences. Medication concerns appropriate use that does not interfere with those goals or with mentation and mobility. Mentation addresses dementia, depression, and delirium. Mobility concerns moving safely and maintaining function so the person can do what matters.[18]

For our application, the next question is what this understanding changes. A preference in a profile should influence a real choice. Medication-support information should reach the qualified professional responsible for review, rather than become a suggestion for an assistant to change treatment. Observations about mood, thinking, or movement should lead to appropriate assessment and support—not an invented diagnosis.

In a Day Center, the framework can help connect a person's chosen activities with the assistance, professional guidance, and environment needed to participate. A recorded fall-risk score alone does not provide that assistance. A medication list alone does not establish that an appropriate review has occurred.

We call this proposed mapping **4Ms-informed**. It is an original application of published guidance, not a claim that Genus implements the full framework, that every Day Center offers the same clinical services, or that a site has received Age-Friendly recognition. That recognition follows IHI's separate process.[19]

Pat's priorities and Ellen's needs remain distinct. Chapter 11 adds a complementary caregiver-support pathway; R1 identifies public sources and evidence limits, and Appendix B offers a short planning aid. Together, these approaches help us ask what

each person needs and who will act on the answer.

Love and purpose must change the plan

It would be easy to leave Casey's conversation feeling that something compassionate had happened, then continue with exactly the same arrangements.

CarePhysics asks us to go further.

What should change because Pat wants to remain involved? People should address him directly, explain the choices, and ask whom he wants included. What should change because Ellen is carrying the calls and arrangements? The plan should identify work that others might take on and services that could provide support.

Love should not become an argument for Ellen to carry more.

Nor should purpose become another demand placed on Pat. He does not need to lead a group, tell a story, complete an activity, or demonstrate progress to deserve care. There can be room to contribute and room to rest.

His history offers possibilities, not assignments.

Later, a Day Center team might learn that he enjoys local history and offer him a role in a discussion. They should still ask whether that interests him now. Being a retired teacher does not mean wanting to teach every afternoon.

This distinction is reflected in the Day Center design materials behind the book: staff are encouraged to ask about both past and present interests, while preserving the ability to watch, decline, change one's mind, or participate differently.

For an organization, this turns broad values into choices about the day. Is there a quiet place? Can an activity be shortened? Can someone contribute without performing for the group? Does the person receiving support have a voice in what is written about them?

Those decisions are where compassion becomes part of the service.

Listen in stages, then use what you learn

> ### In context
>
> Casey cannot resolve every question before Pat leaves the hospital. Immediate safety and discharge requirements come first. Other concerns need time, appropriate expertise, and another conversation.
>
> With Pat and Ellen's permission, she calls Sam, a community social worker, while they are together.
>
> Casey explains the questions they have agreed to share. Sam introduces his role and confirms that he can meet with them to discuss home routines, family support, and available community options. They agree on how to arrange that meeting. Clinical questions remain with Pat's healthcare team.

> **In context**
>
> Casey has done more than give them another telephone number. Sam has accepted responsibility for a specific next conversation.
>
> At their first meeting, Sam does not start over with the entire history.
>
> “Casey told me you wanted help making the week more manageable,” he says. “Is that still the right place to begin?”
>
> Ellen nods.
>
> Pat adds, “As long as manageable doesn’t mean somebody plans every minute.”
>
> “What would you like to leave unplanned?”
>
> “My reading. The grandchildren. Some peace and quiet.”
>
> “And what would help you, Ellen?”
>
> “Knowing which things I really need to handle—and which ones I don’t.”
>
> Sam asks what they want discussed together and offers each of them a way to raise a concern privately. He learns enough to prepare the next steps, without treating this meeting as their only opportunity to explain themselves.

This is staged listening: establish what is needed now, carry it forward accurately, and return to it when circumstances or preferences change.

A long intake that no one revisits is not necessarily more useful than a shorter conversation that changes the next encounter. The revised CarePhysics approach favors a maintained person-and-family profile over information collected once and then left behind.

Let the understanding change the content

Sam also asks how they would like information.

Pat wants the conversation addressed to him, with something he can read afterward. Ellen wants a short summary that separates immediate arrangements from questions that can wait. They agree that Maya and Daniel can receive the shared information needed for an upcoming family conversation, without automatically receiving private notes.

Now the design brief is different.

Instead of sending a general packet about caregiving, Sam can prepare a short meeting guide with a clear purpose: help this family arrive ready to discuss what matters and what is becoming difficult.

An illustrative invitation might read:

Making next week more manageable

Our conversation will begin with what you want to keep doing and what has become difficult to organize.

You do not need to prepare a complete history. You can bring one question, make a short note, or simply talk with Sam when you arrive. For example: “I would like help with the appointments, but I still want to make my own decisions.”

Tell Sam’s office who you would like involved and whether you need help with language, access, or the meeting format. Afterward, Sam will confirm the agreed next steps and who is responsible for each one.

The invitation explains why the conversation matters, gives one main idea, demonstrates a way to begin, offers choices, names the response route, and explains what follows. It uses the familiar content pattern introduced earlier without forcing six headings into a short message.

The same knowledge should influence the medium.

A short video might be useful when someone wants to see what a first visit looks like. A printed page may be better for comparing arrangements at the kitchen table. Audio may offer another route for someone who prefers listening. A demonstration may be more useful than an article when the task involves doing something. A sensitive concern may need a conversation before any written follow-up.

AHRQ’s communication guidance supports plain language, limited key points, demonstrations, questions, and checks of understanding. These are methods to select and adapt, not reasons to assume everyone needs the same format.[6]

Tone needs the same care. Some people will welcome a conversational explanation; others will prefer concise, factual wording. Humor should follow the person’s lead. Faith-based material should be offered when it is wanted, not inferred from a name or neighborhood.

Adapt the expression without changing the facts. A warmer version must not conceal a concern. A shorter version must not omit an important limitation. Clinical instructions and validated questionnaires must retain what their proper use requires.

The goal is not to classify people into permanent “styles.” It is to keep learning what helps them in this situation.

A profile that preserves more than one point of view

The practical output of this chapter is a **Person-and-Family Support Profile**.

Think of it as a working aid to conversation—not a diagnosis, a personality assessment, or a document that everyone automatically receives. A shared summary may be useful, while private concerns require a separate, appropriately restricted place.

For Pat and Ellen, an initial profile could contain the following:

Area	What the profile carries forward
What matters to Pat	Pat wants to remain involved in decisions and continue reading, seeing people, and spending time with his grandchildren. These priorities are confirmed with him.
What Ellen wants help with	With her permission, the shared summary records that she wants help organizing appointments and family communication. Any private concerns remain separate.
What is known and what is uncertain	The current clinician-approved discharge information is identified. Family observations are attributed to the people who reported them. The explanation for the memory concerns remains under assessment.
How to communicate	Pat prefers direct conversation with material to read afterward. Ellen prefers a short summary of immediate arrangements and later questions. Other family members are asked about their own preferences.
Available support and open questions	Sam has accepted the community-support conversation. Maya and Daniel's possible roles need discussion; neither is recorded as responsible for a task they have not accepted. Costs, transport, and service fit are checked when an option is considered.
Ownership, permissions, and review	Each entry has a source and review date. Sam maintains the support summary within his role, checks changes with the relevant person, and revisits it after clinical follow-up or sooner when needed.

Questions about beliefs, routines, language, and access should be recorded in the person's own terms when relevant and willingly shared. "Not yet discussed" is more honest than a guessed answer.

The profile should also make room for changes. Pat may enjoy something on one visit and decline it on another. Ellen may initially want detailed explanations and later prefer fewer updates. A plan should not hold people to an earlier version of themselves.

Most importantly, disagreement should remain visible. "Pat is comfortable with the current arrangement" and "Ellen finds the arrangement difficult to sustain" are not competing facts that a summary must resolve. They are two perspectives that the next

conversation needs to hold.

Where AI can help

Sam now has something useful to work from. He also has familiar administrative work: organizing notes, identifying unresolved questions, preparing a summary, and adapting information for different readers.

This is a good place to consider AI assistance.

In a proposed, organization-approved workflow, an assistant could prepare a draft from selected notes, current service information, and relevant CarePhysics guidance. It could organize material under stable headings, preserve who said what, and flag questions that have not been answered.

Sam would review the result against the sources and decide what belongs in the shared plan.

A useful draft might distinguish:

Pat's stated priority: Continue making decisions about his day.
Ellen's shared request: Help with appointments and family communication.
Still to discuss: Which responsibilities other adults are willing and able to accept.
Clinical question: Refer to the treating team; no conclusion added.

That is assistance with the work around understanding. It does not replace the understanding itself.

A maintained profile can carry preferences into later reviewed work. Verify the local system's update history, permissions, and review route rather than assuming they follow from the presence of an intake form. Appendix J records the dated implementation examples behind this discussion.

The opportunity extends to content. An assistant could help prepare a concise version, a fuller explanation, or an outline for a demonstration from the same approved information. Staff and intended readers would then check accuracy, accessibility, tone, and fit.

A team could also ask it to help turn a useful staff explanation into a reusable resource, with the contributor credited and private family details removed. Repeated questions could become topics for a team discussion about unclear instructions or missing support.

Families could be offered an approved assistant for routine questions between conversations, including outside office hours. Its role would be to explain current information within a defined scope and make human contact easier to request. It must not imply that professional help is continuously staffed when it is not. Human response times and urgent routes need to be clear.

For this chapter, a useful AI assignment is:

Using only our approved guidance and the information we are permitted to share, draft a support profile that separates the person's priorities, caregiver needs, observations, professional findings, and unanswered questions. Suggest communication options

without inferring beliefs or preferences. Identify what a person must check before the draft is used.

The potential gift is less repetitive preparation and more attention available for the conversation. Whether that happens depends on the quality of the draft and the work required to check it. Both belong in the evaluation.

What the organization must make possible

We should not ask Casey or Sam to practice whole-person care while leaving them with no time, no response options, and nowhere useful to put what they learn.

The organization has design decisions of its own.

It needs to decide which information is necessary at first contact and which can wait. It needs a place where relevant staff can find current, permitted information without searching several records. It needs a named owner for follow-up, a correction process, and an alternative when the usual person is unavailable.

Language access, accessible materials, private conversations, and non-digital routes require planning and resources. Training should include practice in asking, listening, checking understanding, and responding when a concern falls outside someone's role—not merely instruction in completing a form.

The service behind the invitation matters just as much. Before encouraging someone to explore a Day Center, the responsible team must establish its current services, eligibility, capacity, costs, and practical access. When it is not a fit, someone should help explore another route.

A kind explanation cannot create an unavailable appointment or an affordable ride.

The same principle applies beyond this family. In an illustrative home-care setting, the important question may be how assistance can respect a household routine. In rehabilitation, it may be which everyday activity the person most wants to return to. For a working caregiver, it may be whether support can fit around employment without requiring constant calls during the day.

Community and state groups can use these questions when planning shared services. A common approach to listening need not produce identical programs. Local teams and residents should help determine the language, delivery routes, partners, and resources that make sense in their setting.

Staff also deserve that attention. Ask which questions help them care, which fields duplicate work, and which promises they cannot reliably fulfill. Their experience should influence the design before a new process becomes another obligation.

How would we know it helped?

Completing a profile is evidence that information was recorded. It is not yet evidence that care became more relevant.

For an initial local test, an organization might choose one intake or transition process and examine it over 30 days. That is an illustrative improvement exercise, not a validated study design.

Begin with the people involved. Can the person recognize their own priority in the plan? Can the caregiver identify what support was agreed? Was a communication preference respected? Did an identified need lead to practical help—or remain unresolved?

Then examine the work. How long did the conversation, drafting, checking, and updating take? Were people asked to repeat the same information? Did staff find the profile when they needed it? Were private concerns kept from inappropriate audiences?

Use clear denominators. Report how many people were offered the process, how many participated, how many gave feedback, and how many did not. A favorable response among a few respondents must not become a claim about everyone. Include people using telephone or paper routes, not only those visible in an app.

Keep the stages separate: receiving a guide, understanding an option, requesting help, and receiving the service are different events. The research review informing this book likewise distinguishes reach, understanding, first action, adoption, useful participation, and outcomes, while treating burden, safety, and equity as separate questions.

Choose a person responsible for reviewing the findings and changing the process. Reduce fields that do not inform care. Correct misleading language. Investigate unmet needs. Pause an AI-assisted step when errors or review demands make it unhelpful.

We are evaluating the support—not how cooperative the family appears, how much they love one another, or whether illness follows a hoped-for course.

One thing to try

Take one existing welcome, intake, or care-planning process.

For this exercise, set aside the diagnosis and service label. Do not remove clinically necessary information from care; simply ask what else the current process allows you to know.

Can you tell what the person wants to preserve or enjoy? Who they want involved? What practical constraints need attention? How they prefer to receive information? What support the caregiver needs?

Choose one gap to address through a conversation with someone the process serves.

Then change one thing because of the answer: the content, the format, the timing, the people involved, or the practical support behind the next step.

That last part matters. Listening should leave a trace in what we do.

From being known to understanding

> **In context**
>
> At the end of their first meeting, Sam reads back the priorities Pat and Ellen have agreed to share.
>
> Pat wants a say in his own day. Ellen wants help with the arrangements. The family needs to discuss responsibilities. Clinical questions need follow-up, and community options can be explored without committing to a service today.
>
> “Does that sound right?” Sam asks.
>
> “Yes,” Ellen says. “But I’m still not sure what we should tell the children about what’s happening.”
>
> Pat closes the booklet in front of him.

“And I’d like somebody to explain what we actually know.”

They have been heard more fully. That does not mean they yet share an understanding.

The next task is to make clear what is known, what remains uncertain, what needs to happen, and who can help—without giving everyone more information than they can use.

That is the second principle: **Awareness — Make Understanding Possible.**

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CHAPTER 2

Awareness — Make Understanding Possible

At a Glance

The central idea: Information only helps when someone can understand what it means for them.

What you'll explore: How to explain what is known, what remains uncertain, what happens next, and who can help. Follow Pat's family as they compare different interpretations without requiring everyone to agree. Learn to check the explanation rather than test the person, and adapt language, depth, format, and timing without changing the facts.

Design and AI: Build articles, videos, and conversations around one useful idea, a visible example, and a dependable route to questions. Explore how an approved AI assistant could explain reviewed information, prepare questions, and help people reach human support—without adding certainty or taking over professional decisions.

Put it to work: Build an **Awareness Plan** and redesign one article or video using familiar headings and clear next steps.

Evidence and evaluation: Examine health literacy, teach-back, COM-B, Self-Determination Theory, and Social Physics alongside supporting studies and limitations. Check understanding, unresolved questions, access, and workload—not merely whether content was delivered or opened.

> *"Communication should be consistent; always tell people what we know, what we don't know and what we're doing to find out more."*
>
> — ***Rima Rudd**, health-literacy researcher, in an interview with Governing, August 23, 2021.*[20]

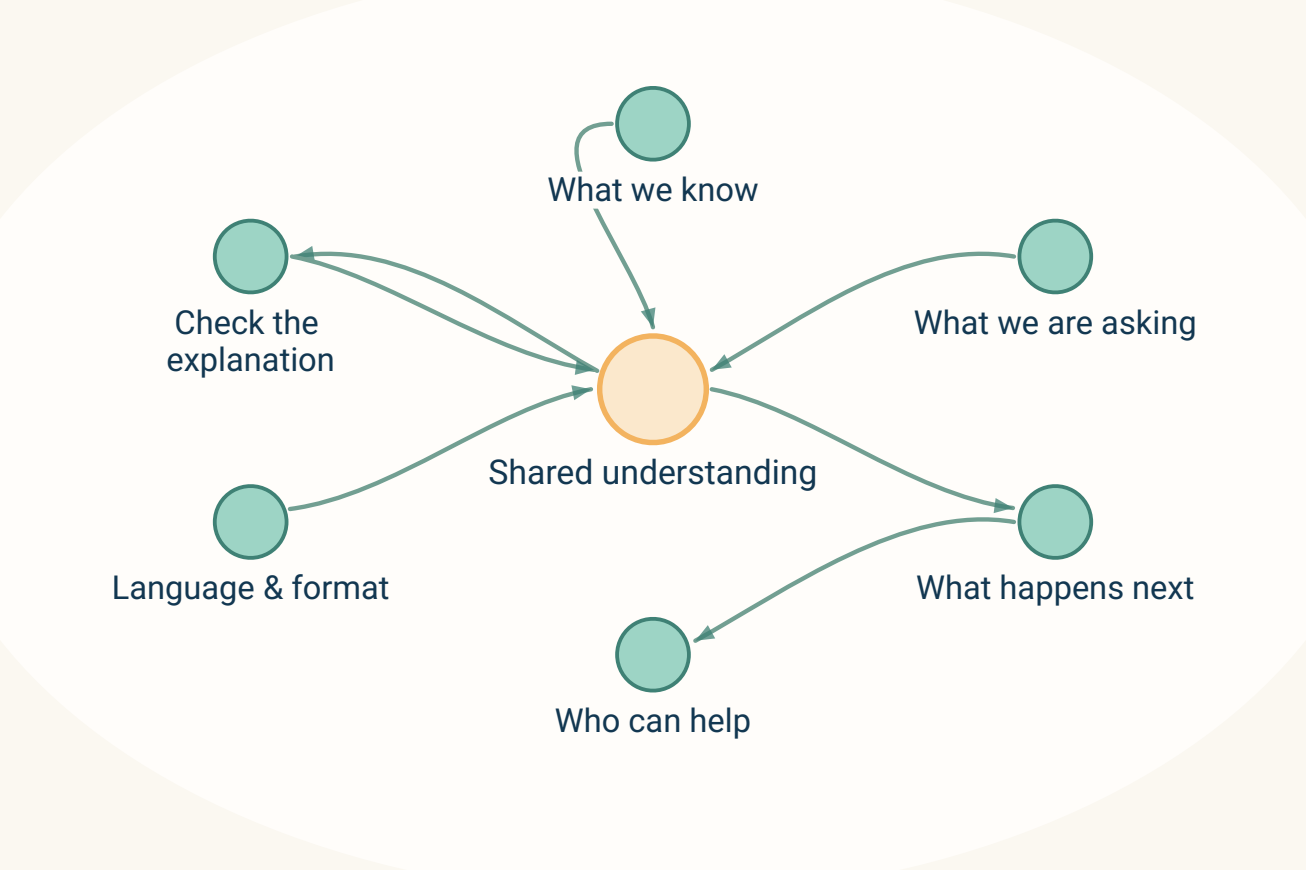


Figure 03 · Four places for understanding. A visual summary of the chapter's Awareness Plan.

Explain what is known to build shared understanding. Make unanswered questions and uncertainty visible within that understanding. Understanding includes a clear account of what happens next. The next step names who can help. Adapt language and format without changing the facts. Check whether the explanation was understandable. Revise the explanation in response to what the person understood and still wants to ask. Checking the explanation is not testing the person, and shared understanding does not require agreement.

What we know

Pat was assessed after a fall. Family observations remain attributed observations, not a diagnosis.

What we are asking

What are the clinicians assessing? What does Pat want explained? What support would help at home?

What happens next

Follow the clinician-approved plan. Confirm the next appointment's purpose. Prepare questions and discuss support with Sam.

Who can help

The clinical team addresses medical questions. Sam helps with community support and family planning within his role.

In Context — Different questions, one family

When Maya joined the next conversation with Sam, she had a page of questions.

Daniel had one.

“Are we sure we need all this?”

He was sitting beside Ellen. Maya had joined by phone, with Pat and Ellen’s agreement. Sam had the shared summary from their first meeting in front of him.

“Dad seemed like himself when I stopped by,” Daniel continued. “We talked for nearly an hour.”

“We had a good visit,” Pat said. “I’d like another one that isn’t a meeting.”

“I’m not saying we shouldn’t talk,” Daniel replied. “I just don’t know what we’re talking about yet.”

Maya had been trying to understand what the family’s observations might mean. She wanted to prepare for what could come next.

“Have the doctors actually said this is dementia?”

Ellen looked at the papers.

“They said we need follow-up. I’m not sure what that means for everything we’re doing at home.”

Sam paused before answering.

“In the clinical information we have here, a diagnosis hasn’t been established. There are questions for the healthcare team. There are also things we can discuss now about what would help at home.”

“So those are different conversations?” Daniel asked.

“Connected, but different,” Sam said. “The clinicians assess the health concerns. We can work together on support and on preparing the questions you want to bring.”

Pat leaned forward.

“I’d like to know what the next appointment is for. And I’d like someone to explain it to me before everyone decides what it means.”

Sam turned the summary so Pat could see it.

“Let’s begin there.”

They were working from some of the same information, but they had arrived with different interpretations.

Maya was looking ahead. Daniel was comparing the concern with a familiar visit. Ellen was trying to understand what she was expected to do. Pat wanted an explanation addressed to him.

> **In Context — Different questions, one family**
>
> Nobody needed another stack of information before those differences were acknowledged.
>
> They needed a way to understand what the information meant.

Information is the beginning, not the result

Information only helps when someone can understand what it means for them.

CarePhysics describes Awareness through practical questions: what is happening, why it matters, how and when something needs to happen, where support is available, and who can help. It includes education about care as well as knowledge of community resources and other assistance.

In practice, Awareness asks us to move beyond delivering an explanation to checking whether it has become usable.

Sending a document establishes that it was sent. Opening a video establishes that it was opened. Neither tells us whether a person understood the distinction between a concern and a diagnosis, a referral and an appointment, or an available service and one they can actually receive.

For Pat and Ellen, the first principle helped the people around them understand their priorities and circumstances. The second principle turns that understanding into an explanation they can work with.

That does not mean making everyone think alike.

Maya and Daniel may understand the same facts and still feel differently about them. Pat and Ellen may agree that support is available while disagreeing about which option to explore. A person can understand a recommendation and choose not to follow it.

Our task is to make the facts, uncertainties, choices, and responsibilities clear enough for those differences to be discussed honestly.

Shared understanding is not the same as agreement.

Start with the question the person is carrying

Sam could begin with a general explanation of care planning. But Pat has already identified a more useful starting point: what the next appointment is for.

Ellen's immediate question is different: what does she need to do between now and then?

The explanation should address those questions before introducing everything else the organization knows.

This is one reason health literacy should be treated as a responsibility of the

organization, not simply a characteristic of the person. AHRQ's *Health Literacy Universal Precautions Toolkit* recommends making information and services easier for everyone to understand and use. It notes that even people who usually manage health information well can struggle when tired, ill, anxious, or overwhelmed.[21]

Pat's teaching career does not tell Sam how clear this particular explanation will be. Maya's research does not mean she has found information applicable to her father. Ellen's familiarity with the household does not mean she knows how the healthcare and community systems divide responsibility.

The appropriate response is not to decide who needs the "simple version." It is to make the starting explanation clear, invite questions, and offer more detail where it helps.

Purpose gives us a way to choose that starting point. Pat wants to remain involved in his own life. Ellen wants a manageable week. The explanation should help them see how the next conversation relates to those aims, without promising that an appointment or service will resolve every concern.

Culture and beliefs deserve the same attention. AHRQ's cultural guidance emphasizes asking about the individual rather than assuming preferences from appearance, identity, or group membership.[13]

In another household, a person might want a trusted friend present before discussing a difficult subject. Someone else may prefer to hear the information privately before sharing it. A family may want a faith leader involved in considering its choices. Those preferences should shape the conversation without changing the underlying facts.

Language requires a separate question. Ask what language someone prefers for speaking and for written information. Arrange qualified interpretation and appropriate translated materials rather than expecting a relative—especially a child—to carry that responsibility.[14]

Knowing the audience helps us choose the explanation. Listening tells us whether we chose well.

What research helps us understand

Research gives this approach both encouragement and limits.

A randomized study of drug-safety messages found that clearer content improved comprehension without improving every other measured response.[22] A systematic review of single-encounter teach-back found no clear pattern of benefit for knowledge acquisition, alongside low- or very-low-certainty findings for other outcomes.[23]

The practical lesson is to design for understanding, check what happens, and avoid assuming that comprehension automatically produces action or better health.

The fuller **Models and Evidence Behind This Chapter** section appears toward the end. It connects these findings—and the behavioral and social-learning models informing the chapter—to specific choices in the family's experience.

First, let us see what those choices look like.

Give uncertainty a place on the page

Sam draws four headings on a fresh sheet:

What we know. What we are asking. What happens next. Who can help.

These headings form the chapter's practical output: an **Awareness Plan**. They organize the family's questions without implying that every question already has an answer. The structure carries forward the continuing storyline's distinction between reliable information, uncertainty, next steps, and responsible contacts.

For this family, the first version could look like this:

Heading	What belongs here
What we know	Pat was assessed after a fall. His current discharge instructions and follow-up information come from the clinical team. Ellen, Maya, and Daniel have described observations; those remain attributed observations, not a diagnosis.
What we are asking	What are the clinicians assessing? What does Pat want explained? What support would make daily life more manageable for Ellen and Pat? Where do family members have different understandings?
What happens next	Follow the current clinician-approved plan. Confirm the purpose and arrangements for the next appointment with the clinical office. Prepare the questions Pat wants to bring. Continue discussing practical support with Sam.
Who can help	The clinical team addresses medical questions. Sam helps with community support and family planning within his role. The working plan includes actual contact routes, expected response times, and an alternative when the usual contact is unavailable.

A real plan would include confirmed appointment details, relevant names and telephone numbers, a review date, and the instructions the clinical team has approved. A generic handout cannot supply those facts.

The distinction between the first two headings is particularly important.

"Maya is worried about dementia" belongs among concerns and questions. It must not become "Pat has dementia" through repeated retelling or a shortened summary.

Likewise, “Daniel had a reassuring visit” does not cancel Ellen’s account of difficulties at other times. Both can remain visible without asking Sam—or an AI assistant—to decide which family member is right.

> **In context**
>
> Sam asks Pat whether the page answers his first question.
>
> “Not quite,” Pat says. “It says follow-up again. What are they following up?”
>
> “That needs a clearer explanation from the clinical office,” Sam replies. “Let’s put your wording in the question.”
>
> The page has done something useful. It has revealed what is still missing.

Check the explanation, not the person

> **In context**
>
> Later in the conversation, Sam explains the difference between preparing clinical questions and arranging community support.
>
> Then he checks his explanation.
>
> “I want to make sure I’ve separated those clearly. How would you describe what we’re doing next?”
>
> Ellen looks at the sheet.
>
> “We speak with you about help at home. And then you tell us what the memory changes mean?”
>
> Sam does not repeat the same explanation more loudly.
>
> “I haven’t made that clear enough. The clinical team answers the medical questions. My part is helping you explore support and organize the conversations around it. We can do that work alongside the clinical follow-up.”
>
> He adds the clinical office beside the medical question and his own name beside the support discussion.
>
> Ellen studies the page.
>
> “So we don’t have to settle the medical question before talking about what would make the week easier.”
>
> “That’s the distinction I wanted to make.”
>
> Pat points to the contact section.
>
> “And we know who gets which question.”

The correction is not a failure of the meeting. It is part of the work.

AHRQ's teach-back guidance recommends explaining in manageable portions, asking people to describe the information in their own words, and trying a different explanation when needed. People may refer to written materials; the method is not intended as a test of memory.[24]

That matters in this story. Pat should not be made to feel that every conversation is an examination. Nor should Ellen's uncertainty become evidence that she is unable to help.

A useful check might be an explanation in someone's own words, a demonstration of where to find a contact, or a supported discussion using an accessible format. The purpose is to discover what assistance is needed—not to award a pass mark.

When understanding remains difficult, change the support. Consider pace, language, hearing or vision needs, the amount of information, the timing, and whether another appropriate person should help. Do not keep asking the same question until someone gives the answer that ends the encounter.

Design the explanation around one useful idea

The Awareness Plan helps Sam see what the family needs. It also gives a content team a focused assignment.

Not: *Produce an educational package about aging.*

Instead: *Help this family prepare for a care conversation without asking them to establish a diagnosis themselves.*

That is one organizing idea. Additional information can remain available without competing for attention at the beginning.

The CDC's Clear Communication Index asks whether material has an identifiable main message, familiar language, useful headings, a clear action, and an explanation of what authoritative sources know and do not know. It is guidance for designing and assessing communication—not evidence that a particular handout has worked.[25]

For Pat's family, a reviewed article could begin this way:

Preparing for the next care conversation

You do not have to work out the explanation yourself before asking for help.

Begin with what you want to understand. Your questions, the experiences you choose to describe, and what matters in your daily life can help shape the conversation.

What this means

Keep what a professional has told you separate from what you have noticed and what you are wondering about. All three can be discussed, but they are not the same kind of information.

A way to begin

"I want to understand what you are assessing, what I need to do next, and whom to

contact when I have a question.”

You can bring a short note, ask someone you choose to help prepare it, or raise your question during the conversation.

What happens next

Use your current care plan for the appointment arrangements and contact details. Ask the responsible professional to explain anything that is unclear. Questions about everyday support can also be brought to Sam.

Before the conversation ends, check that you know which questions were answered, which remain open, and who is following up.

This illustrative article is not a replacement for discharge instructions or individualized clinical advice. Its job is preparation.

A companion video should do more than read the article aloud.

It could show a person looking at an appointment letter and saying, “I know where I’m going, but I’m not sure what we’re discussing.” A staff member then demonstrates finding the appropriate contact and helping the person prepare a question. The closing scene shows the person receiving confirmation—not merely pressing a button labeled “Send.”

That demonstration makes the process visible. It also reveals the human work behind it.

The article and video should use recognizable headings and the same contact language. They should preserve the same facts, even when their wording and length differ. This follows CarePhysics’s proposed pattern of purpose, main idea, demonstration, chosen next step, questions, and follow-through. The pattern remains flexible: urgent instructions lead with the urgent action, and an enjoyable activity need not end with an assigned task.

We are not trying to make every communication identical. We are giving people a familiar way to find what matters.

Different routes into the same understanding

Pat may prefer to read the page after a conversation. Ellen may want the immediate arrangements highlighted. Maya may want access to more detailed, approved background information. Daniel may need a concise explanation of what has—and has not—been established.

These are choices to confirm with them, not permanent learning styles to assign.

AHRQ recommends evaluating whether materials are understandable and actionable, gathering feedback from intended readers, and looking beyond readability scores. A page can contain short words and still leave its meaning unclear.[26]

Offer routes that fit the person and situation: print, conversation, audio, captioned video, a demonstration, or help reviewing the information together. A person who uses one route today may prefer another tomorrow.

Adaptation should change the route into the information, not quietly change the information itself.

A reassuring tone must not turn uncertainty into certainty. A concise summary must not omit a critical condition. A translated explanation needs an appropriate review process. Clinical instructions and validated questionnaires should not be casually rewritten to make them sound friendlier.

The same care applies to sharing. Pat and Ellen can agree that a summary will help Maya and Daniel participate. That does not mean every private concern belongs in that summary. Emma and Noah need age-appropriate support for enjoying time with their grandfather—not access to adult clinical discussions.

Love is visible in these choices: making the explanation available, speaking directly to the person, allowing time for a question, and respecting what they do not wish to share.

Let AI help carry the guidance forward

Maya's questions do not necessarily arrive while Sam is available. Ellen may remember something she wanted to ask after the conversation has ended.

This is one place where properly configured AI assistance could extend support.

In a proposed organizational workflow, an assistant could work from the reviewed Awareness Plan, approved educational resources, current service information, and only the personal context it is permitted to use. It could explain a term, help someone locate an instruction, prepare questions, or offer a shorter version of an approved explanation.

The opportunity is useful, personalized help between human conversations—not an automated substitute for them.

Suppose Maya asks:

"Does the fact that they're arranging follow-up mean Dad has dementia?"

An appropriately bounded response could say:

"The approved summary available here does not establish that diagnosis. It records concerns being assessed and a clinical follow-up plan. A question you could bring to the clinical team is: 'What have you established so far, and what are you still assessing?'"

The response should identify the source it used. It should not turn family observations into a diagnosis or manufacture certainty because Maya asked a direct question.

Ellen might ask something different:

"What should I ask Sam about getting help without giving up all our routines?"

The assistant could help her prepare questions:

"Which parts of our week could receive support?"
"What choices would Pat and I keep?"
"What would the arrangements require from us?"

Ellen chooses what to bring. Her questions should not automatically become a message

to her children.

The organization must define which approved routine answers may be delivered directly and which drafts require review before sharing. Sam reviews personalized support summaries within his role; clinical content requires the appropriate clinical authority. When the available sources cannot answer a question, the assistant should make that limit clear and provide a route to a person.

CarePhysics proposes a workflow of retrieving relevant approved knowledge, adding verified local context, preparing options, reviewing with responsible people, and testing the result with the intended audience. Sources, permissions, ownership, and corrections remain visible.

The same approach could help staff prepare an article, a video outline, and a conversation aid from one approved source set. The reviewer checks that the versions retain the same meaning and direct questions to the correct people.

With reliable knowledge, guidelines, rules, and accountable review, this assistance can become a gift to the organization: less repetitive preparation and more room for human attention. Whether it actually returns time must be measured after checking, corrections, and follow-up—not assumed from the speed of the first draft.

Around-the-clock access needs an honest boundary too. An assistant may be available at any hour while the human service is not. The organization must state when people respond, provide the appropriate urgent route, and assign responsibility for requests.

A request recorded is not help received.

Clarity is organizational work

A clear message cannot compensate for an unclear service.

Before promising that someone will call, the organization must know who will call, when they can reasonably do so, and what happens when the person cannot be reached. Before saying an appointment is confirmed, someone must verify that it is.

The design work therefore reaches beyond editing.

A health system needs ownership of clinical explanations and updates. A community organization needs current service descriptions and realistic response expectations. A Day Center needs to explain what its team provides, what it does not provide, and what families should expect before and after a visit.

Staff need access to the current version and a straightforward way to flag a problem. Training should include practice with real points of confusion—not merely confirmation that a document has been read. AHRQ’s communication guidance recommends listening, open-ended questions, manageable amounts of information, demonstrations, and checks of understanding.[6]

Those choices require resources. Budget for interpretation, accessible formats, content maintenance, review, and answering the questions that clearer communication may uncover. Keep a telephone or paper route for people who do not use the digital one.

The principle applies beyond this family. In rehabilitation, a person may need to understand the purpose of an exercise and see it demonstrated. In home care, the first question may be what a visiting worker can help with. For a working caregiver, it may be how to request support without making several calls during a shift.

Community and state groups can help organizations agree on useful terms while preserving local differences. “Information requested,” “referral accepted,” and “appointment confirmed” should describe different events. Shared headings can remain familiar even when services, languages, and contact arrangements differ.

When staff discover a better explanation, give that knowledge a route into reviewed materials. Credit the contribution. Remove private details. Invite colleagues and intended readers to test it.

That is how local wisdom becomes something the next team can use.

How would we know it helped?

The central measure for this chapter is not content consumption.

It is whether the person can understand the relevant choice, identify what remains uncertain, and find appropriate help.

Offering or exporting a guide does not establish that the person read it, understood it, or completed training. Keep delivery, understanding, and any required skill assessment distinct; the dated implementation example appears in Appendix J.

We do not need to solve that problem by monitoring every page. We need a proportionate way to ask whether the explanation worked.

For a local improvement project, choose one frequently used handout or video. Before revising it, ask a small, varied group of intended readers to explain its main point and locate the next contact. Let them use the material; this is not a recall examination.

Then test the revision using the same questions.

Keep the findings distinct. Someone may find the right contact but misunderstand why they would call. Another may understand the option and decide against it. A third may want the service but be unable to afford or reach it. Those findings require different responses. CarePhysics’s supporting behavioral review separates understanding, first action, adoption, useful participation, outcomes, burden, safety, and equity for this reason.

Name the denominator and time window. Report how many people were offered the review, how many participated, and which access routes they used. Include unanswered questions and people who needed assistance rather than quietly removing them from the result.

Examine preparation time, interpretation, review, repeated explanations, and unresolved requests. Ask whether the experience eased uncertainty or added pressure. A reduction in questions is not automatically an improvement; people may simply have stopped asking.

Assign someone with authority to change the material or workflow. Misunderstood urgency, incorrect AI wording, inaccessible formats, or questions with no responder require correction.

The object of evaluation is the support—not how cooperative the family appears.

Models and Evidence Behind This Chapter

The conversations and design choices in this chapter draw on complementary foundations. Some explain why understanding can be difficult. Others provide ways to clarify information, support choice, or help people work with knowledge together.

A theoretical model, a communication method, an experimental result, and a proposed CarePhysics application do different jobs. The family's story illustrates them; it does not test them.

Health literacy and plain-language design

Make understanding part of the organization's responsibility

The foundation. Health-literacy guidance asks organizations to make their information and services understandable and usable rather than placing the entire burden on the person receiving them. AHRQ recommends clearer communication, easier navigation, and checks of understanding for everyone.[21]

Where we used it. Sam starts with Pat's and Ellen's questions. The Awareness Plan separates known information from uncertainty. The article and video have one purpose, recognizable headings, and a visible route to help.

Supporting study. In a randomized online study published in *Drug Safety* in 2016, Lauren McCormack and colleagues compared two versions of a drug-safety message among **1,244 U.S. consumers**. The revised version used plain-language communication changes. Average performance on five comprehension questions was **63 percent correct with the revised message versus 52 percent with the standard version**. There were no significant differences in behavioral intentions, risk perception, or trust.[22]

What this supports—and its limit. This experiment supports testing clearer wording and organization to improve comprehension. It does not establish that clearer content alone changes behavior or health.

What to examine locally. Can people explain the main point and find the appropriate next step—not simply tell us the material looks good?

Teach-back

Find out whether the explanation worked

The foundation. Teach-back is a communication method, not a theory of motivation. The speaker invites the person to describe important information in their own words so misunderstandings can be addressed. AHRQ emphasizes checking the explanation rather than testing memory; written materials can remain available.[24]

Where we used it. Ellen's description reveals that Sam has not clearly separated his role from the clinical team's role. He changes the explanation and identifies the responsible contacts. The useful moment is discovering what still needs clarification.

Supporting review. Judith Vick and colleagues' systematic review, published September 3, 2026, included **18 randomized trials involving 1,985 participants**. It examined teach-back delivered in a single encounter with adult patients or care partners. The review found no clear pattern of benefit for knowledge acquisition. Pooled findings suggested improved self-efficacy and self-reported, short-term adherence to health behaviors, but certainty was **low or very low**, with substantial variation and wide confidence intervals.[23]

What this supports—and its limit. Teach-back provides a practical opportunity to uncover confusion during a conversation. We should not promise that using it once guarantees retention, adherence, or better clinical outcomes.

What to examine locally. Are important misunderstandings identified and resolved? Does the person feel respected? What time, adaptation, and additional assistance are required?

COM-B

Understanding is one part of making action possible

The foundation. COM-B examines **capability, opportunity, and motivation**. Psychological capability includes the knowledge and understanding needed for an action. Opportunity concerns surrounding conditions, such as available resources and social circumstances. Motivation includes the processes that direct behavior. The model helps distinguish an information problem from an access problem or a question of willingness.[2]

Where we used it. The chapter does not assume that reading an explanation makes the next step possible. A family may understand a service and still lack transportation, time, money, or an acceptable arrangement. Another person may understand the option and choose not to use it.

Foundational research. Susan Michie, Maartje van Stralen, and Robert West's 2011 paper developed the Behaviour Change Wheel through a review of **19 existing frameworks**, placing COM-B at its center. This was framework-development research, not a trial demonstrating that a particular care program improves outcomes. The paper explicitly calls for further research on the effectiveness of the resulting designs.[2]

What this supports—and its limit. COM-B provides a structured way to investigate what is missing. It does not supply a universal engagement strategy or a predictable percentage improvement.

What to examine locally. After the explanation is clear, what else must be available for the person's chosen action to become feasible?

Self-Determination Theory

Help people understand without taking away their say

The foundation. Self-Determination Theory emphasizes **autonomy, competence, and relatedness**: meaningful choice, a sense of capability, and supportive connection. It distinguishes participation that feels self-endorsed from participation driven mainly by pressure or control.[3]

Where we used it. Pat is addressed directly and helps choose the questions for his appointment. Ellen can seek clarification without being judged. Maya and Daniel join with permission. Shared understanding does not require agreement.

Supporting review. A meta-analysis by Nikos Ntoumanis and colleagues, published in the 2021 volume of *Health Psychology Review*, examined **73 experimental studies** of Self-Determination Theory–informed interventions in health promotion and disease management. It found generally small-to-medium changes in motivational measures and health behaviors, with modest, variable effects on health outcomes.[17]

What this supports—and its limit. The wider intervention evidence supports examining autonomy and supportive relationships in design. It does not isolate the effect of the Awareness Plan, a particular sentence, or an AI-generated explanation. The behavioral review informing CarePhysics grades the intervention evidence as **Moderate**.

What to examine locally. Did people feel able to question, disagree, request help, or decline? Did the explanation help them make their own decision?

Social Physics and related social-network research

Help useful information become something people can work with together

The foundation. Alex Pentland's *Social Physics* examines how ideas move through social networks. Its themes of **idea flow, exploration, and engagement** draw attention to discovering information and to the interactions through which people work with it. These are central themes identified in MIT's description of the book.[5]

The supporting CarePhysics review translates this into a practical question: are people discovering relevant resources, and do they have someone with whom to consider whether those resources fit? It grades the broader Social Physics perspective as **Emerging-to-moderate**, while cautioning against assuming that more interaction always produces better results.

Where we used it. Sam brings knowledge from outside the household. Pat, Ellen, Maya, and Daniel compare interpretations rather than receive four disconnected explanations. Maya's question list becomes useful because Pat can review it and the clinical team can respond.

The proposed application is not "send more messages." It is to give relevant information a route into an appropriate conversation.

Related experimental evidence. Damon Centola's 2010 online-network experiment

provides a separate example—not a direct test of Pentland's entire framework. More than **1,500 participants** were assigned to deliberately structured online networks. Adoption of an online health tool averaged approximately **54 percent in clustered networks versus 38 percent in randomly structured networks**. The experiment found that reinforcement from multiple network contacts mattered for adoption in that setting.[27]

What this supports—and its limit. Network structure can affect the spread of a particular behavior. This was not a trial of family care meetings, Day Center participation, or dementia care. It does not establish that repeated messages improve understanding or that socially reinforced information is necessarily correct.

What to examine locally. Did the information reach an appropriate person who could help interpret it, check it, or act on it—with permission?

The network perspective becomes more prominent in the Community chapter. Here, it helps us recognize how relationships can support understanding without turning those relationships into instruments of pressure.

What remains to be tested in your organization

These foundations give us reasons to design for clarity, questions, choice, practical access, and appropriate human connection. They do not validate the whole CarePhysics framework or establish that a particular technology produces the same results. **Evidence for a mechanism is not evidence for a product feature.**

An organization should test the application with its own audience, services, languages, culture, and resources. An explanation that works in one setting may need adaptation in another. The response system behind it may need more substantial change than the words.

The evidence helps us choose what to try. The people using the support help us determine whether it fits.

Using these foundations with an AI assistant

This section can also become a source-linked planning aid. An organization could ask its approved assistant:

Using the relevant models and research summarized here, help us revise one explanation for our audience. Identify the barrier each proposed change addresses. Preserve the evidence limits and our current local facts. Suggest a demonstration, a question route, and a way to check understanding. Flag anything requiring professional review.

The assistant's job is to connect a design choice with a reason—not attach a famous theory to attractive writing.

The organization supplies its services, guidelines, permissions, practical constraints, and local wisdom. Responsible people review the work before it is tried. Feedback then informs the next revision. This follows the proposed knowledge-bank workflow behind

CarePhysics.

One thing to try

Choose one explanation your organization gives often.

Ask someone unfamiliar with it:

“What do you think this is telling you? What would you do next? Where would you go for help?”

Listen before explaining.

Revise the first point where the person’s interpretation differs from what you intended. That may require changing a word, adding a demonstration, naming a responsible person, or fixing the process behind the message.

Then ask again.

The question for your team is:

What are we expecting people to understand that we have not yet made clear?

Understanding makes the next conversation possible

> **In context**
>
> Before the family finishes with Sam, Pat reads the four headings again.
>
> “I like the part that says what we’re still asking,” he says. “It’s better than everyone having a different answer.”
>
> Maya offers to type the questions they have agreed to bring to the clinical team. She checks the wording with Pat rather than turning the list into her own research agenda.
>
> Daniel looks at Ellen.
>
> “I understand why we’re having the conversation now. I was hearing it as though everything had already been decided.”
>
> “It hasn’t,” Ellen says. “I just need us to understand what we’re doing.”
>
> They have not resolved every concern. But the next appointment has questions attached to it, the support conversation has a responsible person, and uncertainty is no longer being mistaken for a settled conclusion.

There is also something important Pat and Ellen have not yet decided: what kind of help they would welcome.

Understanding an option will not necessarily make it feel comfortable, affordable,

practical, or right for them.

That is where the next principle begins.

Behavioral Influence — Support the Next Chosen Step.

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CHAPTER 3

Behavioral Influence — Support the Next Chosen Step

At a Glance

The central idea: Before asking someone to change, understand what is getting in the way.

What you'll explore: Why understanding an option does not automatically make it desirable or possible. Learn to distinguish mixed feelings from practical barriers, connect support with a person's own purpose, and encourage action without using guilt or pressure. Pat and Ellen consider a Day Center while preserving their right to ask questions, explore alternatives, and decide.

Design and AI: Match the response to the need: a conversation, demonstration, clearer explanation, practical assistance, or smaller first step. Explore how an approved AI assistant could prepare relevant options, reduce repetitive work, and help people reach human support without secretly trying to secure agreement.

Put it to work: Create a **Barrier-and-Next-Step Guide** that connects a chosen goal with the support, responsibility, and follow-through needed to pursue it.

Evidence and evaluation: Examine COM-B, motivational interviewing, Self-Determination Theory, the Fogg Behavior Model, and social-learning research. Evaluate informed choice, barriers addressed, useful action, pressure, access, and workload—not enrollment alone.

> *"Put simply, this involves coming alongside the person and helping them to say why and how they might change for themselves."*
>
> — **Stephen Rollnick**, co-developer of motivational interviewing, "About Motivational Interviewing."[28]

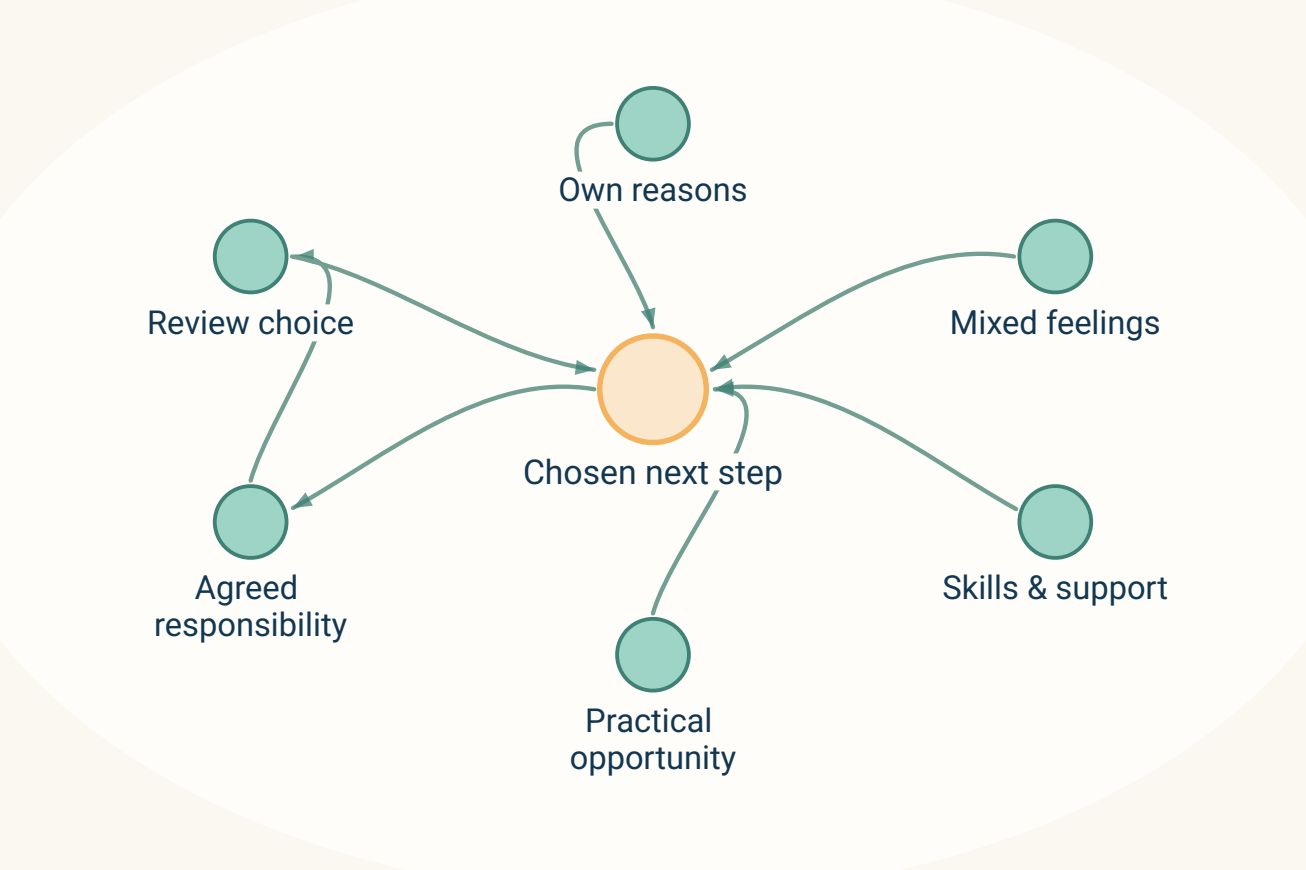


Figure 04 · A chosen step, with the right support. Concept illustration, not an additional event in the family's story.

A person's own reasons guide the next step they choose. Discuss mixed feelings before treating a next step as agreed. Identify the skills and support the chosen step requires. Practical opportunity determines whether the chosen step is feasible. The chosen step connects to an agreed responsibility for support. The responsible person follows through and reviews the experience. Review preserves the person's ability to reconsider or choose another step. The purpose is informed choice and workable support, not securing enrollment or compliance.

The person keeps a say.

1. **Understand:** Know what the offer involves.
2. **Opportunity:** Check timing, cost, transport, and service fit.
3. **Personal reason:** Connect the option with what matters to the person.
4. **Chosen step:** Consider an informational call, another route, or more time.

Asking a question is not enrolling. Pausing or declining remains a choice.

In Context — Pat and Ellen consider an option

Sam placed a short description of a Day Center on the table.

“We’ve talked about finding some support during the week,” he said. “Would you like to hear about one possibility?”

Ellen looked at Pat before answering.

“What would he do there?”

“I’d like to know that too,” Pat said. “And whether I get to choose.”

Sam explained the services described in the center’s current information. Then he stopped.

“What are you picturing when you hear ‘Day Center’?”

“A room where someone tells me what to do until Ellen comes back.”

“And what would you want instead?”

“People I can talk to. Something interesting. Not a whole day organized because nobody knows what else to do with me.”

Ellen turned toward him.

“That isn’t what I want.”

“I know,” Pat said. “I’m asking what they want.”

Sam left the description on the table.

“We should ask them.”

Ellen had a different concern.

“I would like some time when I’m not keeping track of everything. But I don’t want him having a miserable day so I can have a better one.”

“Then we need to look at both experiences,” Sam said. “What the day might offer Pat, and whether the arrangements would actually give you usable time.”

Pat picked up the page.

“Is reading on here?”

“There are activity examples. We would need to ask what they offer now.”

“I’m not joining a committee.”

Ellen smiled. “You usually end up running it.”

“Exactly. I’m trying to avoid that.”

They had not decided to visit. Clinical follow-up was still underway, and the center would need to establish whether its services and eligibility requirements fit Pat’s situation.

> **In Context — Pat and Ellen consider an option**
>
> But something useful had happened.
>
> Instead of arguing about whether Pat should attend, they had begun identifying what each of them needed to understand—and what would make an introduction worth considering.

Understanding does not remove every barrier

In the previous chapter, the family began separating what they knew from what remained uncertain. They could identify the appropriate people for medical questions and practical support.

That was progress. It was not a decision to use a service.

Before asking someone to change, understand what is getting in the way.

Behavioral Influence brings that question into the design of care. Our approach includes questions, purpose, social influence, humor, and other approaches to supporting change. This edition places those approaches within a clear boundary: they should help people pursue worthwhile goals they can understand and endorse, not make agreement the price of being treated well.

We can explain why an option may help. We can recommend appropriate support within our professional roles. We can encourage someone, offer assistance, and return to a question they have asked us to revisit.

But we should remain open to learning that the option is wrong, the timing is wrong, or the organization has not made participation practical.

The question is not simply, “How do we get a yes?”

It is, “What would help this person make and carry out a sound decision?”

What is making the next step difficult?

COM-B provides a useful starting point. It asks us to consider **capability, opportunity, and motivation**: what someone can do, what their surroundings make possible, and what directs their action. Capability includes physical abilities and relevant knowledge or skills; opportunity includes resources and social circumstances. Here, *capability* is a behavioral-model term, not a judgment about someone’s legal decision-making capacity.[2]

Translated into everyday practice, it gives us three questions.

Does the person understand the action and have the support or skills to take it?

A request to “contact the center” assumes that the person knows which center, whom to ask for, what to say, and how to use the contact route. A clearer invitation or supported

first call may address that difficulty.

Is there a practical opportunity?

The person may understand everything and still face an unaffordable fee, an unsuitable schedule, an inaccessible entrance, unavailable transportation, or a service that cannot meet their needs.

Those are not problems to solve with enthusiasm.

Does the action connect with something the person values—and what concerns compete with it?

Someone may want companionship but dislike organized groups. A caregiver may want relief and worry about leaving a loved one with unfamiliar people. Another person may have tried a similar service and had a poor experience.

The research review informing this book makes this distinction central: hesitation about care can arise from knowledge, trust, cost, access, fatigue, family circumstances, or several barriers together. Those situations should not receive the same intervention.

Do not turn these questions into another form people must complete before receiving help. Use them to guide the conversation and the organization's response.

A reminder may help when a willing person has forgotten a manageable task. It will not create a seat in a full program. A video may clarify what happens during a visit. It will not resolve a fee the household cannot afford.

Sometimes the behavior that needs to change is the organization's.

A barrier in the action, a constraint in the pathway

A practical barrier can also reveal a recurring limit in the service around the person. Eliyahu M. Goldratt's Theory of Constraints (TOC) offers a management approach for focusing improvement on what is currently limiting an agreed system goal. Begin by defining that goal, not by labeling a person as the bottleneck.[29]

COM-B already includes the resources and circumstances that make action possible. TOC adds a process-wide prioritization question: which condition should we address first to make the intended support work? An unanswered request is a clue, not its own explanation. The cause may be missing information, unclear ownership, insufficient capacity, an unsuitable offer, or a decision not to proceed.

Investigate with the people involved. Preserve choice, necessary care, and other important improvements even while focusing the project. See Chapter 7's worked example. See R2.5's explanation of the method.

Make room for mixed feelings

Motivational interviewing offers a way to work with ambivalence: wanting something to

change while also having reasons to keep things as they are. It uses a collaborative, purposeful conversation to explore the person's own reasons and possibilities, rather than relying on argument or unsolicited persuasion. It is a learned practice, not a collection of sentences that automatically changes behavior.[30]

In this chapter, we borrow its stance for an illustrative conversation. We are not presenting a few lines of dialogue as a complete motivational-interviewing intervention.

> **In Context — Asking what the hesitation means**
>
> "What might make a day away from home worthwhile?" Sam asked Pat.
>
> "Having a reason to go."
>
> "What sort of reason?"
>
> "A good conversation. Hearing something I haven't heard already."
>
> "And what might make you decide against it?"
>
> "Being treated like I've agreed to everything because I agreed to walk through the door."
>
> Sam wrote that down.
>
> "So an introduction would need to remain an introduction."
>
> "Yes."
>
> He turned to Ellen.
>
> "What would you need to know?"
>
> "That someone would tell me honestly if it wasn't going well. And that I wouldn't spend the whole time wondering."
>
> "Would speaking with the person responsible help you decide what to ask next?"
>
> "It might."
>
> Sam had not answered their concerns with reassurance he could not substantiate. He had helped make the concerns specific enough to investigate.
>
> Back in practice, that is an important distinction. "You have nothing to worry about" closes a subject. "Who would contact you, and under what circumstances?" creates an answer the organization must be able to provide.
>
> Respecting hesitation does not mean leaving people alone with it.

Purpose is a reason, not a pressure point

Self-Determination Theory asks whether participation feels chosen, manageable, and supported through relationships. Its three central needs—autonomy, competence, and

relatedness—give us a way to examine the quality of motivation, not merely whether someone acts.[3]

For this book, purpose begins with what the person values.

Pat may be interested in a discussion because he enjoys history. That is different from telling him the center needs a retired teacher and implying that declining would disappoint everyone.

An invitation to contribute should be genuine, appropriate, and optional. Pat can offer a story, ask a question, listen, or decide he would rather do something else. His history opens possibilities; it does not assign him a job.

The Day Center materials informing CarePhysics make that distinction concrete: they describe optional hosting and activity roles alongside choices to observe, leave an activity, decline, or change one's mind. These are documented design examples, not evidence that contribution produces a particular health outcome.

Love needs the same protection.

We should not tell Pat that attending is how he proves he loves Ellen. We should not tell Ellen that a loving wife ought to manage without help. Both deserve support, and neither should have to make the other feel guilty to obtain it.

Culture, beliefs, and family expectations belong in this conversation, but not as assumptions. Ask whom the person wants involved, which routines or practices matter, and whether the proposed arrangement fits. One person may want a family discussion; another may want to consider the option privately. A trusted community or faith connection may be welcome—or irrelevant.

The organization's task is to discover the difference, not select a script from someone's background.

Make the beginning smaller—not the decision less honest

Once a person has a reason to explore an option, consider how much the first step asks of them.

BJ Fogg's Behavior Model examines motivation, ability, and a prompt coming together at the moment of action. In design, it directs attention to whether the requested behavior is manageable when the invitation arrives. It supplements the broader examination of resources and autonomy; it does not replace it.[4]

"Choose a care program" is a substantial decision.

"Would speaking with the team help you decide what to ask?" is a smaller possibility.

The smaller step must still be truthful. A call described as informational should not trigger enrollment, recurring messages, or wider family sharing without agreement. A visit must not conceal an obligation to attend again.

Make consent easier to understand, not easier to bypass.

A prompt should also follow the person's preference. Someone may welcome an agreed

reminder. Another may want to initiate contact themselves. A decision to pause should not generate increasingly urgent messages.

Small actions are useful when they help people move toward something that matters. They are not valuable simply because a system can count them.

Design content that helps people decide

The content brief now becomes more specific.

Instead of asking a team to create a promotional video, ask it to help people assess whether an introductory conversation or visit would be useful.

The video should show an actual, representative part of the service: the entrance, the welcome, an activity, a quieter option, and the person who answers questions. Filming requires appropriate consent; a staged scene should be identified as a demonstration.

Include a question or exception. Show someone asking whether they can watch before joining. Let the staff response demonstrate the center's real practice.

The companion article can provide information better considered at a person's own pace: services, costs, eligibility, transportation arrangements, assistance offered, and what must be confirmed before attendance.

A proposed invitation might read:

Could this Day Center fit your week?

A conversation with the team can help you explore what the program offers and whether it fits your needs and interests.

You can ask about the day, the people providing support, choices during activities, costs, and arrangements for getting there.

For example: "I would like to see an activity before deciding whether to attend. Is that possible?"

You may request a conversation, ask a question in writing, or take more time. Asking for information is not an agreement to enroll.

The center will explain its next steps, including any assessment required before participation.

Before publication, the organization must add its verified contact, responder, response expectation, and actual introductory options. Do not promise a tour, free trial, transportation, or immediate place because those would make the invitation more attractive.

The familiar CarePhysics pattern remains visible: why it matters, the main idea, a demonstration, a chosen next step, questions, and what follows. Different formats can perform different jobs while preserving the same facts and expectations.

A survey can support the same purpose. Ask what information or assistance would help, explain who receives the answer, and include room to say that the service does not seem

right. A response should lead somewhere—not simply improve an audience profile.

Put the barrier beside the responsibility

The practical tool for this chapter is a **Barrier-and-Next-Step Guide**.

It is a conversation aid, not a validated assessment or a score of readiness. Its purpose is to prevent a concern from becoming another task handed back to the family.

> **In Context — Making the chosen step workable**
>
> Pat and Ellen agree that they would like to speak with Lena, who leads the Day Center team.
>
> Sam first confirms that an informational conversation is available while Pat's clinical assessment continues. That does not establish eligibility for enrollment or participation.
>
> With their permission, he shares the questions they have chosen. Lena accepts responsibility for the call, and they confirm an arrangement that works for Pat and Ellen.
>
> Their guide records:

Question or concern	What needs to happen	Who owns the next step
Pat wants to know whether the activities interest him and whether he has choices.	Explain current activities and actual options to join, observe, rest, or decline.	Lena, with Pat deciding what interests him.
Ellen wants to understand communication when something is difficult.	Explain the center's contact practices and limits; answer her questions.	Lena.
Costs, eligibility, transportation, and required support remain unresolved.	Confirm the requirements and available arrangements before discussing attendance.	Lena provides program facts; Sam helps explore gaps and alternatives.
Pat and Ellen have chosen a conversation, not enrollment.	Keep the call informational; obtain separate agreement for any later step.	Sam and Lena respect the agreed scope.
They may decide not to proceed.	Offer further discussion or alternatives when requested, without treating the decision as failure.	Sam, within his role.

> **In context**
>
> The completed step is a human introduction: Lena has spoken with Sam and accepted the agreed contact.
>
> It is not yet a visit, a delivered service, or respite for Ellen.
>
> That distinction preserves both trust and an accurate account of what has happened.

AI can make the preparation easier

Preparing this kind of conversation involves useful work and repetitive work.

The useful work is understanding what matters, checking what the service can provide, and helping people consider their choices. The repetitive work may include assembling approved descriptions, organizing questions, adapting a handout, and checking whether an agreed contact has been confirmed.

An organization-approved AI assistant could help with that preparation.

It might retrieve current program information and relevant CarePhysics guidance, then draft a comparison of available options. It could distinguish questions already answered from those requiring a person. It could prepare a plain-language article and a video outline from the same approved facts.

A helpful drafting instruction would be:

Prepare options that address the concerns the person has actually expressed. Show what is known, what remains unconfirmed, and who can answer. Do not infer beliefs, diagnose reluctance, invent service availability, or treat enrollment as the required outcome.

Sam would review support-planning material within his role. Lena would confirm program information. Clinical questions would remain with the clinical team. Personal notes would enter the process only with appropriate permission, and a shared draft would exclude private concerns that were not authorized for sharing.

The proposed knowledge-bank workflow keeps research, design guidance, local facts, and personal context distinguishable. It also preserves the source, owner, review date, approved use, and corrections. Giving an assistant the book is a starting resource, not proof that it will apply the ideas correctly.

Properly applied, this assistance can offer a real gift: less time rebuilding routine materials and more attention available for the person.

Families could also ask routine, in-scope questions outside office hours, revisit an explanation, or prepare for a human conversation. The assistant should identify uncertainty and make human help easy to request. Its availability must not be mistaken for continuous professional coverage; actual response times and urgent routes remain explicit.

The assistant should not search for the phrase most likely to overcome a person's reluctance. It should help identify whether a concern needs information, practical assistance, a different option, or a person who can listen.

That is purposeful personalization: adapting support, not exploiting vulnerability.

The organization has a behavior to change too

Suppose a team rarely makes community referrals.

An annual training presentation may be useful when staff lack information. It is not enough when the referral requires duplicate entry, nobody knows whether the service has capacity, or staff never learn what happened afterward.

The same barrier-first questions apply to professionals. The research review informing this book explicitly identifies time, workflow, knowledge, and uncertainty about follow-through as different possible reasons a referral process is not used.

Ask the team what makes the task difficult. Observe the process with permission. Remove redundant steps. Confirm partner contacts. Allow time for introductions and exceptions. Invite staff to contribute better explanations and practical improvements, then show what changed because they spoke.

Training in motivational interviewing requires practice and feedback, not a script pasted beside the telephone. MINT describes it as a skilled approach requiring self-awareness, discipline, and continuing development.[30]

The organizational commitments also include capacity, staffing, costs, language access, accessible formats, and alternatives to digital participation. A simple invitation creates work somewhere: someone must answer, interpret, arrange, or follow up.

This applies beyond Day Centers. In an illustrative rehabilitation setting, a person may want to practice but need a demonstration or different arrangement. In home care, hesitation may concern privacy and who enters the home. A working caregiver may need support at a time the program does not currently offer.

Community and state groups can help investigate repeated barriers across organizations. Where transportation, hours, or language support repeatedly prevent access, the response may require resources or service redesign—not a more persuasive campaign.

How would we know it helped?

The central question is whether people can make and carry out a meaningful choice with appropriate support.

Begin with a baseline for one defined service introduction. Then test the revised approach over a stated period, with a named person responsible for reviewing the results.

Keep the stages separate: people reached, options understood, questions answered, next steps chosen, contacts completed, services begun, and participation that remains useful.

Willingness to recommend, an actual referral, and a referred person receiving help are also different outcomes. The CarePhysics measurement approach makes these distinctions explicit.

Record both the barrier and what happened to it. “Transportation discussed” is different from “a workable ride confirmed.” “Fee information provided” is different from “an affordable arrangement available.”

Ask about the decision itself. Did the person feel heard? Could they disagree? Did they understand that an introductory call did not commit them to enrollment? Did the process add pressure or relieve uncertainty?

A decision not to use a service may be a sound decision outcome. An unmet need caused by unaffordable or unavailable care is different; calling it “choice” would hide the access problem. The supporting review treats informed non-use as potentially successful while separately examining access, burden, and safety.

Report denominators and missing information. How many people were offered support? How many responded? Who could not be reached through the chosen route? Include people using paper, telephone, interpretation, or personal assistance.

Count staff and family effort, including travel, intake, preparation, AI review, corrections, and follow-up. Reduced administrative work must be demonstrated after those costs are included.

Do not rank families by participation or staff by how often they obtain agreement. Use the findings to improve the offer, resolve barriers, change the process, or stop an unhelpful approach.

Models and Evidence Behind This Chapter

These foundations serve different purposes. A model organizes questions. A study tests a particular intervention or relationship. A CarePhysics example proposes an application.

The evidence labels below follow the research review informing this book. They are not a single clinical grade for the whole chapter, and evidence for a mechanism does not establish the effectiveness of a Genus feature or this fictional pathway.

COM-B and the Behaviour Change Wheel

Match the response to the barrier

Foundation and use. COM-B guides the distinction among needing understanding or skills, having a practical opportunity, and wanting to pursue the action. We use it before choosing a reminder, explanation, conversation, or service change.

Foundational research. Susan Michie, Maartje van Stralen, and Robert West’s 2011 paper reviewed **19 behavioral frameworks** to develop the Behaviour Change Wheel. It examined the reliability of applying the framework to existing interventions and called for further research on whether it improves intervention design and effectiveness. It was not a trial of Day Center introductions.[2]

Evidence boundary. The research review informing this book labels this **Strong conceptual** support. It does not justify saying that COM-B increases participation by a predictable amount.

Local question: Did identifying the barrier change what the organization actually provided?

Motivational interviewing

Explore the person's own reasons for change

Foundation and use. Motivational interviewing supports collaborative exploration of mixed feelings, values, confidence, and possible action. In the chapter, Sam asks what would make the option worthwhile and what might make Pat or Ellen decide against it. He does not argue them into agreement.[30]

Supporting review. Sevda Uzun and Nermin Gürhan's 2024 meta-analysis included **38 studies and 25,425 participants with chronic illnesses**. It found a small average improvement in quality of life, but no statistically significant pooled improvement in self-efficacy. Results varied greatly between studies; some studies were small or used before-and-after designs. The underlying search ended in May 2021.[31]

Evidence boundary. The CarePhysics review grades this evidence **Moderate**. The findings concern the studied interventions, not a few conversational phrases or an AI imitation of motivational interviewing.

Local question: Did the conversation clarify a concern or chosen goal while preserving the person's ability to disagree?

Self-Determination Theory

Examine whether participation feels chosen

Foundation and use. Autonomy, competence, and relatedness inform the chapter's emphasis on choice, manageable steps, and supportive relationships. They also help us examine whether purpose is being offered as an opportunity or used as pressure.[3]

Supporting review. Nikos Ntoumanis and colleagues' meta-analysis, published in the 2021 volume of *Health Psychology Review*, included **73 health-domain intervention studies**: 58 randomized trials and 15 quasi-experimental studies. It found generally small-to-medium changes in motivational measures and health behaviors, with smaller positive changes in physical and psychological health. Effects varied across studies and over time.[17]

Evidence boundary. Our commissioned review grades the intervention evidence **Moderate**. It does not establish that offering a choice of activities will improve health, or that every supportive invitation will result in attendance.

Local question: Did people experience meaningful choice and appropriate help, rather than a polite form of control?

The Fogg Behavior Model

Make the chosen beginning manageable

Foundation and use. Fogg's model focuses on motivation, ability, and a prompt at the moment of action. Here, it informs the move from a large decision about care to a manageable informational conversation—after the family's concerns and practical circumstances have been considered.[4]

Supporting review. A 2025 scoping review by Giuliano Duarte-Anselmi and colleagues identified **six studies** applying the model in health-related interventions. The studies addressed different populations, behaviors, and delivery methods. The review reported promising findings but also limited long-term follow-up and a need for stronger comparative research. A scoping review maps a field; it does not provide a dependable pooled estimate of effectiveness.[32]

Evidence boundary. Our commissioned review grades the named model's health-application evidence **Emerging**. A smaller first action is not automatically a lasting habit or a beneficial care outcome.

Local question: Did reducing unnecessary effort help someone take a useful step they had chosen—and did that step lead anywhere helpful?

Social Physics and related network research

Give new information a route into human support

Foundation and use. Alex Pentland's *Social Physics* emphasizes idea flow, exploration, and engagement: discovering ideas beyond one's immediate circle and working with them through interaction. In this chapter, Sam introduces an outside resource and helps the family reach someone who can answer for it. That is a proposed care application of the network perspective.[5]

Related experiment. Damon Centola's 2010 online-network experiment involved more than **1,500 participants** assigned to differently structured networks. Adoption of an online health tool averaged approximately **54 percent in clustered networks versus 38 percent in randomly structured networks**. This demonstrated that network structure and reinforcing contacts could affect that behavior in the experimental setting.[27]

Evidence boundary. This was not a trial of family care or Day Center attendance, nor a validation of Pentland's entire framework. Our commissioned review grades the broader Social Physics perspective **Emerging-to-moderate** and cautions that social learning can carry mistakes as well as useful information.

Local question: Did an introduction help someone obtain reliable answers or practical support—with permission—rather than simply expose them to more messages?

One thing to try

Choose one situation your organization currently describes as "people not engaging."

Replace that label with a specific, observable event: people request information but do

not arrange a conversation, for example.

Ask someone who experienced the process what happened. Do not begin with your explanation.

Identify whether the next useful response is information, a demonstration, a conversation, practical assistance, a different option, or permission to pause. Assign responsibility for providing it, then check whether it helped.

Your team's question is:

Are we asking the person to become more motivated when we should be making the support more workable?

A chosen step still needs people behind it

> In Context — From considering help to sharing responsibility
>
> When the call with Lena was arranged, Pat placed the note beside his book.
>
> "Just questions," he said.
>
> "Just questions," Ellen agreed.
>
> She had written down what she wanted to ask about the day and how the center would keep in touch. Pat had added his own question at the bottom.
>
> "Can I watch first?"
>
> Later, Daniel called.
>
> "Let me know what you decide. I'm happy to help."
>
> Ellen appreciated the offer. She also knew that deciding what help to ask for, finding a time, and checking the arrangements could become another job.
>
> Pat and Ellen had chosen a next step. They had not yet agreed how the adults around them would share the work that might follow.
>
> That would require more than willingness.
>
> It would require people to say what they needed, listen to one another, and make commitments others could rely on.
>
> That is the next principle:
>
> **Communications — Help People Feel Heard.**

Notes

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CHAPTER 4

Communications — Help People Feel Heard

At a Glance

The central idea: Understanding begins with listening, not explaining.

What you'll explore: How to make room for concerns, disagree respectfully, repair misunderstandings, and turn general offers into dependable commitments. Follow Pat's family as they discover that sharing care means sharing the work of arranging it—not simply waiting to be asked.

Design and AI: Give conversations, messages, videos, and family updates a recognizable structure without making them sound scripted. Explore how an approved AI assistant could help people prepare, rehearse, summarize, and respond while preserving their own voices, private concerns, and disagreements.

Put it to work: Create a **Family Conversation Guide**, a short **Shared-Responsibility Agreement**, and a family-update example with a clear route for questions and corrections.

Evidence and evaluation: Examine patient-centered communication, empathy training, autonomy-supportive approaches, and closed-loop communication, alongside early research on digital communication in Day Centers. Evaluate whether people feel heard, understand responsibilities, receive responses, and experience useful support—not merely whether more messages were exchanged.

> *"And the only instruction is: listen generously."*
>
> — **Rachel Naomi Remen, MD**, describing an exercise in listening to experiences of loss, in an *On Being* interview originally broadcast in 2005.[33]

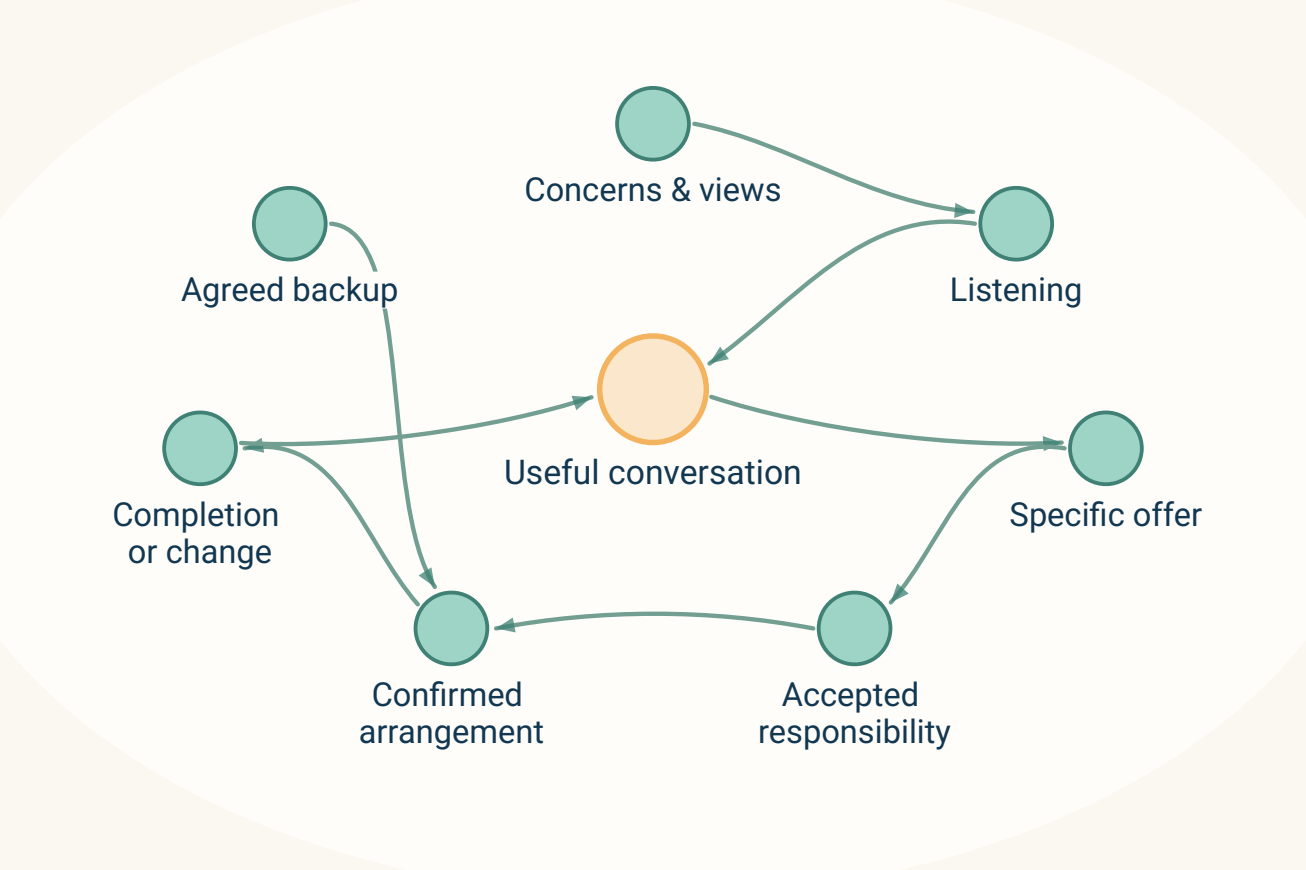


Figure 05 · From an offer to an accepted commitment. A concept sequence for adult care responsibilities.

Listening makes room for people's concerns and different views. What people say shapes the useful conversation. The conversation can turn goodwill into a specific offer. An offer becomes a responsibility only when someone accepts it. Confirm the arrangements behind the accepted responsibility. Check whether the confirmed arrangement was completed or needs to change. Report completion or a change back through the conversation. A backup supports the arrangement only when someone has accepted it; otherwise the gap remains unresolved. A request, an offer, an accepted responsibility and completed support remain distinct.

Make the commitment specific

Offer: Name the action and its limits.

Acceptance: The person agrees to take it on.

Confirmation: Check who will do what, and when.

Backup: Keep an unresolved gap visible until someone accepts it.

An accepted commitment is not yet a completed task.

In Context — “Just tell us what you need”

Before their scheduled conversation with Lena, Pat and Ellen met again with Sam to discuss the arrangements around them. Daniel came in person. Maya joined by phone, with her parents’ agreement.

“I keep telling Mom,” Daniel said, “just call me when you need something.”

“I know,” Ellen replied.

“I mean it.”

“I know you do.”

Sam waited.

Ellen looked down at the appointment information.

“First I have to work out what needs doing. Then I have to think about who might be free. Then I call. And if the time changes, I start again.”

“You can always ask me,” Maya said.

“I can. But sometimes, by the time I’ve explained it, I’ve already done it.”

Daniel leaned back.

“I didn’t realize asking was part of the problem.”

“It isn’t asking exactly,” Ellen said. “It’s keeping all of it in my head.”

Pat had been listening.

“And I would like people to ask me before making arrangements. Yesterday I heard about a possible appointment time from three people. Nobody had asked whether it worked for me.”

Maya began to apologize.

“I was trying to make it easier.”

“I know,” Pat said. “But I’m still available for consultation.”

Ellen smiled, then looked toward Sam.

“I don’t want this to sound as though nobody helps.”

“It doesn’t,” Sam said. “You’re describing what help currently requires from you.”

He turned to the others.

“Before we decide who does what, could we make sure we understand what each person is asking for?”

Daniel answered first.

“Mom needs us to take responsibility for something, not wait for instructions every time.”

> **In Context — “Just tell us what you need”**
>
> “And Dad?” Sam asked.
>
> “To be part of the arrangement before we make it.”
>
> Pat nodded.
>
> “That would be a promising development.”
>
> Nobody had stopped caring. They had been expressing care in ways that left important work unassigned—and important preferences unheard.

Listening changes what we are trying to solve

In Chapter 1, we learned more about the person and family. In Chapter 2, we made information easier to understand. In Chapter 3, we examined what would make a next step worthwhile and possible.

Communications brings those gains into the relationship between people.

Understanding begins with listening, not explaining.

Active listening, empathy, respectful language, and attention to individual differences become useful when they change how people ask, respond, agree, and follow through.

Our aim is not to teach everyone to speak perfectly. It is to create conditions in which people can say something important, discover how it was understood, and influence what happens next.

A warm sentence can open that possibility. What follows must support it.

In the family’s conversation, the problem initially sounded like a shortage of requests. Listening revealed a different problem: Ellen was still responsible for noticing, allocating, explaining, reminding, and checking.

A more encouraging invitation to ask would have left that arrangement largely unchanged.

Listen before deciding what the words mean

Listening is more than leaving enough silence to prepare a reply.

For practice, begin with an open question. Let the answer develop. Reflect what you think you heard, then leave room for correction. AHRQ’s clear-communication guidance recommends attentive listening, questions that invite explanation, and checks of understanding rather than relying on a yes-or-no answer.[6]

A useful reflection might be:

“You want help with the arrangements, but you don’t want to become the person who assigns and checks every task. Have I understood?”

It should not become:

“You’re overwhelmed because your family isn’t supportive.”

The first invites clarification. The second adds an interpretation and assigns blame.

The same discipline applies when someone sounds angry, hesitates, or goes quiet. Ask what the experience means to them. Do not treat a facial expression, a pause, or a computer-generated sentiment label as a reliable account of their inner life.

Acknowledging an experience also does not require accepting every conclusion attached to it.

“I can hear that you felt left out” is different from “Everyone deliberately excluded you.” We can take the feeling seriously while remaining careful about what is known.

Sometimes the person needs a practical response. Sometimes they need to finish speaking before considering one.

“Would it help to think through options, or would you like me to listen a little longer?” gives them a say in that decision.

Turn goodwill into something someone can rely on

A general offer leaves several questions unanswered.

What is being offered? When is the person available? Does the offer include arranging the task? What happens if plans change? Who tells the other people involved?

The supporting CarePhysics behavioral review proposes chosen, bounded roles for this reason. It distinguishes the plausible value of reducing ambiguity from evidence that a particular family-task feature improves care.

> **In Context — An offer becomes a commitment**
>
> Daniel looked at the next follow-up appointment.
>
> “I can take you next Thursday, Dad.”
>
> “Both ways?” Pat asked.
>
> “Both ways.”
>
> “Then yes.”
>
> Daniel checked the appointment details with him.
>
> “I’ll call you Wednesday evening to confirm when I’m coming. And I’ll bring the car around rather than have you waiting outside.”
>
> Ellen started to add something, then stopped.
>
> “What were you going to say?” Sam asked.
>
> “I was going to remind him to check the time.”

> **In Context — An offer becomes a commitment**
>
> Daniel looked at the page again.
>
> “That part should be mine too.”
>
> Maya offered to make one scheduling call about a different follow-up question, once Pat approved the request and the office had the necessary permission to speak with her.
>
> “I can do that Tuesday,” she said. “I can’t take over all the calls, but I can take this one.”
>
> “That helps,” Ellen replied.
>
> Sam asked what would happen if Daniel’s work prevented the Thursday trip.
>
> They did not yet have a confirmed alternative. Rather than write “family backup” as though someone had accepted the job, they recorded the gap. Daniel would tell Pat and Ellen promptly if his availability changed and take responsibility for exploring an acceptable alternative with them. Sam would help investigate available support within his role.
>
> “Let’s check that before we depend on it,” Sam said.
>
> The agreement was modest. That was part of its value.
>
> It identified something people could actually undertake—and something they still needed to resolve.

Confirm understanding, then confirm completion

AHRQ’s TeamSTEPPS guidance describes *closed-loop communication*: a message is given, the recipient confirms what they understood, and the sender verifies or corrects that understanding. A check-back is one way to do this.[34]

In a family conversation, it need not sound like a clinical procedure.

“So you’re handling the ride and checking the time with Dad?”

“Yes. I’ll confirm it with him Wednesday.”

“That is what we’re agreeing.”

That closes the understanding loop. It does not complete the ride.

CarePhysics adds the practical follow-through question: how will the people relying on the arrangement know it happened—or know promptly that it cannot?

The same distinction applies to a professional message. “Received” may mean someone has seen the request. “Accepted” means someone has taken responsibility. Neither necessarily means the requested support has been provided.

Use those words carefully. Do not let an automated acknowledgment sound like a human

has already acted.

Make disagreement possible without making it the whole relationship

A family conversation does not need to resolve every difference before it becomes useful.

One person may want more information. Another may feel there have already been too many conversations. The person receiving care may want a different balance of assistance and independence than relatives initially propose.

Start with the specific issue rather than a judgment about character.

“I did not know the appointment time had changed” gives people something to clarify.

“You never tell me anything” may express real frustration, but it makes the immediate repair harder to identify.

That does not mean asking a distressed person to rephrase everything politely before receiving help. The facilitator can acknowledge the frustration and help find the concern underneath it.

Repair can be direct:

“I moved too quickly. I should have checked with you.”

“The note does not accurately reflect what you agreed to. I will correct it.”

“I said I would call, and I did not. Here is what I can do now.”

An apology should not become a substitute for correcting the arrangement. Nor should a carefully written summary erase a disagreement to make the meeting appear successful.

Some matters need a private conversation. Others require a qualified professional rather than another family discussion. Where someone cannot speak freely or there is a safety concern, the appropriate response may be private support—not gathering everyone into the same room.

Adapt the conversation without assigning people a cultural script

A familiar structure should make communication easier to navigate. It should not prescribe one acceptable way to express concern.

Ask about language, privacy, who should be involved, and how people prefer difficult information to be discussed. AHRQ’s cultural guidance emphasizes learning from individuals and avoiding assumptions based on how they look, sound, or identify. It also notes that expectations about eye contact and touch can differ.[13]

Do not equate directness with honesty, quietness with agreement, or strong emotion with lack of understanding.

Someone may find it easier to begin in writing. Another may prefer a private call before a group meeting. A person may wish to include a trusted friend or faith leader. Another may want fewer people involved.

Language support is a separate responsibility. Ask what language people prefer for speaking and reading, and arrange qualified assistance for consequential care conversations rather than relying on children or untrained relatives to interpret.[14]

Accessibility belongs in preparation too: readable materials, captions when needed, appropriate communication aids, enough time, and a setting where people can hear and respond comfortably.

Preserve the same facts while adapting the route into them. A softer tone must not hide an important concern. A shorter version must not remove a condition on which the plan depends.

Design the conversation before designing the form

The practical output for this chapter begins with a **Family Conversation Guide**.

It is not an assessment or a compulsory script. It helps the facilitator and participants identify what the meeting is for, what needs discussion, and what should remain outside it.

Before the meeting, ask each participant what they want addressed and what information they are comfortable sharing. Explain who will attend, whether notes will be taken, and who will receive the summary. Recording or AI assistance requires its own appropriate explanation and permission.

During the meeting, begin with the person receiving care and make room for the caregiver's separate needs. Discuss one manageable issue at a time. Confirm offers before recording them as commitments.

Afterward, share only the agreed information through the chosen routes. Include a way to correct it.

A brief working guide can hold the following:

Conversation element	What needs to be clear
Purpose	What are we trying to make easier, protect, or decide?
Voices	What does each person want understood? Who has not yet had an opportunity to speak?
Boundaries	What is private, outside this meeting's scope, or awaiting professional assessment?
Commitments	What has someone actually accepted, by when, and with what limits?

Conversation element	What needs to be clear
Follow-through	How will completion, a change, or an unresolved gap be communicated?
Review	Who checks the summary, receives corrections, and revisits the arrangement?

Do not make the family explain its entire history every time it meets. Start from the reviewed information already available and ask what has changed.

The organizing idea is straightforward: **share the work, not merely the information about the work.**

Show people what a useful conversation looks like

The content surrounding the meeting should help people participate, not add another lesson to complete.

A short preparation article might explain that an offer can include arranging and confirming a task, not only performing it. A video could demonstrate the difference between “Call me when you need something” and a bounded offer the other person can accept, change, or decline.

Show an imperfect moment too. A person realizes they cannot commit to every Thursday and offers one specific date instead. The family adjusts without treating the limit as evidence of insufficient love.

End the demonstration with confirmation and a fallback question—not just a warm exchange.

A companion prompt might ask:

“What is one part of the week you could realistically take responsibility for, including the arrangements?”

Someone can answer “none at present.” That answer identifies a limit the plan must respect.

The video, article, invitation, and follow-up can use the same recognizable headings: **What matters** / **What we agreed** / **What is still open** / **Who responds**. Each medium performs a different job while preserving the same meaning. Our communication approach explicitly distinguishes consistent meaning from identical wording across channels.

Chapter 6 develops the creative choices within that consistency: a demonstration, metaphor, story, photograph, welcomed humor, or quiet moment can be appropriate when it fits the person and the purpose.

For a feedback question, explain what the answer will influence and who will review it. A reply box without a response process is not a conversation.

Send an account people can use—and correct

> **In Context — The summary they agree to share**
>
> Before ending the meeting, Sam reads back the proposed family summary.
>
> What matters
>
> Pat wants arrangements discussed with him before they are finalized. Ellen wants help that includes organizing and following through, not only responding when she asks.
>
> What we agreed
>
> Daniel will provide the agreed Thursday ride and confirm details directly with Pat on Wednesday. Maya will make one scheduling call on Tuesday after Pat approves the request and the office confirms the necessary permission.
>
> What remains open
>
> A backup ride has not been confirmed. Regular Day Center attendance has not been agreed. Clinical questions remain with the healthcare team.
>
> Questions or corrections
>
> Contact Sam through the route provided with this summary. A change affecting an immediate arrangement should also go directly to the people relying on it.
>
> Maya asks Sam to keep “one scheduling call” in the final version.
>
> “I don’t want Mom to think I’ve taken all of that over.”
>
> “That stays,” Sam says.

Pat asks for his own copy.

“It would be helpful to know what I’m agreeing to.”

The family chooses who receives the summary. Private conversations are not included.

The document does not claim the tasks are complete. It records an agreement they can check against what happens.

Communication should carry life, not only tasks

Not every family update should become an action list.

A person’s day may include enjoyment, disappointment, humor, quiet, and a conversation worth remembering. The organization can make room for those experiences without turning every moment into a clinical interpretation.

A useful family update can distinguish something to talk about, an optional idea for home, support for the caregiver, and a question for the next visit. In our proposed

design, each section has a clear purpose and review route. The dated Genus example and its limits appear in Appendix J.

Consider a separate, invented example—not a later event in Pat's story. A participant enjoys discussing gardens, then chooses a quieter seat when the room becomes noisy.

A note could offer an optional conversation about gardens, describe the quieter setting that was offered, and say that there is no additional task for the family that evening. It should not declare that the person was happy all day or infer why they wanted quiet.

Important concerns need their own clear place and appropriate human follow-up; they should not be hidden among cheerful suggestions.

Give families an appropriate way to correct the account and request a reply. A saved comment or notification is only one step; name who reads it, accepts the response, and follows through.

The purpose is to bring the day into the relationship—not require relatives to quiz someone about it.

A photograph, story, or poem may also offer a point of connection when the person welcomes it. It need not produce a measurable action to deserve a place in family life.

Where AI can help people find their words

A person may know what they need to say and still struggle to begin.

In a proposed, organization-approved workflow, an AI assistant could help rehearse a conversation, organize questions, or revise a message for clarity. The person remains the author and decides whether the wording sounds like them.

For example:

"Help me explain that I need assistance with the arrangements, without implying that my family does not care."

The assistant could offer several openings and ask which fits. It should not decide that a relative is selfish, infer motives, or turn frustration into a diagnosis of the family.

Meeting preparation offers another useful role. With appropriate permission, an assistant could organize selected notes by source and distinguish concerns, proposals, accepted commitments, and unresolved questions.

Its first draft still needs checking.

"Family will share transportation" sounds reassuring but may be inaccurate. "Daniel accepted one Thursday ride; no recurring arrangement or backup has been confirmed" preserves the actual agreement.

Likewise, "Everyone agreed" must not replace a record that one person remained uncertain.

The proposed CarePhysics workflow keeps approved research and guidance separate from current organizational facts and permissioned personal information. It identifies

sources, review owners, permitted uses, and corrections. Supplying the book to an assistant is not model training or proof that it will follow the material reliably.

Properly applied, AI could reduce repeated preparation, help staff draft useful updates, and let families revisit routine information at any hour. The human service must still explain when people are available and provide a clear route for urgent or consequential concerns.

Private notes should not automatically enter shared summaries or become training examples. The named reviewer checks accuracy, omissions, permissions, tone, and responsibility before a personalized care summary is released. Where the Day Center workflow uses AI drafting, its documented rule is that a person approves family-facing content.

The opportunity is more support around the conversation—not a machine taking over the relationship.

Help the team practice—and listen to the team

Communication requires organizational support.

A team needs protected time to learn, clear responsibilities for incoming questions, access to current guidance, and enough staffing to carry out the commitments made in its messages.

Short paired practice and branching fictional scenarios can give staff a supported place to rehearse. Keep voluntary reflection private rather than turning personal commitments into rankings. Appendix J identifies the dated training examples; required competency assessment remains a separate professional process.

A team might practice responding to a family correction, clarifying a vague request, or explaining a service limit without becoming dismissive. Then ask staff what would make the real encounter easier.

Perhaps the form obscures the responsible person. Perhaps different shifts receive different information. Perhaps a promised callback window is unrealistic. Those problems require operational changes, not another reminder to be compassionate.

Budget for interpretation, accessible materials, preparation, human review, and responses. Keep telephone and paper options. Agree how staff cover absences and how an unresolved concern reaches someone with authority to act.

A health system, home-care organization, and Day Center may use similar communication structures while retaining different professional responsibilities. Community and state groups can help partners agree on status terms and response expectations without erasing local voice.

Capture useful staff suggestions, credit their contributors, and report back on what changed. AI could help organize permissioned feedback for that discussion. It should not secretly score staff emotion, attention, or kindness.

Listening should reach the people providing care as well as those receiving it.

How would we know it helped?

Begin with one communication process: a family meeting, routine update, or request for help.

Establish a baseline, then try a defined change over a stated period. A short local improvement project can identify practical problems; it should not be presented as proof of long-term clinical benefit.

Ask the people involved whether their concern was accurately represented, whether they could disagree, and whether they know who is doing what. A locally written feedback question is useful for improvement, but it is not automatically a validated measure.

Track follow-through separately. For example, the team could count routine questions due for a response during a month and report the proportion that received a substantive answer—or a clear, owned next step—within the stated service window. Urgent concerns require their own process.

Also examine commitments completed, unresolved gaps, corrections, privacy problems, and time spent preparing, reviewing, and responding. Include people using different languages and non-digital routes. Report missing feedback rather than treating silence as satisfaction.

Do not make a low correction rate the goal. Corrections may reveal that people feel able to speak and that the process is working. What matters is whether the error is understood, repaired, and prevented where possible.

Separate communication activity, understanding, useful participation, experience, and outcomes. The CarePhysics measurement framework includes access, burden, and safety alongside these stages.

Give a named leader authority to revise or stop a process that creates more work, hides concerns, or leaves questions unanswered.

We are evaluating the support—not how well a family performs harmony.

Models and Evidence Behind This Chapter

This chapter emphasizes listening, compassion, practical commitments, and reviewed communication. The external studies and guidance below help examine those choices.

They do not all provide the same kind of evidence. A conceptual model explains possible mechanisms; a training trial tests a particular intervention; a feasibility study asks whether an approach appears workable.

Patient-centered communication

Connect the conversation to what happens afterward

Foundation and use. Richard Street, Gregory Makoul, Neeraj Arora, and Ronald Epstein's 2009 paper, *How Does Communication Heal?*, describes pathways connecting

clinician–patient communication with understanding, trust, decisions, support, agency, and health. It is a conceptual synthesis, not a randomized trial demonstrating one communication package.[35]

In this chapter, its contribution is to look beyond whether the exchange sounded warm. Did listening change the problem being addressed? Did the resulting plan reflect the person's priorities? Did someone gain practical support?

Evidence boundary. The paper helps identify intermediate outcomes worth examining. It does not establish that the proposed family summary, AI workflow, or CarePhysics chapter improves health.

Local question: What changed because the concern was heard—not merely recorded?

Empathic communication skills

Practice can matter, but a course is not the whole solution

Supporting study. Helen Riess and colleagues' 2012 randomized trial involved **99 resident and fellow physicians** from six specialties at two Boston institutions. The intervention added three one-hour empathy-training sessions to standard education.

Patient-rated empathy improved more in the training group than in the control group, with a **2.2-point difference in change on the CARE measure**. Patient ratings were collected one to two months after training. The study had a small, volunteer sample, one instructor, and no long-term follow-up. It did not establish improved clinical outcomes or reduced burnout.[36]

Where we used it. The chapter proposes practice, feedback, and organizational support rather than asking staff simply to "be more empathetic."

Evidence boundary. This is experimental support for one training approach in medical trainees. It does not validate automated emotion-reading or staff empathy scores.

Local question: After practice, do the people receiving care experience better listening and clearer responses?

Self-Determination Theory

A commitment needs an authentic yes

Foundation and use. Self-Determination Theory's attention to autonomy, competence, and relatedness carries forward from Chapter 3. Here, it informs chosen roles, realistic limits, and the ability to disagree.

The research review informing this book specifically proposes bounded family responsibilities and grades the wider intervention evidence as **Moderate**, while distinguishing it from stronger claims about individual product features.

Maya's offer of one call and Daniel's agreement to a particular ride illustrate this application. Neither is assigned unlimited responsibility because of distance, proximity, or family role.

Evidence boundary. The family agreement is a proposed application, not a validated intervention. More accepted tasks do not necessarily mean less strain; the arrangements may redistribute or increase work.

Local question: Did people accept roles they could realistically carry, without pressure or hidden obligations?

Closed-loop and family-centered communication

Confirm the meaning and support the process

Practice foundation. AHRQ's TeamSTEPPS guidance recommends feedback that confirms a message was correctly understood. The chapter applies that principle to checking responsibilities, while distinguishing understanding from actual task completion.[37]

Related study. Alisa Khan and colleagues' 2018 multicenter study examined a family-centered communication program across **3,106 pediatric admissions in seven North American hospitals**. The program combined structured bedside conversations, written summaries, staff training, and implementation support.

Harmful errors fell from **20.7 to 12.9 per 1,000 patient-days** after implementation. The overall medical-error rate did not change significantly. This was a before-and-after study, not a randomized comparison; other changes could have contributed, and the intervention's components cannot be separated into individual effects.[38]

Evidence boundary. Pediatric hospital rounds differ from family care planning and Day Center communication. The result supports investigating structured, supported communication—not promising the same reduction elsewhere.

Local question: Do people have an opportunity to raise concerns, check the plan, and identify who follows through?

Digital communication in Day Centers

Test usefulness inside the working day

Supporting study. Amy Zheng and colleagues' 2024 mixed-methods study examined a **CareMOBI prototype with 22 Day Center staff members** from three U.S. states. Staff generally viewed the proposed communication tool favorably, while identifying training, technical support, language access, and fit with existing work as important issues.

Participants explored a prototype and completed interviews and questionnaires. The sample was small and entirely women; the study did not establish long-term adoption, reduced workload, or improved family or health outcomes.[39]

Where we used it. The chapter treats a digital update as part of a human response process, not as proof that communication has improved.

Evidence boundary. This is early acceptability and feasibility evidence for a different product, not validation of Genus. The added value of a reviewed family summary remains a local evaluation question.

Local question: Does the communication channel help families and staff exchange useful information without introducing unacceptable work or excluding people?

Where Social Physics fits

The Social Physics perspective remains useful in the background: information becomes more valuable when people can discuss, interpret, and work with it. The research review informing this book emphasizes both discovering resources and having relationships through which to consider them, while warning that social learning can also spread mistakes.

In this chapter, that suggests a design question rather than another claim: does the message reach someone able to respond, clarify, or help?

More messages are not the objective. A useful exchange is.

One thing to try

Choose one recurring offer in your organization, such as “Contact us with questions” or “Let us know how we can help.”

Follow it through as though you were the person receiving it.

Who responds? What can they do? When should an answer arrive? What happens when the usual person is unavailable? How does someone correct a misunderstanding?

Improve the weakest part, then test it with the people using the service.

Your team’s question is:

After we invite someone to speak, have we made it possible for their words to change what happens?

The conversation makes room for something else

> In Context — A call that is not only about care
>
> On Wednesday evening, Daniel called Pat.
>
> “I checked the appointment details. I’ll be there at the time we agreed, and I’m taking you home afterward too.”
>
> “Good,” Pat said. “Have you finished that book?”
>
> “What book?”
>
> “The one you borrowed.”
>
> “I’ve been busy.”
>
> “So have I. Apparently I have a full calendar.”

> **In Context — A call that is not only about care**
>
> Daniel laughed.
>
> “I’ll bring it.”
>
> Ellen was nearby, but she did not need to take over the call. Daniel and Pat had made the arrangement together.
>
> One small piece of the week had a responsible person behind it.
>
> There were still questions about care, and the family had not solved them all. Better conversation had helped them share some responsibilities. It could not create every service they might need.
>
> They could offer a ride. They could make a call. They could remain family.
>
> The next step was to discover what could become possible with people beyond the household: a welcoming place, appropriate support, useful relationships, and opportunities for Pat to participate in a community of his own choosing.
>
> That is the fifth principle:
>
> **Community — Make Belonging Practical.**

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CHAPTER 5

Community — Make Belonging Practical

At a Glance

The central idea: Care becomes stronger when people know how they can help—and how they can belong.

What you'll explore: How a community becomes more than a collection of services. Follow Pat and Ellen from an introduction to a Day Center toward chosen participation, familiar relationships, and usable respite. Examine why transportation, affordability, culture, language, staffing, and program fit belong in the same conversation as compassion and connection.

Design and AI: Create invitations that show what people can expect, introduce the person who will respond, and make room for questions. Explore how an approved AI assistant could help maintain resource information, prepare introductions, adapt materials, and capture useful ideas without replacing human relationships or assuming a referral succeeded.

Put it to work: Build a **Community Introduction and Follow-Through Plan** that connects a person's priorities with an appropriate service, a responsible contact, practical arrangements, and a review.

Evidence and evaluation: Examine social support, Social Physics, community-access research, and adult day services studies. Measure actual connections, participant experience, caregiver relief, access, and burden—not simply referrals or attendance.

> *"Being connected to others socially is widely considered a fundamental human need — crucial to both well-being and survival."*
>
> — **Julianne Holt-Lunstad, PhD**, psychologist and social-connection researcher, quoted by the American Psychological Association in 2017.[40]

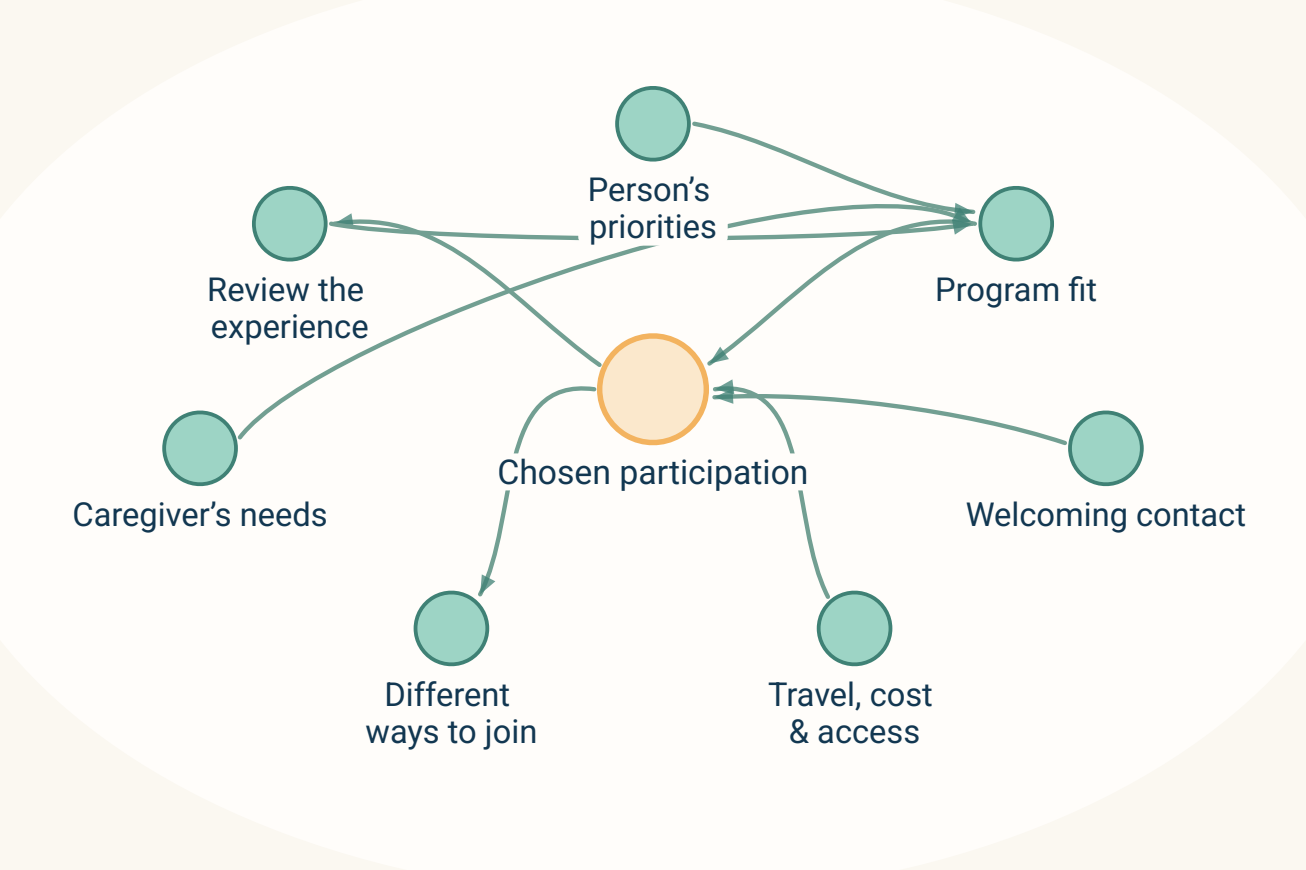


Figure 06 · A place to belong. Fictional illustration of a welcome, not a depiction of a specific Day Center.

The person's priorities guide the assessment of program fit. Program fit informs the person's choice about participation. A welcoming contact makes an introduction and a route for questions available. Travel, cost and access arrangements affect whether chosen participation is usable. Participation leaves room for different ways to join, including quieter company. Consider the caregiver's needs separately when examining fit. Review the experience of participation rather than counting attendance alone. Use that experience to reconsider program fit. An introduction is not proof that support or usable respite was received.

> **In Context — Someone at the door**
>
> Pat stopped just inside the Day Center.
>
> "Do I have to stay for the whole morning?"
>
> "No," Lena said. "Today you and Ellen are here to look around and ask questions. That is what we agreed."
>
> The telephone conversation had answered some things. Seeing the place raised others.
>
> Pat looked past the reception area. There were people talking around a table, someone reading near a window, and another group preparing an activity.
>
> Lena spoke to him directly.

> **In Context — Someone at the door**
>
> “Sam mentioned that you enjoy books and local history. What do you like reading now?”
>
> “History. And mysteries, provided nobody explains the ending.”
>
> “Would you like to see what we have?”
>
> “Is it all reading aloud?”
>
> “Not all. Some people prefer listening. Some read on their own. We can show you.”
>
> Ellen asked where she could sit during the visit.
>
> “Come with us,” Lena said. “Then we can find somewhere to talk.”
>
> On a table lay photographs of neighborhood streets. Two participants were discussing what a building had once been used for.
>
> Pat slowed down.
>
> “I thought that was a bakery.”
>
> “One of us thinks so,” a participant replied.
>
> Lena waited.
>
> “Would you like to join them for a few minutes?”
>
> “I’ll listen first,” Pat said. “Nobody’s appointed me historian.”
>
> “No appointment necessary.”
>
> “That makes a change.”
>
> Ellen sat nearby. She had not decided whether the center would work for them. Neither had Pat.
>
> But the question was becoming more concrete. They were no longer trying to imagine an unfamiliar service from a description.
>
> They were meeting people.

Community has to become usable

A family can communicate more clearly and still need support it cannot provide alone.

Daniel can offer a ride. Maya can take responsibility for a call. Ellen and Pat can explain what matters to them. None of those commitments creates a staffed program, an accessible vehicle, or someone available when family members are not.

The Community principle extends care beyond the household.

Care becomes stronger when people know how they can help—and how they can

belong.

Community connects the person receiving care with chosen supporters, professionals, volunteers, and appropriate services. It also makes room for people to give as well as receive support.

That is broader than a directory and more personal than a referral network.

A directory can tell someone that a service exists. An introduction can bring them into contact with a person. A workable arrangement can make participation possible. Over time, the experience may become somewhere they feel recognized and welcome.

Those are different achievements.

A person can arrive at a building without feeling included. A caregiver can have an appointment on the calendar without receiving any relief. An organization can have many partners without knowing whether people reach them.

Community becomes practical when we examine what happens between those points.

Being connected is not the same as being supported

Social-support research distinguishes the existence of relationships from the help those relationships provide. Sheldon Cohen and Thomas Wills' foundational review examined both the general benefits of social connection and the possibility that support protects people during stressful events. Their analysis emphasized the relevance of interpersonal resources to the needs a stressful situation creates.[41]

For our purposes, that distinction changes the questions we ask.

Instead of stopping at "Does this person have family?" ask who is willing and able to help, with what, and under which circumstances.

Instead of asking only whether someone attends a group, ask whether the experience offers the connection they want.

Instead of describing a program as respite, ask what time and responsibility it actually releases for the caregiver.

Pat may find companionship around a history discussion. Ellen may need dependable time when someone else has accepted responsibility for the agreed support. A friend who listens to Ellen may be important in another way.

These forms of support can complement one another. They are not substitutes.

And someone without a large family, a trusted circle, or nearby relatives should not have to build those relationships before receiving appropriate services.

Help knowledge travel through people

Alex Pentland's *Social Physics* draws attention to idea flow: how people discover information and work with it through their social connections. Its themes of exploration and engagement give us a useful way to examine whether knowledge reaches beyond a

familiar circle—and whether someone helps turn that knowledge into something usable.[5]

In the care application proposed here, Casey's introduction to Sam opened a route beyond the hospital. Sam's relationship with Lena helped the family ask questions about a community option. Lena could answer for the program rather than leave Pat and Ellen interpreting a brochure.

The information mattered. So did the people who could discuss it and act on it.

This does not mean every person needs a navigator. Someone may prefer to use a directory independently. Another may want a telephone introduction, a conversation with a peer, or help arranging a visit.

Choose the amount of assistance with the person, not for them.

A peer's experience can be useful when offered honestly and with permission. It should not become a testimonial presented as a typical result. Nor should a familiar messenger make unverified advice appear authoritative.

The research review informing this book is explicit about this limit: social learning can spread mistakes as well as useful ideas. It recommends connecting the discovery of a resource with a trusted person who can help examine whether it fits—not simply increasing message volume.

A welcoming place still has to be the right place

An encouraging first visit does not establish that a service can meet someone's needs.

Before attendance begins, the organization must confirm eligibility, required assessments, available staffing, the support it can provide, costs, access arrangements, and the limits of its role. Pat's interest in a discussion cannot answer those questions.

The same care applies when a service is not suitable. Explain the reason clearly and, with permission, help identify another route. Do not leave the family believing that a poor fit means the person is too difficult or that they asked for too much.

Research on community-service access reinforces why this matters. Molly Waymouth and colleagues' 2023 study analyzed 35 in-depth interviews with service providers, administrators, and advocates. It identified barriers at several levels, including infrastructure, cultural differences, awareness, and caregiver circumstances. This was qualitative research about access—not an estimate of how common each barrier is or proof that one navigation method solves them.[42]

> **In Context — From a visit to an agreed day**
>
> Clinical follow-up continued alongside the family's conversations about support.
>
> Over the following weeks, further assessment led Pat's clinicians to explain a diagnosis of early-stage dementia to him and Ellen. They needed time and further conversations to understand it. The diagnosis did not settle what Pat wanted his days to be like.

> **In Context — From a visit to an agreed day**
>
> Lena's team reviewed the relevant clinical information and completed its own intake and assessment of service fit. They established what support the center could provide and discussed the arrangements with Pat and Ellen.
>
> The family reviewed the costs and a limited initial schedule. Transportation for the first attended day was confirmed; Daniel's earlier offer of one medical-appointment ride was not silently converted into an ongoing responsibility.
>
> They also agreed when to review the experience.
>
> Pat had one condition.
>
> "If I don't like that history table, I'm allowed to do something else."
>
> "Yes," Lena said.
>
> "And I don't have to explain myself to a committee?"
>
> "You can tell us what would work better."
>
> "I can usually manage that."
>
> This was not simply a successful invitation. It was an invitation followed by assessment, practical arrangements, and a choice Pat could revisit.

Design a welcome people can recognize

The experience begins before the front door.

A first-visit message should answer the questions a person actually needs resolved: why they are coming, whom they will meet, what will happen, what they need to bring, and what they have—or have not—agreed to.

An illustrative message might read:

Your introductory visit

This visit is a chance to meet the team, see the setting, and decide what else you would like to know.

Lena will meet you at the entrance identified in your confirmation. She will explain what is happening that day and show you the places available for activities and quieter time.

You may ask questions, look around, or spend a little time observing an activity where appropriate. An introductory visit is not an agreement to enroll.

Please tell Lena before the visit about any language, access, or other assistance you would like us to arrange.

Afterward, you can discuss whether to explore participation, consider another option, or take more time.

A real message needs confirmed local details: the entrance, date, time, contact route,

available assistance, and the person covering if Lena is absent. Do not promise choices the program cannot provide.

A short video can show the route from arrival to welcome. With appropriate consent—or clearly identified demonstration footage—it can show someone asking to observe before joining. The article can carry fuller details about services and costs. A telephone conversation can address an individual concern.

The formats differ, but the meaning should remain consistent.

The CarePhysics design pattern applies: why this matters, the main idea, a visible example, a chosen next step, a route to questions, and what follows. It is a flexible design proposal, not a requirement to turn every welcome into a six-part lesson.

Belonging includes the freedom to participate differently

Knowing a person's interests creates a starting point. It does not give the organization a permanent activity assignment.

Ask what someone enjoys now. A past occupation, cultural background, or faith tradition may suggest a question, but it should not determine the answer.

A retired teacher may enjoy leading a discussion—or be relieved never to lead one again. Someone may want familiar music, new music, or no music during lunch. A participant may appreciate a community celebration without wanting their identity represented in every activity.

Ask about language, food, routines, beliefs, accessibility, and privacy in terms the person can choose to discuss. Then examine whether the service can respond.

A quiet option is not useful if no one can help someone reach it. An invitation to contribute is not meaningful if staff take over as soon as the person begins.

The Day Center export offers concrete design examples: ask about present as well as past interests, offer different ways to take part, and preserve the ability to observe, decline, or change one's mind. Those are documented approaches, not evidence that every implementation achieves them.

> **In Context — An invitation, not an assignment**
>
> During a later attended day, Lena asked Pat whether he would like to read a short passage that introduced the afternoon discussion.
>
> "How short?"
>
> "One paragraph."
>
> "I've heard that before."
>
> She showed it to him.
>
> Pat read it silently.

> **In Context — An invitation, not an assignment**
>
> “That is unusually honest.”
>
> He agreed to read it to the group. When he finished, another participant asked a question, and the conversation moved beyond the passage.
>
> Later, the room became busier. Pat asked to sit somewhere quieter.
>
> The team helped him move. They did not describe the change as a loss of interest in the program.
>
> At pickup, Lena told him what she intended to mention in the family update and invited his correction.
>
> “The reading was fine,” Pat said. “The room got a bit much afterward.”
>
> Both parts belonged in the account.
>
> Pat had contributed. He had also needed support. Neither canceled the other.
>
> **People do not have to earn belonging by being useful.** Purpose can be offered through genuine opportunities to contribute, while rest, enjoyment, and receiving care remain enough.

Ellen needs a life beyond the arrangements

Pat’s experience matters in its own right. So does Ellen’s.

On an attended day, do not calculate respite solely from the program’s opening and closing times. Ask what the arrangements require from the caregiver: preparation, travel, waiting, collecting information, remaining available, and managing changes.

The Daily Stress and Health study found that caregivers reported fewer care-related stressors on adult-day-service days, alongside more positive experiences—but also more stressors unrelated to care. That is a useful reminder that time away from caregiving is not automatically restful time.[43]

> **In Context — Time that is hers to use**
>
> On Pat’s first attended day, Ellen stayed nearby.
>
> She had the contact information and knew what the team had agreed to communicate. Even so, she found herself looking at her phone.
>
> At the review, Lena asked what had been useful and what remained difficult.
>
> “I knew where he was,” Ellen said. “I didn’t quite know what to do with myself.”
>
> Sam did not prescribe a list of self-care activities.
>
> “What would you like that time to make possible?”

> **In Context — Time that is hers to use**
>
> “Lunch with a friend. An appointment without asking someone to sit with Pat. Sometimes nothing.”
>
> “Nothing is an option,” Pat said.
>
> On a later day, Ellen met her friend. The transport and pickup arrangements were already settled. The Day Center had accepted responsibility for the agreed support, and Ellen knew how to contact the team.
>
> She did not become unworried. She had a meal, a conversation, and time that did not require her to organize the next task.
>
> That was something she could describe at the next check-in.
>
> Relief should not have to look productive to count. Nor should every period of respite be filled with caregiver education. Offer learning and support, but leave room for the person’s own choices.

Put the introduction and follow-through in one place

The practical tool for this chapter is a **Community Introduction and Follow-Through Plan**.

It can be brief. Its purpose is to make the next responsibility visible, not create a second care record.

Element	What the plan should establish
Purpose and permission	What does the person hope to receive or explore? What may be shared, with whom, and for what reason?
Named connection	Who is making the introduction? Who at the receiving service has accepted the next action?
Fit and access	What is confirmed about eligibility, support needs, cost, language, transport, and capacity? What remains unresolved?
Current stage	Was information requested, contact made, a visit arranged, assessment completed, or a service actually received?
Responsibility and fallback	Who acts next, by when, and who helps when the usual route fails?

Element	What the plan should establish
Review	How will the person, caregiver, and relevant team members describe usefulness, difficulties, and any change they want?

The stages matter. An introduction can be complete while service access remains unresolved. A first visit can happen without leading to enrollment. A booked day can be canceled.

In the proposed family pathway, Lena confirms the completed visit with Sam, within the information Pat and Ellen have agreed to share. Later, the team records actual attendance separately from the original referral.

Agree how relevant information will return to the referring service and who accepts that work. Verify the actual event dates before calculating time to care. Neither task should be assumed automatic; see the dated examples in Appendix J.

The plan should therefore say who keeps any additional record needed. Technology cannot supply an event nobody recorded.

Where AI can help the connections hold

Sam may know several relevant services, but preparing accurate information for each family still takes work. Lena's team may repeat the same introductory explanations while needing to adapt them to different questions.

An approved AI assistant could help with those tasks.

In the workflow proposed here, it retrieves current organizational information and relevant CarePhysics guidance, then prepares options based on the needs the person has actually expressed. It identifies what remains unconfirmed rather than inventing availability, eligibility, funding, or a transport arrangement.

A useful instruction might be:

Help prepare this community introduction using our approved sources and the information we have permission to share. Explain the options, identify unresolved access questions, and name the person who must confirm each one. Do not record a request as an accepted referral or an accepted referral as a delivered service.

Sam reviews the navigation material. Lena confirms program facts. Clinical questions return to the clinical team. Each organization retains responsibility for its own service and decisions; Genus supplies technology, not the people or capacity behind the promise.

The knowledge collection should preserve sources, owners, review dates, approved uses, and corrections. Research, design examples, local facts, and private personal information should remain distinguishable. Providing the book is not training a model or proving that it will follow the guidance correctly.

Families could use a properly configured assistant to revisit routine information or

prepare questions outside office hours. When a question needs a person, the route should be visible, with honest response expectations and separate urgent guidance.

AI could also help staff turn a useful explanation into a draft welcome resource, with the contributor credited and private details removed. It could organize voluntary feedback for a review meeting and help compare versions of an invitation.

That is a positive use of assistance: less repetitive preparation, more useful knowledge available, and more attention for the people arriving. Whether time is actually returned must be measured after checking and corrections.

The assistant should help people reach community, not make the assistant the community they are expected to settle for.

Let the community help shape the service

A program should not have to guess everything its participants need. It should create practical ways for them—and the people supporting them—to influence what happens.

Ask which part of a first visit was confusing. Invite suggestions about activities, timing, food, or communication. Provide a private route for concerns. Offer conversation or paper alongside digital feedback.

Explain who reviews the response and what can realistically change.

When the team acts, return the result: “You asked for a quieter place to talk at pickup. Here is the arrangement we are trying.” When it cannot act, explain the limit rather than letting the suggestion disappear.

Our approach treats this exchange of ideas as part of Community: participants, families, and staff contribute to improvement, and the organization shows what happened to their input.

Staff need the same opportunity. They may see a confusing entrance, an unreliable handoff, or an activity that works better in a smaller group. Ask what support they need to respond, not merely what else they can take on.

Budget for welcoming, navigation, training, interpretation, coordination, and review. Establish cover for absences and limits for volunteers. Companionship should not quietly become responsibility for clinical or personal-care tasks outside someone’s role.

This principle travels beyond Day Centers. A person receiving rehabilitation at home may want to remain connected with an existing club. A homebound adult may prefer a regular telephone conversation to a group meeting. A working caregiver may need a service whose hours match the working day.

Community and state groups can help organizations examine repeated gaps—such as inaccessible transport or unavailable service hours—without turning different populations into a league table.

A good relationship can reveal an unmet need. It cannot replace the service or resources required to meet it.

How would we know it helped?

Evaluate the connection, the experience, and the effort separately.

Before changing an introduction process, establish what currently happens. For a defined group of referrals over a stated period, record the date and stage of each request, the responsible person, unresolved barriers, and whether appropriate help was actually received.

Then ask about life on the receiving side.

For the participant: Was there something they wanted to do? Could they choose differently? Did they have someone to talk with? What would they change?

For the caregiver: Did the arrangement provide usable time? What did getting to and from the service require? What responsibility or uncertainty remained?

These are proposed improvement questions, not a validated questionnaire. Where an organization uses a validated instrument, preserve its required wording and scoring and confirm its suitability for the setting.

Belonging should not be inferred from attendance or a staff member's impression alone. Participation, meaning, belonging, and autonomy need separate attention; one activity count cannot describe them all.

Report denominators, time windows, and missing information. Include people who wanted a service but could not reach it, not only those who enrolled. Examine access by language, geography, care needs, and other relevant circumstances where appropriate data can be collected safely.

Count travel, fees, paperwork, staff time, family coordination, and AI review. Examine safety concerns and missed follow-through separately from routine satisfaction.

An informed decision not to attend can be a sound decision. An unmet need caused by cost or unavailable support should not be relabeled as personal preference.

Willingness to recommend, an actual referral, and a referred person receiving services also remain distinct. None alone establishes improved health or attributable impact.

Give a named leader responsibility for reviewing the findings with the team and authority to change, narrow, or stop an approach. Share difficult findings as well as encouraging ones.

Models and Evidence Behind This Chapter

The following foundations help explain the chapter's choices. The family scenes and practical tools are proposed applications, not tests of the models or results of the studies.

Social support and the buffering hypothesis

Ask what the relationship makes available

Foundation. Cohen and Wills' 1985 review distinguished integration into a social

network from interpersonal resources responsive to particular needs. It found evidence consistent with both a general benefit of support and a stress-buffering process, depending on what was measured.[41]

Where we used it. The chapter separates companionship, practical help, professional support, and caregiver relief. A person can have relationships while still lacking the assistance needed for a particular situation.

Evidence boundary. This is a foundational review and model, not evidence that adding contacts or a care-circle feature necessarily improves health.

Local question: What help can the person actually rely on—and is it the help they need?

Social Physics and social learning

Connect discovery with someone who can help

Foundation. Pentland's Social Physics perspective emphasizes idea flow, exploration, and engagement. We apply it to the route from discovering a service to discussing and using relevant knowledge. MIT's book description establishes these themes, not the effectiveness of the care pathway proposed here.[5]

Where we used it. Casey, Sam, and Lena connect distinct areas of knowledge while retaining their own responsibilities.

Evidence boundary. The research review informing this book grades the broader perspective **Emerging-to-moderate**. Its value is a network lens, not a rule that more interaction produces better outcomes.

Local question: Did the introduction help someone obtain a reliable answer or usable support?

Adult day services and daily caregiver stress

Examine the time that service days make possible

Supporting study. Steven Zarit and colleagues' Daily Stress and Health study, published in the 2014 volume of *The Gerontologist*, followed **173 family caregivers of people with dementia over eight consecutive days**. Caregivers reported fewer care-related stressors, more positive experiences, and lower anger on adult-day-service days, while reporting more noncare stressors.[43]

Where we used it. Ellen's own experience is an outcome to ask about, not something inferred from Pat's attendance.

Evidence boundary. This was a within-person observational study, not random assignment to service use. It supports examining day-level relief, not promising that attendance eliminates strain, delays residential care, or that a digital summary produces the same effect.

Local question: What usable time did the caregiver receive, and what did the arrangement cost them in effort?

ADS Plus

Add support for the caregiver, not only a place for the participant

Supporting trial. Laura Gitlin and colleagues' multisite trial involved **203 caregivers across 34 adult day service sites**. Sites were randomized to usual services or services plus staff-delivered education, support, referrals, problem-solving, and caregiver self-care strategies.

At 12 months, adjusted caregiver depression scores were lower in the added-support group. The sample was predominantly female and college educated, and **22.7 percent were lost to follow-up**. The reported attendance difference did not meet the conventional statistical-significance threshold.[44]

Where we used it. Sam and Lena make room for Ellen's questions and support needs separately from Pat's program.

Evidence boundary. The trial tested a structured, multicomponent human-support program. It does not establish that a brochure, occasional check-in, or AI assistant delivers the same benefit.

Local question: What caregiver support is actually offered, who is trained to provide it, and what changes for the caregivers receiving it?

Community-service access

Keep structural barriers visible

Supporting study. Waymouth and colleagues' 2023 qualitative study analyzed **35 interviews** with stakeholders in home- and community-based services. It identified interacting barriers involving infrastructure, information, culture, service systems, and individual or caregiver circumstances.[42]

Where we used it. The introduction plan includes affordability, transport, language, staffing, and eligibility—not only willingness to attend.

Evidence boundary. These were stakeholder interviews, not a representative prevalence survey or an intervention trial.

Local question: Which obstacle requires a clearer explanation, and which requires a change in resources or service design?

Person-centered outcomes in Day Centers

Measure more than being present

Supporting study. Clara Scher and colleagues' 2025 e-Delphi study engaged **22 practitioners and researchers** in reviewing measures of meaning and purpose, engagement, social networks, and belonging. The panel reached consensus on selected measures in three domains but did not agree on a single engagement measure. Real-world testing remained necessary.[45]

Where we used it. Pat's choices and experience are considered separately from

attendance, while staff observations remain distinct from his own account.

Evidence boundary. Expert consensus helps select candidates for measurement; it does not validate every instrument for every person or show that a center improves those outcomes. The commissioned review classifies this measurement work as Emerging.

Local question: Can the organization learn what matters without making measurement another burden?

One thing to try

Select five recent community referrals.

Find out what happened after each was sent. Was the person contacted? Was the service appropriate and reachable? Did help begin? Who knows whether it was useful?

Do not ask families to reconstruct missing organizational records unnecessarily. Begin with the responsible teams, then seek the person's perspective through an appropriate, permissioned conversation.

Choose one recurring gap and name who will address it.

Your team's question is:

Where are we counting a connection that the person has not yet experienced as support?

A place in the day—and something to bring home

> ### In Context — "We could read that together"
>
> After one of Pat's attended days, Ellen asked whether he wanted to go back.
>
> "For the reading," he said. "Not that loud activity afterward."
>
> "We can tell Lena."
>
> "I already did."
>
> At their next conversation, Lena confirmed that they would revisit the afternoon options. She also mentioned the short illustrated story Pat had enjoyed and asked whether he would like information about finding an appropriate copy for home.
>
> "The grandchildren might like it," Pat said.
>
> Ellen looked at him.
>
> "You could read it together."
>
> "They can do some of the reading," he replied. "I'm not doing all the work."
>
> They did not need another care assignment. They had found something they might enjoy sharing.

> **In Context — "We could read that together"**
>
> The community had offered more than a place for Pat to spend time. It had introduced people he could get to know, a contribution he could choose, support Ellen could use, and an idea that could return home with them.
>
> Now the design question became smaller and more specific.
>
> How could the family make that reading experience comfortable, accessible, and worthwhile—without turning it into a lesson, a test, or another task to finish?
>
> That is where the next part of CarePhysics begins.

Notes

5. Massachusetts Institute of Technology, Industrial Liaison Program. Social Physics: How Ideas Turn into Action. Book description of Alex Pentland's work on idea flow, exploration, and engagement. Source

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40. American Psychological Association (2017). So Lonely I Could Die. Public research report quoting Julianne Holt-Lunstad on social connection and health. Source

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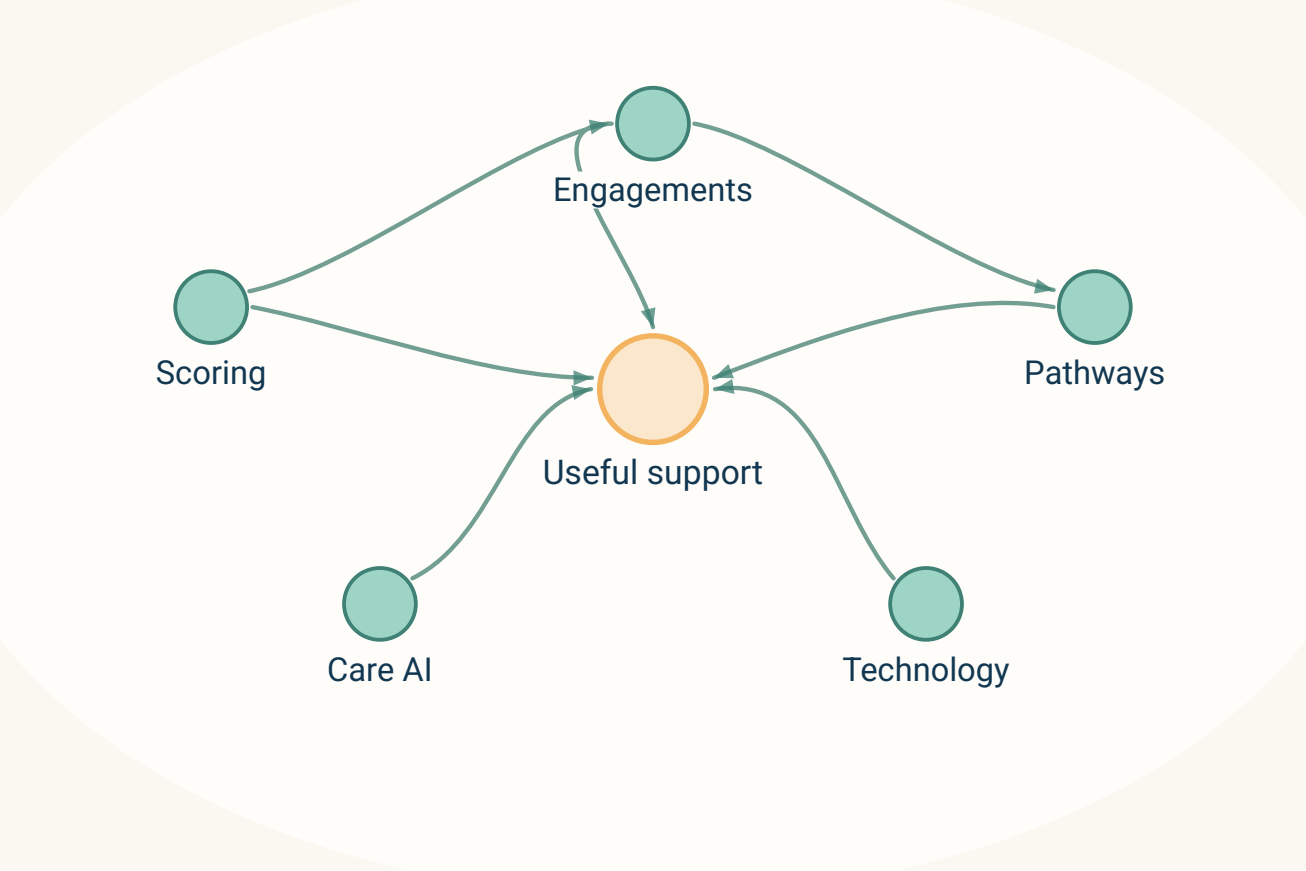
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PART II — Putting Care into Practice



Connection map — Turn the foundations into usable support

Engagements asks what makes each encounter worthwhile. Pathways connects encounters through time and responsibility. Technology examines whether people can reach and use the support. Care AI assists preparation with reviewed knowledge and responsible oversight. Scoring examines what helped, what was difficult and what should change. Useful engagements become parts of an adaptable pathway. Learning from the experience informs revisions to engagements. These are Principles 6–10; they do not require introducing more technology.

The first five principles asked us to understand the people involved: what matters to them, what they need to understand, what makes action possible, how they communicate, and where they can find support and belonging.

Now we turn to the experiences those people actually encounter.

An invitation arrives. A family watches a video. A staff member prepares a conversation. Someone opens a survey, asks a question, or tries an activity with a person they love.

Each encounter is a place where the organization's intentions become visible—or fail to.

We may say that choice matters while providing only one way to participate. We may

promise support while leaving a question unanswered. We may understand that a caregiver is exhausted, then send another lengthy guide without explaining which part could help today.

The next five principles turn the human foundations into practical design: encounters people can use, pathways that connect, accessible tools, responsible assistance, and a way to learn.

Engagements asks what makes an individual interaction worthwhile. **Pathways** connects those interactions through time, responsibility, and changing circumstances. **Technology** examines whether people can reach and use the support. **Care AI** considers how reviewed knowledge and appropriate assistance can help people prepare, explain, adapt, and decide. **Scoring** asks what helped, what created difficulty, and what should change.

These are not five reasons to introduce more technology. They are five ways to examine whether the support works.

The practical choices will differ. A hospital preparing someone for a procedure, a Day Center planning an activity, and a community organization welcoming a new family need different content, skills, and resources. They can still share a commitment to understandable information, meaningful choice, accessible design, and dependable human help.

AI can assist with the preparation: locating relevant guidance, organizing ideas, drafting alternatives, and helping a team refine its work. People remain responsible for what they offer and what happens afterward.

We begin with an ordinary evening.

A grandfather, his grandchildren, a story, and a screen.

The design question is not how to keep them watching.

It is how to help them enjoy being together.

CHAPTER 6

Engagements — Make Each Interaction Worthwhile

At a Glance

The central idea: Do not ask for someone's attention unless you have something worthwhile to give back.

What you'll explore: How the first five principles become a video, article, survey, message, conversation, or shared activity. Follow Pat, Emma, and Noah as they read together without turning the evening into a lesson or memory test. Learn to distinguish teaching a skill, supporting a decision, gathering feedback, and simply making room for enjoyment.

Design and AI: Begin with a human purpose, choose one main idea, demonstrate where useful, and make questions and next steps easy to find. Explore how an approved AI assistant could turn reviewed knowledge and local experience into drafts while preserving sources, privacy, and human judgment.

Put it to work: Develop a complete **Shared-Reading Engagement** and a reusable **Engagement Design Brief**.

Evidence and evaluation: Examine backward design, ADDIE, ARCS, Self-Determination Theory, accessible communication, and research on personally tailored activities. Evaluate understanding, usefulness, choice, access, and effort—not screen time or completion alone.

> *"If we can infuse creativity into care, caregivers can invite a partner into meaning-making."*
>
> — **Anne Basting, PhD**, creative gerontologist, *TEDMED 2020*.[46]

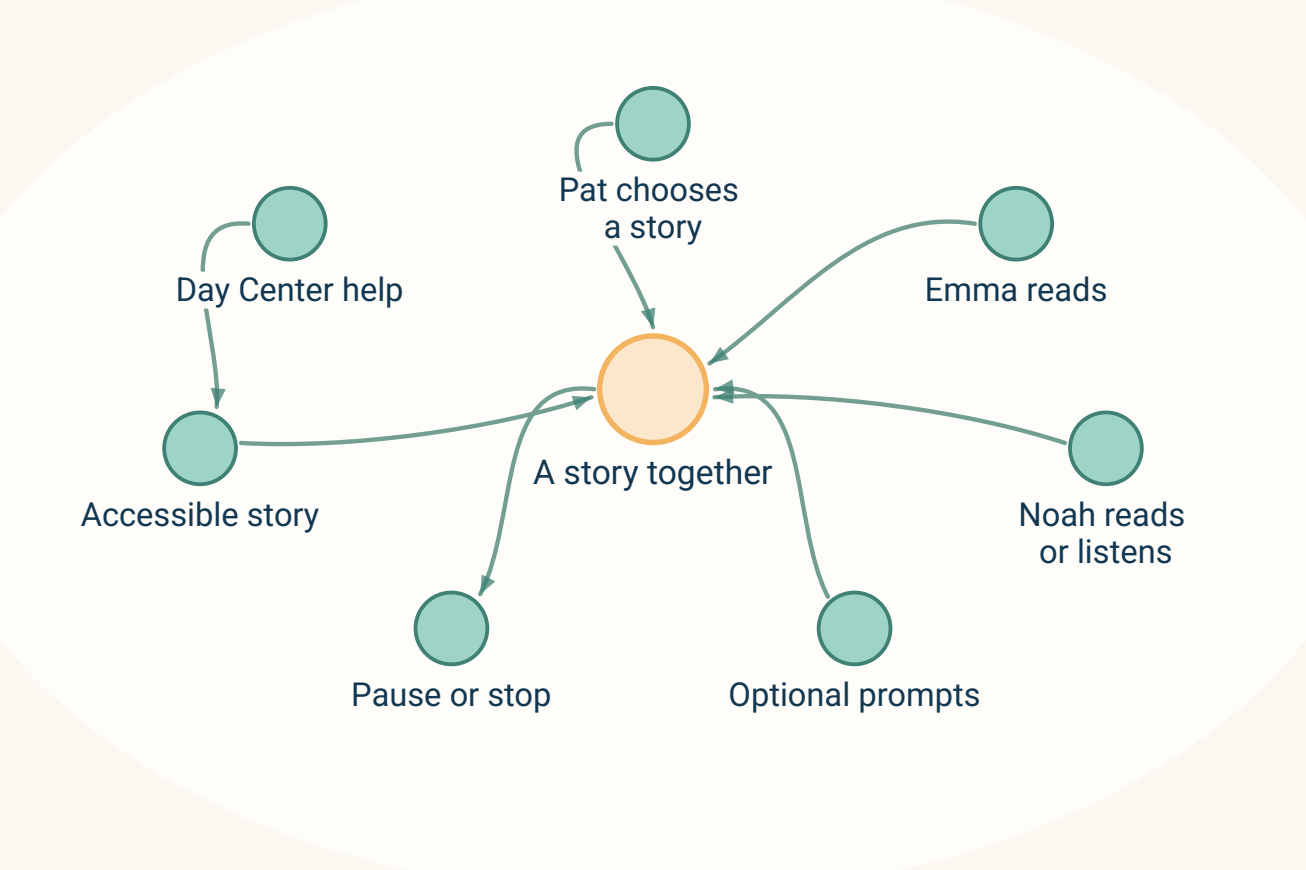


Figure 07 · A story together. Fictional family scene; enjoyment rather than testing.

In the fictional family scene, Pat chooses the story they will share. Emma reads with Pat as part of their shared family time. Noah can choose to read or listen rather than being assigned a task. Optional prompts are available if useful; they do not have to direct the evening. The shared story leaves room to pause, comment or stop. An accessible story and recognizable controls help the family use the activity. The adults can contact a person at the Day Center about adapting the resource. The purpose is enjoyment together, not testing Pat's memory or asking the grandchildren to assess him. This is a concept map of the fictional scene, not a claim of deployed product capability or clinical benefit.

In Context — A story, not an assignment

The continuing family scenes and shared-screen arrangement are fictional illustrations, not documented cases or claims of deployed product capabilities.

Daniel had helped prepare the television before the reading began. Only the story was on the shared screen. The family's care information remained elsewhere.

Emma sat beside Pat. Noah was still deciding whether he wanted to read or listen. Ellen had the short guide Lena's team had offered with the activity.

"Are we supposed to ask these questions after every page?" Ellen asked.

Pat looked at the sheet.

"I was hoping for a story, not an examination."

> **In Context — A story, not an assignment**
>
> “They’re ideas,” Daniel said. “It says we can leave them out.”
>
> “An excellent idea already.”
>
> There were two stories to choose from. Pat picked the one set in a railway station.
>
> Emma began reading. A picture showed a traveler sitting beside a large bag.
>
> “Wait,” Pat said as she reached for the next page. “Look how much room he’s taking.”
>
> Noah leaned forward.
>
> “That bag needs its own ticket.”
>
> Pat laughed.
>
> “Write to the railway.”
>
> They stayed with the picture for a moment before continuing.
>
> Nobody asked Pat to remember a station he had visited. Nobody asked Noah to assess how Grandpa was doing. They were talking about a picture in a story they had chosen.
>
> The guide remained beside Ellen.
>
> It was available if it helped.
>
> It did not need to direct the evening.

An engagement is an experience, not a piece of content

In CarePhysics, an engagement can be a conversation, a visit, a lesson, a message, or a shared activity. The format is only part of the experience.

Do not ask for someone’s attention unless you have something worthwhile to give back.

That value may be a clearer explanation, a practiced skill, a useful answer, an opportunity to contribute, or a few enjoyable minutes with another person.

It need not always be an action.

A well-designed medication lesson and a family reading activity have different responsibilities. The lesson may require a qualified professional to check understanding and practical technique. The reading activity may succeed because people enjoyed part of a story and decided to stop.

The mistake is to use the same definition of success for both.

Before choosing the medium, complete this sentence:

This encounter is intended to help these people _____.

“Spend more time in the app” is not enough.

“Prepare one question for the next appointment” gives the designer a useful direction.

“Enjoy a story together without pressure to remember or perform” gives a different direction.

In both cases, the design begins with what the person receives—not what the organization can distribute.

Carry the first five principles into the room

The reading evening brings the human foundations together.

Holistic Care contributes the knowledge that Pat enjoys books and wants to remain Grandpa, not become the subject of every conversation.

Awareness makes the invitation understandable. The family knows what the activity is and what it is not.

Behavioral Influence preserves a manageable, chosen beginning. Pat can choose the story. Noah can listen. Nobody has to complete the activity.

Communications shapes the exchange. People can pause, comment, ask for help, or say they have had enough.

Community supplies a useful resource and a person at the Day Center whom the adults can contact about adapting it.

Those principles do not appear as five separate features. They influence the same experience.

Here the earlier principles become visible in the design of content and encounters.

Love is visible in someone waiting before changing the page. Purpose is visible in Pat choosing to read with his grandchildren. Trust is visible when “you can stop” means exactly that.

The designer’s work is to make room for those actions—not prescribe the emotions people should have.

Start with purpose, then work backward

Instructional design offers useful tools for organizing this work.

Backward design, associated with Grant Wiggins and Jay McTighe, begins with the intended learning, considers what would demonstrate it, and only then selects instruction and activities. It helps avoid beginning with an appealing video or worksheet and trying to invent its purpose afterward.[47]

For a staff lesson, that might mean deciding that the learner should be able to explain a service limit respectfully, then designing a realistic practice conversation.

For recreation, we borrow the planning discipline without turning leisure into a curriculum. The purpose might be shared enjoyment; the review concerns whether the experience felt comfortable and worthwhile, not whether someone can pass a quiz.

ADDIE—Analyze, Design, Develop, Implement, and Evaluate—provides another organizing process. Robert Maribe Branch's instructional-design text presents these stages as a framework for planning educational work.[48]

In our proposed application, the team first learns about the audience and circumstances, designs a small experience, prepares the material, tries it with appropriate support, and revises it. Evaluation is not something saved until hundreds of copies have been distributed.

These tools should make the work more thoughtful, not more bureaucratic.

Sometimes the result of the analysis should be: do not create another video. The person needs a telephone call, a working transport arrangement, or time to rest.

Keep the controls familiar

Think again about the remote control in someone else's home.

The activity is familiar. The controls are not. You may know exactly what you want to watch while still needing someone to explain how to get there.

That is a design problem, not evidence that you have lost an ability.

Care content can create the same unnecessary work. "Help" becomes "Support" on the next screen. A familiar button moves. One video includes a question route; another sends people searching through a separate menu.

W3C's guidance on consistent navigation explains the value of keeping repeated navigation in a predictable order, including for people using magnification, screen readers, or other ways of navigating.[49]

For our engagement, the family should be able to find the next page, return to the previous one, pause, and leave. Those functions should not change because a different story is selected.

The same applies beyond controls. Use recognizable headings and stable meanings across articles, videos, invitations, and messages. The communication approach used here emphasizes that consistency does not require identical wording; each medium should perform its own useful job.

Keep the way through familiar. Adapt what people find there.

Give each encounter a recognizable shape

CarePhysics proposes six functions for content and communication: explain why it matters, make the main idea clear, demonstrate where useful, offer a chosen next step, provide a route to questions or connection, and explain what follows. These are design functions, not a compulsory script.

For shared reading, they might appear like this:

Design function	What it looks like in the experience
Why it matters	“Here is something you might enjoy reading together.”
Main idea	The purpose is time together, not finishing or remembering the story.
Demonstration	Show someone pausing over a picture, making a comment, and letting another person continue.
Chosen next step	Choose a story, look at one picture, listen, or leave it for another day.
Questions and connection	Adults know whom to ask about the material or setup. Sharing beyond the household remains permissioned.
What follows	Stop comfortably. Return another time only if useful. Feedback is optional.

For a skill lesson, the demonstration and practice would receive more attention. For a service decision, the options, conditions, and question route would be central. For a survey, people need to know what their answers will inform and who will act on them.

Urgency overrides the pattern. An urgent instruction starts with the necessary action.

And enjoyment can be the ending. We do not need to attach a task to every pleasant moment.

A complete example: A Story Together

The following is a proposed engagement, not a dementia treatment or a validated intervention. Its purpose is to make an ordinary family activity easier to begin and adapt.

The invitation

A Story Together

Choose a short story or picture you would enjoy sharing. You can read, take turns, listen, or talk about what catches your attention.

There is no need to finish. The time together is the point.

The preparation

An adult checks the display or printed copy before beginning. Ask whether the words and pictures are comfortable to see from the chosen seats. Make page changes simple. Keep a paper alternative available rather than making technology essential.

Choose material the organization may appropriately use and share. Keep it adult and respectful while considering the children's interests too. Do not replace accessible writing with childish language.

The shared screen contains the activity—not private messages, care notes, or clinical information.

The material

Here is a short, original fictional passage that could support a small demonstration. It is not presented as anyone's personal memory.

A Seat by the Window

At the railway station, a man in a blue coat placed his bag on the only empty chair.

"Is that seat taken?" a woman asked.

"Only by my bag."

"Has it bought a ticket?"

He moved the bag to the floor.

She sat down and unwrapped a sandwich. The man looked toward the tracks. Then he looked at the sandwich.

"Long journey?" she asked.

"Long wait."

She divided the sandwich and offered him half.

When the train finally arrived, they stayed seated long enough to finish.

"You nearly missed it," the conductor said.

"Not at all," the woman replied. "We were having lunch."

A simple illustration could show the two travelers, the bag, and the window. It should support the scene rather than compete with the text.

The reader's guidance

Begin with a choice: "Would you like to read, or shall I?"

Read at a comfortable pace. Pause when someone wants to comment. A question such as "Which seat would you choose?" offers a preference rather than requiring a correct answer. It is equally acceptable to make a comment or keep reading.

The prompts are optional. Do not work through them as a checklist.

If the experience becomes tiring, uncomfortable, or uninteresting, stop or try something else. The activity does not need a completed page count to justify the time.

The close

“Shall we leave it there?”

A comfortable ending gives people control over the experience. It also prevents a short activity from growing into something they did not agree to do.

The support

In an organization offering this resource, a named staff member maintains the material and answers adult questions about using it. The instructions include the real contact route and response expectations. Questions about changes in health follow the appropriate clinical route rather than being interpreted through reading performance.

The children remain grandchildren. They are not asked to supervise, record symptoms, or take responsibility for the activity’s success.

One purpose, several kinds of content

The engagement may be supported by more than the story itself. Each additional item should solve a different problem.

The video shows the experience. A short demonstration could show adults offering a choice, a child reading, and someone pausing to enjoy an illustration. Include an ordinary exception: the reader loses interest, asks another person to take over, or decides to stop. Use consented footage or clearly identified demonstration scenes.

The article supports preparation. It can explain the activity’s purpose, offer a few examples of invitations, and show alternatives to the screen. Put optional detail below the main guidance rather than requiring everyone to read it first. AHRQ recommends selecting and testing material for understandability and actionability rather than assuming that short words or a low reading-grade score make it usable.[26]

The message makes a relevant invitation. It should not imply that completing an activity is expected:

“Here is the reading idea you asked about. There is a short guide and a print option. Try it when it suits you, or keep it for another day.”

The conversation provides personal assistance. Someone can ask whether the material fits, request a different language or format, or say that reading is not what the household wants. A conversation should be allowed to change the offer.

The feedback question helps the organization learn. Instead of asking, “How much did your family enjoy this wonderful activity?” use a neutral introduction:

“We are reviewing this resource to make it easier to use. The activity lead will review responses. You can skip these questions or tell us by phone or in person.”

Then ask whether they tried it, what was useful or difficult, and whether they want a response. Include “not tried” without treating it as failure.

These are illustrative improvement questions, not a validated instrument. An organization using a validated questionnaire must preserve its required wording and scoring.

Most families will not need every item. The purpose of creating alternatives is to offer suitable routes, not send the entire collection to everyone.

Let the experience change the plan

> **In Context — The page can wait**
>
> Noah took the next turn reading.
>
> When he finished the passage, Emma asked Pat which seat he would choose on a train.
>
> “By the window.”
>
> “So you can see where you’re going?”
>
> “So nobody asks me to move every five minutes.”
>
> Ellen laughed.
>
> “I would sit across from you.”
>
> “That has worked reasonably well.”
>
> They talked for a while. The page stayed where it was.
>
> Later, Pat asked Emma to read another passage. After that, Noah went to find a game.
>
> “Are we stopping?” Daniel asked.
>
> “I think we are,” Pat said.
>
> They had not used every prompt or read everything available. They had done what they came to do.
>
> The design had left room for the people, not just the pages. It should also leave room for a different response: “This did not suit us.”
>
> That answer is useful information, not a reason to send a more insistent invitation.

Different ways to open a meaningful moment

Care communication can be accurate and still have imagination. A demonstration can make a task visible; a metaphor can make an unfamiliar idea easier to discuss; a

photograph, poem, or welcome moment of humor can open a conversation. Choose the form for this person and this encounter.

Purpose and possible form	An original way to begin—and what to protect
Make a task understandable: demonstration	“Let me show you, then we can try it together.” Demonstrate one relevant action and invite a question or supported practice. Keep required clinical steps intact.
Explain an unfamiliar idea: metaphor	“Think of finding your way with an unfamiliar remote.” Choose a recognizable comparison, then explain its limits. The remote concerns controls, not symptoms.
Open a conversation: question	“Which part would you like us to explain first?” Listen to the answer and adapt the explanation. Offer privacy, time, and a preferred language or format.
Enjoy something together: photograph or story	“What catches your attention here?” Let a photograph or story invite preference, imagination, or quiet enjoyment rather than a test of recall.
Share warmth: welcomed humor	Enjoy humor the person welcomes, as Pat and Ellen do in the train conversation. Laugh with, not at, someone; leave worry and disagreement room to be heard.
Invite reflection or rest: poetry, music, quiet	“Would you enjoy a poem, some music, or a quiet moment?” Match the material, sound, and pace to the person; use appropriately licensed material and make stopping easy.

Creativity makes room for expression, understanding, and enjoyment. It is an invitation, not an obligation or a treatment promise. Keep necessary instructions clear, ask how the experience felt, and be ready to choose differently.

Personalization begins with asking

Pat’s interest in reading does not establish what another participant will enjoy. It does not even establish what Pat will enjoy every evening.

Ask about current interests, language, beliefs, routines, preferred company, and practical access. AHRQ’s cultural guidance recommends learning from individuals rather than assuming preferences from group membership.[13]

One household may welcome a story connected with a religious tradition. Another may prefer secular material. Someone may want familiar places and themes; someone else may enjoy discovering something new.

Do not assume nostalgia is always comfortable or that every family wants an activity involving children. A person without nearby relatives may prefer a friend, volunteer, peer, or an activity alone.

Adapt the amount of text, pacing, format, and assistance. Preserve the person's adult identity. Offer quiet participation without treating it as an inferior version of engagement.

Music may help establish a setting when people want it, but silence is also a design choice. Avoid adding background sound simply to make a video feel more polished. Check whether it competes with speech, and use only material the organization is authorized to use.

AHRQ's communication guidance supports limiting key points, demonstrating actions, inviting questions, and checking understanding. These practices are relevant to educational encounters; they do not require turning recreation into a comprehension exercise.[6]

Use reviewed knowledge before asking AI to draft

Lena's team does not need an assistant to invent what Pat likes. They have information he has chosen to share and an experience he has described.

They may need help turning that knowledge into a useful resource.

The proposed starting collection contains several distinct things: the CarePhysics design pattern, relevant professional guidance, the selected story and its reuse permissions, the center's actual support arrangements, and any personal preferences authorized for this task.

Those sources do different jobs. The story supplies content. Research helps the team understand possibilities and limits. Local guidance establishes who answers questions. Personal context may shape the invitation. None should silently become another.

Keep sources, owners, review dates, permitted uses, and corrections with reusable material; keep private personal information separately controlled. The detailed knowledge-stewardship approach appears in Chapter 13.

An AI assignment could be:

Using these approved sources, prepare a short shared-reading guide and a demonstration outline. The purpose is enjoyable time together, not memory testing or content completion. Preserve choice, provide a print alternative, identify the adult support route, and show which sources informed the draft. Mark missing information rather than inventing it.

The assistant could prepare alternatives for staff review. It might help shorten instructions, identify inconsistent labels, or propose an accessible layout.

But the reviewer must look beyond fluent wording.

“Ask Pat to remember the station he used as a boy” introduces an unsupported personal history and makes recall part of the task.

“Which seat would you choose?” does neither.

The team also checks that a story is not presented as a family memory, that historical details are verified where relevant, and that an adaptation does not exceed the permissions attached to the material.

AI can make this preparation less repetitive. It can help preserve a staff member’s useful explanation, draft variations, and organize feedback for revision. Those are valuable possibilities when they leave people more time and attention for the encounter.

The review work still counts. A quickly generated draft that requires extensive correction may not save time.

Uploading a book does not train a model or prove it will follow the material. A source collection, a configured assistant, and a tested service are different things.

Keep the assistance available without putting it in charge

An approved assistant could help an adult revisit the guide at any hour, prepare a question, or find an available alternative. It should work within its defined sources and scope.

It should not infer cognitive decline from how long Pat reads, decide that the family needs more reminders, or turn a missed activity into a concern requiring intervention.

The person can also ask for human help without first completing a conversation with the assistant. State when staff are available and which route is appropriate for a concern that cannot wait.

The shared-reading experience here is a proposed design. Verify the actual sharing, access, media, and question routes before using it. Related dated product examples—and features described as planned—are kept in Appendix J.

For the proposed reading engagement, the simplest successful arrangement may require no live AI at all. The assistant helps prepare the material, an adult helps with setup, and the family spends the evening with one another.

A reusable Engagement Design Brief

Before commissioning content, complete a brief that another team member could understand and use.

Design question	Shared-reading example
Whose situation are we addressing?	Pat and family members who want an enjoyable activity together; preferences and access are confirmed with them.
What is the purpose?	Offer shared reading, listening, and conversation without pressure to perform.
What informs the design?	Approved guidance, the person's stated preferences, permitted story material, and reviewed local experience. Keep research, fiction, and personal information distinct.
What will happen?	An invitation, a choice of material, simple setup, optional prompts, and an easy stopping point.
Who supports and reviews it?	A named activity lead reviews the resource; an adult handles family setup; the organization provides its actual question route.
What may be adapted?	Story choice, language, text size, format, pace, company, and assistance. The person's privacy and right to decline remain unchanged.
How will we learn?	Optional feedback on usefulness, comfort, access, and preparation effort; a named owner makes and tests revisions.

This brief is a proposed design tool, not an assessment of the family.

The same questions can guide a rehabilitation demonstration, a home-care orientation, a staff learning session, or a community survey. The answers—and the evidence needed—will differ.

Give staff the means to deliver the design

Content production is only part of the cost.

Someone must select and review material, check permissions, prepare accessible versions, help with first use, answer questions, and maintain the resource. Budget for that work rather than expecting staff to fit it around everything else.

Distinguish preparing training, making it available, practicing, and demonstrating the required skill. These are separate responsibilities. Offering family education does not establish that learning occurred.

Practice should support the team. Ask staff to try the material, identify confusing steps, and suggest alternatives. Do not use their suggestions as evidence that they were previously performing poorly.

Health systems and community partners can share reviewed resources without imposing one voice or format everywhere. Retain the source and essential meaning; adapt examples, language, delivery, and support to local needs.

A shared library is valuable only when someone maintains it. Outdated contacts, unavailable services, or inaccessible formats can undermine an otherwise thoughtful resource.

The detailed production specifications belong in a Design Guide. The main book's responsibility is to make the decisions understandable and demonstrate how they affect the experience.

How would we know it helped?

Begin with the purpose, not the available analytics.

For a skill lesson, examine whether the person can perform the relevant task with appropriate support. For a decision aid, examine understanding and whether the choice reflects the person's priorities. For a survey, examine whose views were heard and what changed because of the answers.

For shared reading, ask whether the experience was wanted, accessible, comfortable, and worth offering again.

Do not make the family document every evening. A voluntary check-in with a small, clearly described group may be enough for an initial design review.

An organization might compare the existing resource with a revised version over a defined four-week improvement period. Record how many households were offered each version, how many provided feedback, and which access routes they used. Include people who did not try it and those who needed help.

Ask about preparation time, difficult controls, unsuitable material, pressure to continue, and unanswered questions. Count staff drafting and review time, including AI corrections.

Keep participant reports, family reports, and staff observations distinct. A smile is an observation, not a complete account of someone's experience.

The behavioral review behind CarePhysics separates reach, understanding, first action, adoption, useful participation, outcomes, burden, and safety. A content opening or completed activity cannot stand in for all of them.

A recommendation to another family is another question again. Willingness to recommend is not an actual referral; a referral is not proof that the next family received useful support.

Give a named person authority to revise or withdraw the resource. Share unsuccessful findings as well as encouraging ones.

We are evaluating the design—not measuring how well the family loves one another.

Models and Evidence Behind This Chapter

The chapter combines planning frameworks, professional guidance, and research findings. Their roles should remain visible. None establishes that the proposed shared-reading engagement or a particular technology produces a clinical benefit.

Backward design and ADDIE

Choose the purpose before choosing the product

Foundation and use. Wiggins and McTighe's backward-design approach places intended learning and evidence before instructional activities. Branch's ADDIE text organizes instructional development through analysis, design, development, implementation, and evaluation. Both approaches are named in the original CarePhysics Engagements section.[47]

Here, they inform the decision to identify the purpose, prepare a small experience, try it, and revise it.

Evidence boundary. These are planning frameworks, not treatment packages. Applying their logic to recreation is a CarePhysics design adaptation; it does not make family enjoyment an educational test.

Local question: Did the intended human purpose determine the content and evaluation, or did the available technology determine them?

ARCS

Make participation relevant and manageable

Foundation and use. John Keller's ARCS model organizes motivational design around **attention, relevance, confidence, and satisfaction**. In this chapter's proposed application, an interesting scene invites attention, the activity connects with chosen interests, assistance makes participation manageable, and the experience has value beyond completion. They help us ask what the intended audience will receive from the experience.

Foundational research. Keller's 1987 paper describes developing the model and field-testing it in two in-service teacher-education programs. The paper reported useful design assistance while calling for more controlled studies.[50]

Evidence boundary. Those field tests were not studies of dementia care or shared family reading. ARCS helps formulate design questions; it does not guarantee motivation or benefit.

Local question: Was the encounter worth beginning, manageable to use, and worthwhile from the participant's perspective?

Self-Determination Theory

Preserve choice inside the experience

Foundation and use. Autonomy, competence, and relatedness inform the invitation, the available assistance, and the freedom to participate differently. Choosing to listen or stop should not make someone a less valued participant.[3]

Supporting review. Ntoumanis and colleagues' meta-analysis included **73 health-domain intervention studies**. It found generally small-to-medium changes in motivational measures and health behaviors, with modest, variable health effects. The interventions and settings differed substantially.[17]

Evidence boundary. The research review informing this book grades this intervention evidence **Moderate**. It supports examining the quality of participation, not claiming that optional prompts or a choice of stories produce the same effects.

Local question: Did support make participation easier while leaving the decision with the person?

Personally tailored activities

Relevant interests are a starting point, not an outcome promise

Supporting review. A 2020 Cochrane review by Ralph Möhler and colleagues included **five randomized studies**, with **262 people with dementia completing the studies**. Participants lived at home, generally had mild-to-moderate dementia, and were followed for two weeks to four months.

The review found low-certainty evidence that personally tailored activities might reduce some behavioral difficulties and slightly improve quality of life. It found no clear benefit for several other outcomes, including caregiver burden; evidence for engagement itself suggested little or no effect. Adverse effects were not assessed.[51]

Where we used it. The chapter takes personal interests seriously while asking about effort, fit, and experience.

Evidence boundary. The studies did not test this story, shared television reading, or Genus. They do not justify a claim that personalized activities slow dementia or reliably reduce family strain.

Local question: Did this particular activity suit these people, in these circumstances?

Clear and accessible communication

Test what people can use

Practice foundation. AHRQ recommends understandable, actionable materials and feedback from intended users. Its communication guidance includes demonstrations and checks of understanding. W3C explains how predictable navigation supports people finding repeated functions.[26]

Where we used it. The reading resource separates instructions from the story, keeps

controls recognizable, provides alternatives, and identifies help.

Evidence boundary. Guidance supplies design expectations, not proof that a finished resource is accessible to every person. It must still be tried in the setting where it will be used.

Local question: Can people reach and use the intended value without unnecessary assistance or effort?

Creativity and shared meaning

Let a question open possibilities

Basting's professional work offers a relevant perspective on imagination and questions that do not depend on producing one correct remembered answer. Her published interview with the University of Wisconsin–Madison's *Dementia Matters* discusses creativity as a route into expression and connection.[52]

The chapter's optional picture conversations draw on that perspective. They are not presented as a formal TimeSlips intervention or a tested clinical technique.

Local question: Did the prompt invite the person's contribution—or make them feel that something was being demanded?

One thing to try

Choose one recurring interaction your organization already offers.

Write down what the person is supposed to receive from it. Then walk through the experience using the same device, materials, language, and support available to the intended audience.

Find one point where the design asks for effort without providing clear value. Remove it, explain it, or provide help.

Try the revision with the people it is meant to serve.

Your team's question is:

What does this interaction give back for the attention, effort, and trust it asks of someone?

One good evening is not a whole pathway

> In Context — Something worth returning to
>
> At a later check-in, Lena asked Pat and Ellen about the reading idea.
>
> "The story was good," Pat said. "We spent quite a while discussing the bag."
>
> Ellen explained that the questions had initially looked like instructions.

In Context — Something worth returning to

“We thought we were supposed to use them all.”

“That should be clearer,” Lena said.

She noted a change for the next version: place the optional guidance separately and make its purpose explicit.

“Would you like another story?” she asked Pat.

“Yes. But not homework.”

“No homework.”

“And something Noah can read too.”

The family had found something worth trying again. Their feedback had also identified a design problem.

That is how an individual engagement can improve.

The next challenge is how useful encounters fit together: who offers the next resource, when to ask about changing needs, how agreed support continues, and what happens when a plan no longer works.

A worthwhile interaction is a beginning.

A dependable pathway connects it to what follows.

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CHAPTER 7

Pathways — Turn Good Intentions into Supported Progress

At a Glance

The central idea: A pathway connects useful information, human relationships, and practical support into a planned sequence that can change as people's needs change.

What you'll explore: What a pathway can contain: a tile with a video, article, survey, or interactive element; a contact added to a phone book; a telephone call; a virtual meeting; a planned visit; or a shared activity. Learn how these elements work together rather than becoming another collection of things for a family to manage.

Design and AI: Plan what comes next, why it matters, who responds, and what happens when circumstances change. Explore how reviewed knowledge and AI assistance can help teams prepare and adapt pathways to different people, communities, and available resources.

Put it to work: Build a **Supported Pathway Map** that identifies the sequence, responsible people, decisions, confirmations, alternatives, and measures.

Evidence and evaluation: Examine coordinated-care research, adaptive-intervention design, and improvement methods. Learn to distinguish adjusting one person's plan from improving a reusable pathway—and to measure useful support rather than content completion alone.

> *"We know that good health care must align with the goals of the individual."*
>
> — **Mary D. Naylor, PhD, RN**, transitional-care researcher, quoted by Penn Nursing, August 2, 2021.[53]

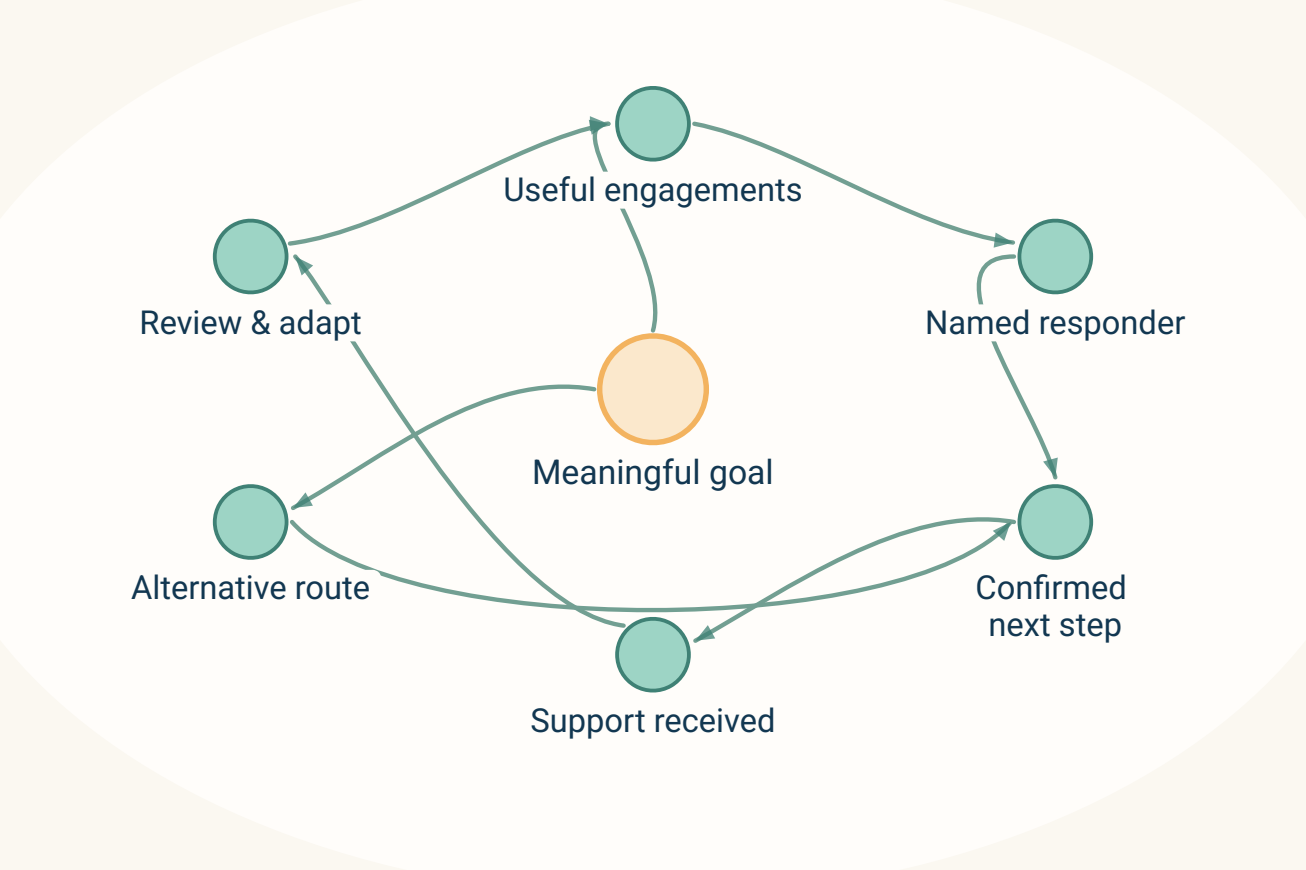


Figure 08 · The next step has an owner. Concept pathway; a request is not a service received.

Plan useful engagements around a meaningful goal. Each engagement that asks for a response identifies who will respond. The named responder accepts responsibility and confirms the next step. Check whether the confirmed step led to support actually being received. Plan an alternative route when the usual route cannot support the goal. The alternative route changes the next arrangement. Review what the received support made possible and what burden remained. Adapt the engagements and sequence from what is learned. This is a proposed working sequence; a request or referral does not establish that service was received.

1 · Request	2 · Acceptance	3 · Arrangement	4 · Service received	5 · Review
A need is raised.	A receiving person accepts the next action.	Details are confirmed.	The agreed support actually occurs.	People discuss what helped and what remains open.

If a step is unconfirmed, changes, or cannot proceed → contact the named responder → discuss alternatives → confirm any new arrangement.

In Context — “Is Tuesday arranged?”

Ellen brought three things to the next meeting with Sam: the Day Center calendar, a note about a clinical follow-up, and the reading guide the family had tried.

“The story worked,” she said. “The rest of the week still takes some figuring out.”

Pat pointed at the calendar.

“I thought that was what the calendar was for.”

“It tells me what we’ve written down,” Ellen replied. “Not always what has actually been arranged.”

She had asked whether Pat could attend the Day Center on an additional Tuesday so she could keep an appointment of her own. It was not one of his agreed regular days.

Maya, joining by phone, had seen Tuesday mentioned in the family’s messages.

“I thought that was confirmed.”

“I asked,” Ellen said.

“Did the center answer?”

“They said they would check.”

Sam looked at the note.

“Then we have a request, not a confirmed day.”

Pat leaned toward the calendar.

“And I’d still like to know what’s happening there on Tuesday.”

“That belongs in the conversation too,” Sam said.

The family had made progress. Pat had received clinical assessment. They had met Lena and found activities he enjoyed. Ellen had begun using dependable time for herself. Daniel and Maya had accepted particular responsibilities.

But this new request exposed a gap.

Who was checking? When would the family hear? What would happen if the center could not offer the day?

The information, conversations, and arrangements needed to work together.

They needed more than a calendar.

What a pathway actually is

A pathway is a planned, adaptable sequence of engagements, resources, and human

support, organized around a meaningful goal.

It describes what is offered, when it becomes relevant, who participates, who responds, and how the next step is chosen.

An engagement is one encounter. A pathway connects encounters over time.

A short video may help someone understand a service. A question attached to that video may reveal what they want to discuss. A telephone call can address the concern. A planned visit can help them assess whether the service fits. A later conversation can establish what worked and what should change.

The value lies in how those elements connect.

The original CarePhysics manuscript describes pathways in this broader way: combining content with phone calls, social connections, reminders, virtual visits, and responses to feedback. It also proposes manageable segments that teams can review and improve individually.

A pathway can be short. It might help someone move from one unanswered question to a completed conversation.

It can also extend over weeks or months, supporting a transition, participation in a program, family coordination, or continuing learning.

It is not simply a playlist, a calendar, or a sequence of automated messages. Nor does it replace a clinician-approved care plan. It organizes the information, interactions, and support through which the relevant plan can become understandable and workable.

A referral is not help until someone actually receives the help.

The same distinction applies throughout a pathway. Information offered is not necessarily understood. A contact saved is not a conversation completed. A meeting held is not an agreement carried out.

We plan the sequence so that each useful beginning has somewhere to go.

Map the work—and the experience of it

A pathway describes the support we intend to offer. Before designing it, learn how the present journey actually unfolds. A sequence that looks simple on an organizational chart may require several calls, repeated explanations, or uncertain waiting at home.

Use three related views. **A process map** shows events, responsibilities, and transitions. **A human-experience map** records what the people involved say they understand, want, encounter, and find difficult. **The designed pathway** sets out the information, encounters, assistance, and follow-through arranged in response.

Keep the person’s account, a caregiver’s account, and staff observations distinguishable. Record the source and timing of each contribution. “She sounded worried” is an interpretation to check, not permission to record fear as a fact. An unanswered message does not establish low motivation.

Choose a manageable segment, such as asking about a first visit through receiving a substantive reply. Walk through it with intended users and the people doing the work. Notice what already helps as well as where they wait or repeat something. Ask about language, private concerns, preferred contact routes, cost, and practical assistance; do not require disclosure of every personal detail.

For each stage, ask: **What happened? Whose experience do we know? What remains uncertain? What support or response is missing? Who can change it?** Mark ideas as proposals until the appropriate person accepts the work. A private caregiver disclosure may explain a personal support need without belonging in the shared operational map.

Experience-based co-design provides a related, established way of bringing service users' and staff members' accounts into improvement. Our short mapping aid is a CarePhysics adaptation, not the complete co-design method or a claim that drawing a map improves outcomes.[54]

The map helps us choose the next question. TOC can focus attention on a suspected limiting condition in the process. People's accounts help us understand what that limitation means in daily life. Then a reviewed change—and its effects—can be examined through the improvement cycle. Use the stage card and experience map in Appendix D.

The building blocks of a pathway

A pathway does not need every possible type of engagement. It needs the combination appropriate to its purpose.

A tile: one place for a useful topic

A **tile** is a clearly named digital item that brings related material together. Depending on the design and available capabilities, it may contain a video, article, audio recording, document, survey, questions, or interactive elements. The original CarePhysics description includes media, articles, questions, links, and opportunities to use material together.

A tile called *Preparing for Your First Visit* might contain a short welcome video, an article about what to expect, an optional question about access needs, and a way to request a conversation.

It should not contain everything simply because it can.

The tile's job is to help someone with one recognizable need. The pathway determines when to offer it, what support accompanies it, and what happens after a response.

A contact: make the right person easier to reach

Adding a verified contact to a care phone book—or providing it on a printed contact sheet—can be a pathway step.

The entry should explain more than a name and number. What can this person help with? When are they available? Which route should be used when they are not?

Saving the contact should be offered with permission and supported where needed. It should not imply that a service has accepted the person or that the contact is continuously available.

The original pathway examples place phone-book resources alongside educational tiles and coaching calls, rather than treating resource information as a separate directory nobody helps people use.

A telephone call: provide an actual conversation

A call can clarify a concern, make an introduction, check an arrangement, or discuss something sensitive.

Plan who initiates it, its purpose, and what happens if the person cannot be reached. “Someone will call” leaves too much unresolved.

The call may also change the next step. After listening, the professional may offer different information, practical assistance, or another service instead of continuing with the original sequence.

A virtual meeting: bring chosen people together

A virtual meeting can connect people who cannot easily be in the same room. Its design still needs an agreed purpose, appropriate participants, accessible joining arrangements, privacy, and a person responsible for facilitating.

A link sent is not a meeting held.

Provide another route when the technology does not work or is not preferred. Recording and AI-assisted notes require their own appropriate explanation and permission; they should not be assumed merely because a meeting is online.

A planned encounter: make the service experience part of the pathway

A home visit, Day Center introduction, clinical appointment, skills demonstration, or family meeting can be a pathway element.

These encounters are not separate from engagement design. The invitation, preparation, welcome, conversation, and follow-up all belong.

The pathway must also include what makes the encounter possible: confirmed availability, eligibility where required, transportation, assistance, and the people providing the service.

A shared activity or check-in: support life between formal encounters

A pathway may include an optional story, conversation, activity, or invitation to contribute. It can also include a review of what has been helpful.

Not every element needs to advance a clinical task. Pat’s reading with Emma and Noah

belongs because family life is part of what the support is intended to preserve.

These elements should leave room for enjoyment, quiet, pausing, and declining. Children remain family members, not monitors responsible for reporting progress.

Together, these building blocks allow a pathway to connect learning, relationships, services, and ordinary life.

Plan the sequence around the person's next question

A useful sequence does not begin with "What can we send?"

It begins with "What would help now?"

Before a community introduction, someone may need to understand why the conversation could be useful. Before a visit, they may need practical details. Afterward, they may want to discuss whether the experience felt right.

Sending the same material at each stage misses that difference.

The proposed CarePhysics content pattern remains useful: explain why something matters, make the main idea clear, demonstrate where helpful, offer a chosen next step, identify a question route, and explain what follows. It is a flexible pattern, not a requirement to make every message equally long.

For a first-visit pathway, the sequence might begin with a human invitation. A tile then helps the person prepare. A call answers individual questions. A visit makes the service visible. Feedback shapes the next conversation.

The order can change. A person may need the call before the article. Someone else may want to read first. Neither should have to complete optional content before being allowed to speak with a person.

Some steps depend on time. Others depend on a decision, an event, or a stated need.

An appointment reminder follows a confirmed appointment. A post-visit question follows an actual visit. A request for support should prompt the appropriate response—not wait until the next scheduled educational message.

Planning is what allows that flexibility to remain dependable.

One pathway, several kinds of engagement

The following example shows how a team could plan a Day Center introduction and early-support pathway. It draws on the family's experience without implying that every digital step already occurred.

> **In Context — Looking back at what helped**
>
> Sam asked Pat and Ellen which parts of the introduction had made a difference.
>
> "Talking to Lena before we went," Ellen said.

> **In Context — Looking back at what helped**
>
> “Seeing the place,” Pat added. “The description did not tell me who I might talk to.”
>
> “And the reading guide?” Sam asked.
>
> “That was useful later,” Ellen said. “Not something I needed in the first conversation.”
>
> Their answers suggested a sequence—not simply a larger information package.

When or why	Planned pathway element	Responsibility and what comes next
The person wants to explore support	A conversation about interests, concerns, and practical needs	Sam establishes what Pat and Ellen want to explore and what may be shared. Clinical questions remain with clinicians.
They want a clearer picture of the service	A first-visit tile: welcome video, companion article, and optional questions	Lena’s team maintains the program facts. Questions requiring a person reach an identified responder. Print and conversation alternatives remain available.
They need a dependable contact	Offer to add Lena’s verified details to the care phone book or provide a contact card	Explain Lena’s role, availability, and backup route. Confirm that the family can find the information.
Individual concerns need discussion	An agreed telephone call	Lena answers program questions and identifies what must be assessed or confirmed. A call is not enrollment.
Chosen family members need to plan together	An in-person or virtual meeting with a short preparation guide	Sam facilitates within his role. Pat is included, private matters stay private, and responsibilities are accepted rather than assigned by assumption.

When or why	Planned pathway element	Responsibility and what comes next
An introduction is wanted and appropriate	A confirmed visit, with arrival information and access arrangements	The center confirms who will welcome them. Subsequent assessment and eligibility requirements are addressed before attendance begins.
Participation begins	The agreed service day, followed by reviewed communication	Record actual attendance separately from booking. Invite corrections and identify any follow-up.
The family wants something useful between visits	An optional activity tile, conversation aid, or other relevant resource	Offer material connected with their interests. Participation is not a test or an obligation.
It is time to review the experience	A brief feedback question, call, or review meeting	The responsible person discusses usefulness, burden, and changes. The next version of the person's plan reflects that discussion.

A working map also needs actual dates or response windows, names and coverage arrangements, information permissions, and confirmation requirements.

It does not need to be displayed to the family as a complicated diagram. The organization may need the full map; Pat may need only the next relevant part.

Let a response change what follows

An interactive element is useful when the organization has decided what a response can influence.

Suppose a first-visit tile asks:

What would you like to discuss before visiting?
You may ask about activities, the support available, costs, getting here, or something else. You can also request a conversation instead.

The purpose is not to collect another answer. It is to prepare the appropriate response.

A question about activities may lead to an honest demonstration or a conversation with the activity lead. A question about affordability needs current cost information and someone able to explore available options. A transport problem needs practical help.

Those are different branches of the pathway.

COM-B provides a useful reason to make that distinction: an obstacle may concern

understanding, skills, opportunity, motivation, or a combination. The research review informing this book specifically warns against sending the same prompt when the underlying barriers differ.

Do not infer that a person needs persuasion because they have not chosen a next step.

A question may lead to less content, a different medium, a human conversation, an alternative service, or a pause.

The respondent should know who reviews the answer and what response to expect. For urgent concerns, provide the appropriate immediate route rather than relying on an ordinary feedback form.

Keep a shared foundation, then adapt locally

Organizations do not need to start from a blank page for every person. They can maintain a reviewed pathway that serves as a starting point and adapt it deliberately.

There are three useful levels.

The shared foundation holds the purpose, essential information, design pattern, permission boundaries, and expectations for responsibility and review.

The local version identifies the services, contacts, capacity, costs, languages, access arrangements, and practices of the organization and community.

The person's version reflects what the individual wants, which people they choose to involve, the assistance they need, and what has already happened.

This distinction keeps reuse from becoming uniformity. Share knowledge while preserving local judgment, voice, resources, and individual preferences.

Consider two hypothetical communities using the same introductory pathway.

One has a Day Center with its own transport arrangements. Its local version explains how transport is requested and confirmed.

The other depends on an external provider. Its pathway needs a separate contact and confirmation before attendance is treated as workable.

Changing the name and logo on the first community's material would not make it accurate for the second.

The same is true of hours, fees, referral requirements, interpreter availability, and family-support services. Where a resource does not exist, mark the gap and determine who can explore alternatives. Do not leave an attractive but unusable option in the pathway.

Adapt communication with the people served. Ask about language, culture, beliefs, privacy, preferred decision-making, and the relationships they want involved. Do not assume that everyone in a neighborhood or cultural group wants the same approach.

For some people, a trusted community organization may be the best introduction. Others may prefer direct contact. A person may want a faith-based resource or explicitly prefer

a secular one.

Preserve the same standard of evidence and care while adapting how support is offered.

Two kinds of learning: this person and the next person

Feedback can improve a pathway in two different ways.

First, adjust the current plan.

Ellen asks for a call instead of another long article. Pat wants a different afternoon activity. A family member's availability changes. The team reviews the request and updates the relevant arrangement.

That is individual adaptation. It does not require waiting for a formal study before respecting a stated preference.

Second, improve the reusable pathway.

Several families may encounter the same confusing term. Staff may repeatedly explain the difference between requesting a day and receiving confirmation. A video may leave out the entrance people actually use.

The team can investigate whether the standard material or sequence needs revision.

The Model for Improvement, used by the Institute for Healthcare Improvement and developed by Associates in Process Improvement, combines clear aims and measures with small tests of change. Its Plan–Do–Study–Act cycle supports trying a change, examining the result, and deciding what to modify before broader implementation.[55]

For CarePhysics, the practical cycle is:

Plan the sequence → try it with appropriate support → listen and measure → review → adjust → try again.

A small adjustment might move the contact information earlier, shorten a preparation article, offer a call before a visit, or explain a service condition more clearly.

Sometimes the necessary change is larger: different service hours, additional staffing, or another community partner.

Learning should be allowed to change the service, not only its wording.

Record what changed—and why

In Chapter 6, Ellen explained that the optional reading prompts initially looked like instructions.

The immediate response was to clarify the guide for her family. A broader improvement would be for the activity lead to review the wording and prepare a revised version for other households.

The reason should remain visible: readers could mistake suggestions for required tasks.

The team could then ask whether the new wording is clearer, whether families still find the prompts useful, and whether the change creates any new difficulty. Ellen’s comment identifies a problem worth addressing; it does not prove that the revision works for everyone.

The dated Day Center export proposes a learning record containing the finding, decision, responsible person, actual change, date, and remeasurement. It explicitly says that this register is maintained outside the product described there.

Keep versions of the pathway and its content. Record which version was used, for which audience and period, and what local adaptations applied.

Otherwise, a team may see a change in results without knowing which materials or arrangements people received.

Not every revision needs an elaborate experiment. But every important claim needs evidence appropriate to it. A clearer explanation can be tested for understanding. A claim of reduced caregiver strain or fewer hospital visits requires a stronger evaluation than favorable comments about the new design.

Keep the next responsibility visible

The planned sequence still depends on people accepting and completing the work.

A resource can be shared without being reviewed. A contact can be added without a conversation occurring. A meeting can finish while its decisions remain unassigned.

The communication guide makes this distinction explicit: a message sent, a referral transmitted, and a service received are different events.

Use status language that reflects what is actually known.

“Requested” should not look like “confirmed.” “Accepted for review” should not imply “eligible.” “Appointment completed” should not automatically become “need resolved.”

A digital acknowledgment can confirm receipt. It should not sound as though a person has already acted.

The pathway needs a responsible person at the next step, a response expectation, and a fallback. Coordination also needs limits: Sam does not become the owner of every task simply because he helps the family see the overall plan.

Plan for the route that does not work

> **In Context — An honest answer about Tuesday**
>
> Lena checked the request and called Pat and Ellen.
>
> “The additional Tuesday is full. I can keep the request open for a cancellation, but I cannot confirm a place.”

In Context — An honest answer about Tuesday

Ellen looked at her own appointment.

“So I still need another arrangement.”

“Yes,” Lena said. “I don’t want you planning around a place we cannot promise.”

Pat asked what the program would include that day. Lena explained it. His interest did not create a space.

With Pat and Ellen’s agreement, Sam accepted responsibility for checking other appropriate support for the required period. They agreed when he would report back, including if he had not found an option.

Lena remained responsible for reporting any change in the center’s availability.

The pathway now held two separate matters: a Day Center request that could not yet be met, and a support need still being explored.

Ellen did not need another welcome video. She needed an answer about the arrangements.

The change in circumstances required a different response.

An alternative must still be checked for fit, cost, availability, and the person’s preferences. “There is another provider” is not yet a workable solution.

A compassionate pathway keeps the unresolved need visible rather than marking the matter complete because someone answered the telephone.

Allow pausing and returning

A planned sequence should make support dependable without making participation compulsory.

People may want fewer messages, time to consider, a different service, or no further optional content. They should be able to say so without losing the ability to ask for appropriate help.

Silence is not an answer to every question. A message may not have arrived, the person may prefer another route, or circumstances may have changed. Follow the agreed contact approach and the organization’s appropriate safety procedures.

Do not infer a medical crisis from an unopened article. Time-sensitive clinical follow-up belongs to the responsible clinical team’s process, not to a content-completion rule.

When someone returns, begin with what matters now. Review relevant changes and permissions rather than asking them to work through a backlog of material.

The pathway should retain useful knowledge without holding the person to an earlier version of their life.

AI can help prepare, adapt, and learn

Designing and maintaining this kind of sequence creates substantial preparatory work: selecting reviewed content, checking contacts, drafting invitations, organizing questions, comparing versions, and identifying missing information.

These are useful places for AI assistance.

In a proposed, organization-approved workflow, an assistant could combine relevant CarePhysics guidance with the organization's verified services and permitted personal context. It could draft a sequence containing a tile, a contact, a call, a meeting, and a review—then explain why each element belongs.

A useful assignment would be:

Using our approved knowledge and current service information, draft a pathway for this need. Identify the purpose of each element, its audience, timing, responsible person, and response route. Offer adaptations for the preferences and access needs we have actually established. Mark missing resources and unverified assumptions. Propose measures that distinguish delivery, understanding, action, service use, and outcomes.

People then check the design.

The clinical team owns clinical instructions. The program lead confirms service information. The content owner checks accuracy, accessibility, and reuse permissions. The pathway owner verifies that staff and partners can deliver the proposed sequence.

The knowledge collection retains sources, contributors, review dates, approved uses, and corrections. Research, design guidance, local facts, fiction, and private personal context remain distinguishable. Chapter 13 explains how to maintain that knowledge and its permissions.

AI can also help organize permissioned feedback and prepare revision options. It might identify repeated questions about arrival or highlight where a summary has confused a request with a confirmation.

It should not silently rewrite clinical guidance, infer preferences from cultural identity, or declare that a service happened because a calendar entry exists.

Rules-based reminders may support agreed steps where configured. AI-generated revisions require review appropriate to their consequences. Neither process should create commitments that a person or partner has not accepted.

With reliable knowledge, clear guidelines, and accountable people, this assistance can be a gift: less routine assembly, more useful support, and more attention available for the human encounter.

An approved assistant may also let families revisit routine information around the clock. Human availability must remain honest, and people should have a direct route to request a person when needed.

Uploading the book does not train a model or prove that it will follow the material. The configured assistance must be tested.

Build a pathway the team can actually deliver

The pathway describes an organizational commitment, not simply a content schedule.

Budget for staff time, interpretation, accessible materials, content maintenance, calls, meetings, human review, and follow-up. Confirm capacity with the organizations receiving introductions.

The original CarePhysics checklist includes resources, workflow, accessibility, training, feedback, and budget alongside content and personalization. Those decisions belong in the design from the start.

Practice the ordinary route and an exception. Ask staff where the plan duplicates work or promises something they cannot reliably provide.

A useful local adaptation may be a different division of responsibility, not another interface. Make staff suggestions part of the learning process and credit what they contribute. Do not use pathway data to rank how much individual staff members care.

The approach also extends beyond family dementia support. A rehabilitation pathway may combine a professionally reviewed demonstration, supervised practice, follow-up, and a route for questions. A home-care pathway may introduce the visiting team, explain its role, arrange a first encounter, and review how the service fits household routines.

Community and state groups can help share reviewed starting points, definitions, and lessons. Local organizations still need to verify resources and adapt the sequence with the people they serve.

Genus supplies technology. Partners retain responsibility for their care, staffing, programs, relationships, and voice.

Find What Is Holding the Support Back

A family can understand an invitation, want the conversation, and still be waiting for someone to make it happen. Staff may want to respond just as much. The next useful improvement is the one that addresses what is holding the support back—not necessarily the one that produces more material.

Theory of Constraints asks teams to focus on the limiting condition in relation to a defined goal. Improving a faster step alone may not improve the whole result. Its Five Focusing Steps provide a way to investigate, coordinate, and revisit that decision.[9]

For a care pathway, agree what matters first. Reaching a useful introductory conversation is different from maximizing enrollment. Appropriate care, privacy, rest, and the freedom to decline remain requirements, not obstacles to remove.

> **In Context — The invitation reached the family; the response did not**
>
> This is an original hypothetical service-design example, not a new event in Pat and Ellen's story or a report of a deployed workflow.
>
> A Day Center receives requests for introductory conversations. The guide is clear

> **In Context — The invitation reached the family; the response did not**
>
> and the requests arrive, but several families are still waiting. The program lead asks staff and willing families to describe what happens after a request is sent.
>
> “I knew what you offered,” one family member explains. “I didn’t know whether anyone was going to call.”
>
> The team’s review suggests a problem with response capacity at the busiest part of the day. Requests arrive without a consistently assigned responder or a protected callback period. Some require staff to reconstruct information before they can make a useful call. These are working explanations to test, not conclusions about anyone’s commitment.
>
> The lead arranges appropriate coverage, a named responder, and a callback window families can actually use. The team agrees what information is needed before a call and how absence or urgent concerns are handled. Where approved, an assistant can prepare a brief from permitted information; staff still check it and speak with the family.
>
> In this fictional teaching scenario, the first review finds that more families receive the agreed conversation after response time and coverage are protected. Staff have less information to reconstruct. Yet some people who want a visit still cannot obtain a place on the day they need. The next limiting condition is available service capacity, not the clarity of the invitation.

The lead checks the accounts behind that conclusion: requests due, substantive replies, still-open cases, actual visits, and the effort experienced by families and staff. A better response count does not establish caregiver relief or a clinical benefit. The decision is to maintain the workable callback arrangement while the responsible service owner investigates capacity and alternatives.

If callbacks had remained unreliable, the team would not declare the method a success. It would examine whether the agreed coverage actually occurred, whether the contact times fitted families’ lives, and whether its first explanation was wrong. Either result can change the next version. Appendix F6 shows how to keep response, attendance, and unresolved demand distinct.

The example illustrates coordinated improvement, not a guarantee. Protect useful response time from avoidable rework, align surrounding tasks, provide the resources that are genuinely needed, and review what changed. Necessary staffing or safety support should not wait for every inexpensive option to be exhausted.

Some changes remain worthwhile even when they do not increase service volume. An honest update can protect someone’s time and understanding while a practical resource is still unavailable. See the full Five Focusing Steps in R2.5. See the planning and measurement tools in Appendices D and F.

Before asking people to do more, find what is preventing the support from working

—and direct the next improvement there.

How would we know it helped?

Measure both the individual elements and the sequence they form.

A tile being delivered answers one question. Understanding its content answers another. A contact being saved does not establish that the person reached help. A completed call may clarify a decision without leading to enrollment.

The research review informing this book separates reach, understanding, first action, adoption, useful participation, outcomes, burden, equity, and safety. Those distinctions should remain visible in pathway evaluation.

For one defined pathway segment, establish a baseline, a review period, and a named owner. Record which pathway and content versions were used.

Then examine what you intended to improve. Did people understand the next step? Were questions answered? Did requested conversations happen? Did appropriate services become accessible? Did Pat find worthwhile participation? Did Ellen receive usable time?

Include the effort required: messages, calls, travel, paperwork, family coordination, staff preparation, and AI review.

Use accurate denominators and keep people still waiting in view. A favorable result among respondents should not become a claim about everyone offered support. Compare differing populations and local resources carefully.

Verify the record before selecting a measure: bookings, attendance, educational delivery, and understanding are different events. Required dates may be missing. Appendix J records the dated examples behind these checks; no field should be renamed to manufacture an answer.

A service received is still distinct from an outcome improved. An outcome change is distinct from a change credibly attributable to the pathway.

Likewise, willingness to recommend, an actual referral, and a referred person receiving useful services remain separate.

For improvements, make a prediction, try a manageable change, and examine benefits alongside burden, safety, and access. IHI's testing guidance recommends repeated small tests under different conditions before making a change standard practice.[56]

Retain unsuccessful findings. A shorter tile may be easier to finish but omit something important. An earlier call may help some families while arriving at an inconvenient time for others.

The goal is not a universally winning sequence. It is a better-understood starting point, with appropriate variations and evidence about where each is useful.

Models and Evidence Behind This Chapter

The pathway definition, building blocks, and examples come from the CarePhysics source materials and the proposed applications in this chapter. The following research and guidance help examine those choices. They do not validate the entire pathway or a particular technology implementation.

Care-transition guidance

Connect preparation with practical follow-through

AHRQ's **IDEAL discharge-planning approach** includes patients and families as partners, addresses life at home and follow-up, uses plain-language explanations, checks understanding, and listens to goals and concerns. It informs the hospital-to-home portion of the pathway. This is practice guidance, not proof that providing a checklist or tile produces better outcomes.[15]

Local question: Does the person leave with understandable information, workable arrangements, and an appropriate contact?

The Care Transitions Intervention

Human support can be part of the effective sequence

Eric Coleman and colleagues' 2006 randomized trial included **750 community-dwelling adults aged 65 or older** in a Colorado integrated delivery system. The intervention combined communication tools, support for expressing preferences, and guidance from a transition coach.

Thirty-day rehospitalization was **8.3 percent with the intervention and 11.9 percent with usual care**; the adjusted comparison was statistically significant. Participants were required to speak English, have telephone access, and have no documented dementia in their medical record. The findings therefore cannot simply be applied to Pat's later dementia-care situation.[57]

The trial tested a multicomponent support intervention—not the independent effect of a message sequence, contact list, or calendar.

Local question: Which people and services make the pathway more than information delivery?

Just-in-time adaptive intervention design

Use changing information to reconsider the next step

Inbal Nahum-Shani and colleagues' 2018 paper describes adaptive interventions through longer-term and near-term outcomes, decision points, relevant tailoring information, available options, and decision rules. It also addresses the burden of repeated intervention.[58]

The chapter borrows that vocabulary for human-reviewed decisions: a stated preference,

unanswered question, or changed service arrangement can lead to different support. No additional message may sometimes be appropriate.

Evidence boundary: This is a design framework, not proof that continuous AI adaptation improves care.

Local question: What information justifies changing the sequence, and who reviews that change?

The Model for Improvement and PDSA

Make revision a learning process

The **Model for Improvement**, developed by Associates in Process Improvement and used by IHI, links aims and measures with tests of change. **Plan–Do–Study–Act** asks teams to prepare a test, carry it out, examine what happened, and decide what to modify.[55]

Here, it informs the pathway's learning cycle: revise a confusing tile, alter the timing of a call, or test a different introduction while examining consequences.

Evidence boundary: An improvement method does not guarantee improvement. A small local test can reveal practical problems without establishing long-term clinical effectiveness.

Local question: What did the team learn, what changed because of it, and what happened when the change was tried again?

Theory of Constraints

Focus the improvement, then test the whole experience

TOC supplies a management method for choosing where improvement effort may help. R2.5 explains the sequence; R1.3 examines a public home-care study. The proposed callback example is not a validated intervention. Local question: what evidence identifies the limiting condition, and did the change improve the intended support without moving the burden elsewhere? See R1.3's operational research note.

Coordinated dementia care

Evaluate the actual program, not the label

The 2019 **Care Ecosystem** randomized trial included **780 people with dementia and their caregivers** in California, Nebraska, and Iowa. Its collaborative program, delivered through telephone and internet support, showed benefits in caregiver-rated quality of life, caregiver depression and burden, and emergency-department use compared with usual care. Of the enrolled pairs, **571 completed the 12-month survey**.[59]

The 2025 **D-CARE** randomized trial included **2,176 person–caregiver pairs**, comparing health-system-based care, community-based care, and usual care over 18 months. It found no significant differences in its primary outcomes of patient behavioral symptoms and caregiver strain. Caregiver self-efficacy, a secondary outcome, was higher in both

intervention groups than with usual care.[60]

These studies tested different programs and comparisons. Their results do not establish that coordination always works or never works. Neither tested this CarePhysics design or a Genus pathway.

Local question: Which outcomes improve under this particular combination of services, support, and implementation?

COM-B, autonomy, and Social Physics

Keep the human foundations inside the sequence

The research review informing this book contributes three continuing checks: investigate the barrier before selecting the response, preserve self-endorsed choice, and connect new information with appropriate human support.

Its evidence judgments differ: COM-B has strong conceptual support; Self-Determination Theory's intervention evidence is moderate; the broader Social Physics perspective is emerging-to-moderate. These are not interchangeable grades or a combined rating for this chapter.

The chapter applies these ideas when a transport concern leads to practical assistance, optional content can be paused, and a resource introduction leads to a person who can explain its local relevance.

Local question: Does the pathway continue to serve the person's goals, or has completing the sequence become the goal?

One thing to try

Choose one recurring need your organization supports.

Map the current sequence using the actual elements: tile, article, contact, call, meeting, visit, activity, and review. Leave out anything that does not serve the purpose.

At each step, identify who acts, what confirms the step occurred, and how feedback could change what follows.

Then choose one small adjustment and test it with the intended audience. Record the pathway version, the reason for the change, the result, and what you will do next.

Your team's question is:

Are we sending a sequence of things—or providing a sequence of support?

A clearer pathway should leave people with less to carry

> **In Context — “Could I have the useful part?”**
>
> At the end of the meeting, Sam separated the current arrangements from the unresolved request.
>
> “The additional Tuesday is still not confirmed,” he said. “Lena owns the availability update. I own the alternative-support inquiry we agreed on. You will hear from me at the time written here, even if I have not found an option.”
>
> Ellen looked over the summary.
>
> “So I don’t have to call both places to find out whether someone is checking.”
>
> “That is the arrangement.”
>
> Maya wanted her permitted part of the plan where she could find it on her phone. Daniel needed the details of the responsibility he had accepted. Ellen preferred a short printed copy and a telephone call for changes.
>
> Pat looked at the longer working document.
>
> “Could I have the useful part?”
>
> “What would that be?” Sam asked.
>
> “Where I’m going, who I’m seeing, and whether I need to do anything.”
>
> “And the next story?” Ellen asked.
>
> “That can stay.”
>
> The pathway held more than appointments. It held explanations, contacts, conversations, support, and something the family might enjoy.
>
> The organization needed to understand how those pieces connected.
>
> The family needed the useful part to be within reach.
>
> That is the next design question.

Notes

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CHAPTER 8

Technology — Make Help Easier to Reach

At a Glance

The central idea: Technology should remove work from care, not add another place to do it.

What you'll explore: How the pathway becomes reachable through the routes people can actually use. Follow Ellen, Maya, Daniel, and Pat as they choose different ways to receive information, ask questions, and participate. Examine familiar controls, accessible content, first-use assistance, permissions, and alternatives when digital tools are not useful.

Design and AI: Begin with one meaningful task rather than a tour of features. Show what happens, make help visible, and preserve choice. Explore how an approved AI assistant could explain instructions, prepare accessible drafts, and support staff—without becoming a barrier between someone and a person.

Put it to work: Create a **First-Use and Multi-Channel Access Plan** covering the task, preferred route, permissions, assistance, fallback, and review.

Evidence and evaluation: Examine accessibility standards, human-centered design, behavioral models, and research on technology use by older adults and caregivers. Measure successful tasks, useful support, privacy, access, and total effort—not accounts created or time spent online.

> *"The power of the Web is in its universality. Access by everyone regardless of disability is an essential aspect."*
>
> — **Tim Berners-Lee**, inventor of the World Wide Web, in W3C's accessibility statement.[61]

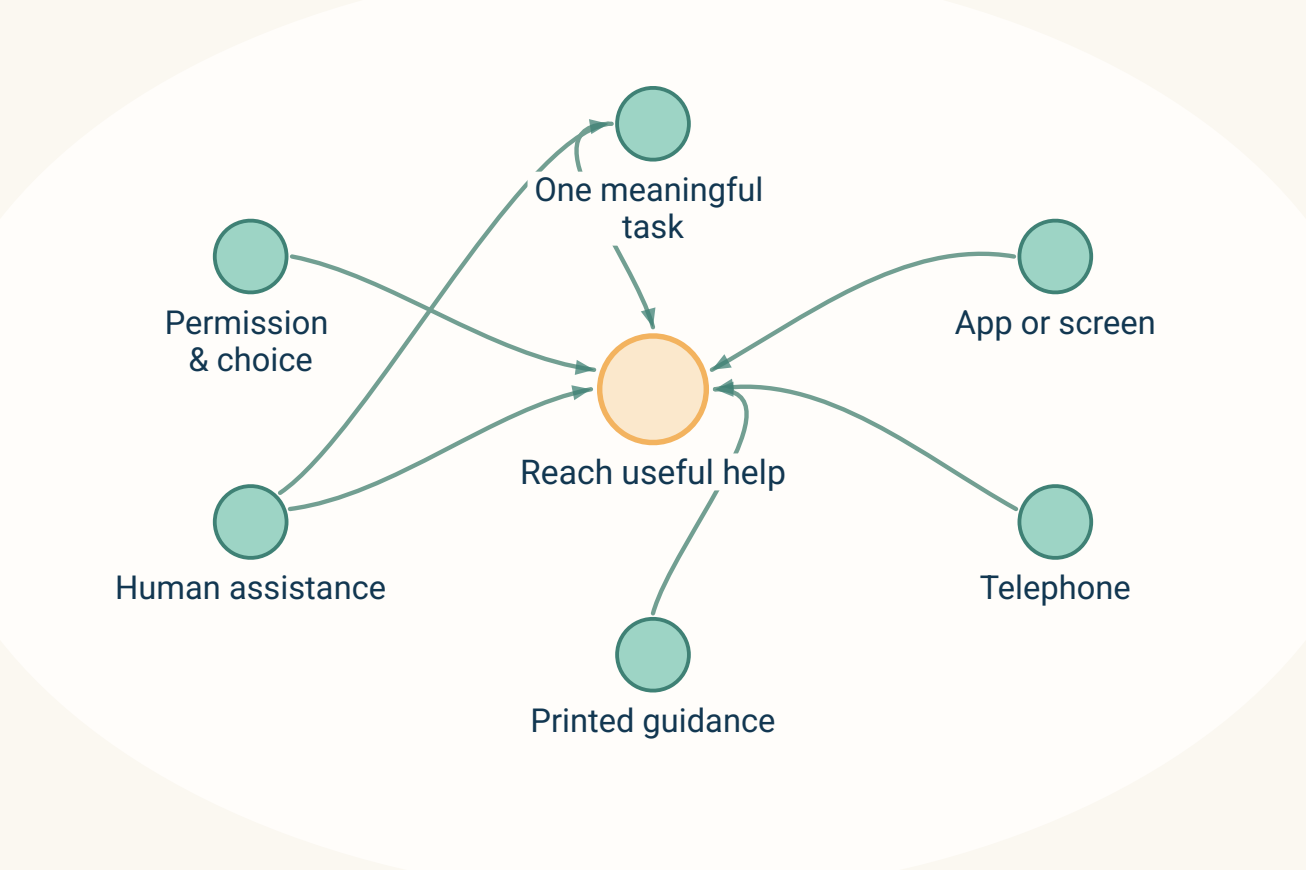


Figure 09 · Different routes, the same useful help

Begin with one meaningful task to define the help someone needs. An app or screen can offer a route to the help. Telephone access offers another route to the same support. Printed guidance offers another route without requiring digital participation. Human assistance is available where someone gets stuck. Permission and choice govern access and any shared use. First-use assistance helps the person attempt their own task. Accessible routes should preserve the same facts; success is useful support, not becoming more digital.

A chosen route	The same responsibility
Print or telephone	The person receives current information and knows who will answer.
Accessible digital route	The same service facts, choices, and human help remain visible.
Personal assistance	Support first use without making another relative responsible by default.

In Context — “Do we all need to do this?”

Maya could see the value of having the agreed information in one place.

“I’d use this,” she said, looking at the proposed family view. “Especially when we’ve had a meeting and I want to check what we actually decided.”

Ellen held the printed summary Sam had prepared.

“This is enough for me most of the time.”

Daniel looked between the page and the screen.

“Do we all need accounts for this to work?”

“Not for every part of it,” Sam replied. “Let’s begin with what each of you needs to do.”

Maya wanted to find the information her parents had agreed to share and prepare questions for the next conversation.

Daniel wanted the details of responsibilities he had accepted, without having to search through every family exchange.

Ellen wanted a short summary, someone to call, and a dependable way to hear when an arrangement changed.

Pat wanted to see his upcoming plans and keep reading with the grandchildren.

“The television has been doing quite well,” he said. “I haven’t asked it to manage my appointments.”

“Then we don’t need to put them there,” Sam replied.

They were not four versions of the same user.

They were four people trying to do different things.

The design needed to begin with that difference—not with an instruction that everyone learn the same system.

Make the pathway reachable

Chapter 7 connected content, contacts, calls, meetings, visits, and review into a planned sequence of support.

Technology now has a practical job: help people reach and use the parts that matter to them.

The original CarePhysics Technology principle describes a collaborative environment with shared resources, calendars, phone books, content, communication, and tools for care teams. Its emphasis is broader than one application or device.

The practical question is: can each person use the designed pathway through an

appropriate route, with assistance when needed?

Technology should remove work from care, not add another place to do it.

That does not mean technology requires no learning, setup, or maintenance. It means those demands must be justified by what people receive in return.

A family should not have to become proficient in a care platform before discovering whom to call. A staff member should not have to enter the same information repeatedly so that a dashboard appears complete. A person should not lose access to an appropriate service because they prefer the telephone.

The technology is there to support the relationship and the work—not become another relationship everyone must maintain.

Start with the useful task, not the whole system

A family's first question is rarely, "What are all the features?"

It is more likely to be, "Where is the information we agreed on?" or "How do I ask about next week?"

Start there.

A **tile** can hold an explanation, video, article, or question. A **phone-book entry** can make a verified contact easier to find. A **calendar** can present arrangements. A **shared session** can help people look at something together. A **staff workspace** can support review and follow-through.

Those possibilities are relevant only when they serve a recognizable task.

Do not make people understand how the entire collection fits together before letting them use one useful part. Keep permissions and partner responsibilities visible rather than making separate organizations appear to be one service.

For Maya, the first useful task might be finding the latest approved family summary.

For Ellen, it might be saving Lena's contact in the phone she already uses—or receiving a readable contact card.

For Daniel, it might be checking the time of the appointment he has agreed to help with.

For Pat, it might be choosing a story without navigating through unrelated care information.

These are possible starting points, not assignments based on age or family role. Ask each person.

The unfamiliar remote, again

At home, you know how your television works. In someone else's house, you may face an unfamiliar remote, a different sequence, or two controls that seem to do the same thing.

The task has not become unreasonable. The design has become unfamiliar.

Care technology can create that experience repeatedly.

A help button moves. A familiar action acquires a new label. A page shows an icon without explaining it. A survey opens differently from the article beside it. An update changes the route someone has just learned.

We should not make people relearn the controls whenever we offer something new.

W3C's guidance on consistent navigation calls for repeated navigation to appear in a predictable relative order. The purpose is to help people anticipate where recurring functions will be, including when they use magnification or other ways of navigating.[49]

The CarePhysics application is to preserve familiar action labels, help routes, and expectations across related experiences. That does not require every screen to look identical. A telephone display and a television need different layouts.

Keep the meaning and behavior recognizable.

And keep this analogy where it belongs: it explains a design problem that anyone can encounter. It is not an illustration of Pat's dementia.

Offer different routes without creating different truths

A digital route, a telephone conversation, and a printed summary can serve different preferences while carrying the same approved facts.

That takes deliberate work.

Someone must identify the current version, decide which changes require direct communication, and ensure that people relying on paper or calls are not left with obsolete arrangements.

In the family's situation, the additional Tuesday from Chapter 7 remains unconfirmed. It should not look confirmed in Maya's view while Ellen's paper says a request is pending. Nor should the family be expected to resolve the discrepancy.

The responsible service needs to correct it and communicate through the agreed routes.

A useful service may provide a guide in print and a schedule in an accessible format. Keep requests, approvals, waiting-list decisions, and confirmed arrangements distinct in every route. Verify which alternatives the local service actually supports; dated examples appear in Appendix J.

An alternative route should provide timely access to the essential support, not an identical copy of every digital feature.

Ellen does not need an animated calendar on paper. She needs to know what is arranged, what is not, and who will contact her.

Design accessibility into the ordinary experience

Accessibility is not a special version prepared after the main design is finished.

W3C's **Web Content Accessibility Guidelines 2.2**, or **WCAG 2.2**, provide testable

requirements for web content. For the digital examples in this book, WCAG 2.2 at Level AA is a useful baseline design target. It is not a claim that a particular product conforms, and conformance alone cannot address every individual need.[62]

Begin with practical questions.

Can the person perceive the important information? Can they operate the controls? Can they understand what an action will do? Can their assistive technology work with the experience?

Readable text, appropriate contrast, meaningful labels, captions, alternatives to visual-only information, keyboard access, and usable controls belong in that assessment. So do understandable errors and enough opportunity to complete a task without unnecessary pressure.[62]

Then test the actual experience.

A large heading will not repair an unclear instruction. A caption button will not help if the captions are inaccurate. A printable document may still be difficult to read. A video available on a phone may be impractical over the connection someone has.

W3C's supplemental guidance for cognitive and learning disabilities emphasizes familiar patterns, clear content, manageable processes, help, and involvement of people with those disabilities in design and testing. It extends beyond the formal WCAG conformance requirements.[63]

Ask about the person's language, devices, connectivity, setting, preferred assistance, and ability to use a private space. Do not turn those questions into a test of whether they deserve the service.

Culture and beliefs may influence what support someone welcomes, but they do not tell us which interface that person can use. Ask rather than infer. The organization's access plan should reflect the answers, not a demographic stereotype.

Make sign-in usable without making privacy optional

For public information, consider whether an account is necessary at all.

A general introduction to a Day Center or a public activity handout may not need the same access process as a private family summary. Do not collect personal information merely because the platform offers a registration form.

Private care information needs an appropriate protection process. That process also needs to be usable.

W3C's accessible-authentication guidance addresses barriers created by memory tests, puzzles, and unnecessary transcription. It describes support such as properly implemented password-manager access, autofill, and copy-and-paste rather than requiring people to remember and manually reproduce credentials.[64]

The design question is not whether to choose security or accessibility. It is how to provide appropriate protection through methods the intended people can use.

Test recovery too. What happens when an invitation expires, a device is replaced, or someone cannot use the usual verification method?

Provide a legitimate route to assistance. Staff should not solve the problem by asking someone to disclose a password or by encouraging relatives to share an account.

Family access should identify who is acting and what they are authorized to see or do. Being a daughter, son, or spouse should not silently become permission to access everything.

Keep setup assistance separate from taking over the person's identity.

Show the first task—and let the person do it

A tour can show where features are. First-use support should help someone do something worthwhile.

AHRQ's communication guidance recommends limiting key points, demonstrating actions, inviting questions, and checking understanding. Those methods provide a useful foundation for introducing a care tool without overwhelming someone with every possibility.[6]

A first-use invitation might say:

"We can help you find the current summary and see where questions go. We will only look at the information you are permitted to access. You can try it yourself, ask us to guide you, or use the telephone or printed version instead."

Then demonstrate the chosen task on the actual device and configuration, using a safe example where needed.

> **In Context — One thing she can find again**
>
> Ellen wanted Lena's number where she could find it without searching through papers.
>
> With her agreement, Sam helped her save the contact in her phone.
>
> "What should I call it?" she asked.
>
> "Something you will recognize."
>
> She entered the Day Center's name and Lena's role. They checked the number against the center's current information.
>
> Sam did not continue into a tour of unrelated features.
>
> "Could you show me where you would find it again?"
>
> Ellen returned to the contact.
>
> "There."
>
> They also checked the opening hours and the route for a question when Lena was

> **In Context — One thing she can find again**
>
> unavailable. Ellen kept the printed contact information as well.
>
> Maya's first task was different. With her own authorized access, she located the approved summary.
>
> "Who sees a question I send from here?" she asked.
>
> "That needs to be clear before you send one," Sam said.
>
> They reviewed the actual recipient information together. Where a channel did not provide the privacy Maya needed, they chose an approved private contact route instead.
>
> Neither task was impressive as a technology demonstration.
>
> Both answered a question the family actually had.
>
> The point of first use is not to prove that someone can manage without help. It is to establish a workable route, including appropriate assistance.
>
> Some people will want to practice. Some will prefer continuing support. Both should be planned honestly.

Put human help where the person gets stuck

Help is not useful merely because a support page exists.

Place the route near the task, explain what the responder can help with, and state when someone is available. Distinguish technical assistance from clinical or program decisions.

A technical support person may help Maya open a summary. They should not interpret Pat's clinical findings. Lena can explain a program arrangement. She cannot resolve every account problem without the appropriate technical support.

W3C's **Consistent Help** criterion requires recurring help mechanisms to appear in a consistent location relative to other content. It does not require round-the-clock human staffing. The accompanying guidance encourages clear availability information and ways to express a question in the person's own words.[65]

CarePhysics goes further as a service-design proposal: when we invite questions, we should assign responsibility for answering them.

The dated Day Center export describes tile feedback that saves a response and sends an email notification to the center, with comments available where enabled. That establishes a delivery mechanism. It does not establish that a staff member has answered or resolved the concern.

A callback request needs an owner and a stated response expectation. An automated receipt should not sound like a professional has already acted.

People should not have to complete a chatbot conversation before they can ask for a

person.

Make shared use genuinely permissioned

Technology can help people read, plan, or examine information together across a room or across a distance.

The useful experience may be simple: “We are looking at the same page.”

But shared viewing needs boundaries.

Before starting, explain what the helper can see, whether they can control anything, and how to end the session. Limit the shared area to the task. Keep unrelated records, credentials, notifications, and private notes outside it.

These are requirements for the proposed experience, not protections to assume every screen-sharing tool already provides. Where the available configuration cannot support an appropriately limited session, use a safer demonstration or another route.

The Day Center export describes co-browsing and shared educational experiences. It separately labels some AI participation in sessions as planned. The exact permissions, devices, and deployed configuration still need verification before an organization promises a particular experience.

For Pat’s family television, the shared material is the story—not the care record.

Emma and Noah can choose a page, read, listen, or make a joke. They do not need access to adult conversations or responsibility for technical support.

Pat can benefit from the prepared experience without managing another account. That does not mean excluding him from digital tools he wants to use. It means making the choice with him.

Personalize the help, not the location of every button

Personalization should make the experience more relevant without making it unpredictable.

Offer a suitable language, accessible format, appropriate level of detail, and relevant resources. Keep core actions recognizable.

A tile containing a video and article should make both options easy to find. A survey should explain its purpose and who receives the answer. A message should distinguish information from a request. A contact should make its role and availability clear.

The familiar CarePhysics content pattern still applies: why it matters, the main idea, demonstration, a chosen next step, questions or connection, and what follows. The format can be brief when the task is brief.

A help video might demonstrate how to locate a confirmed appointment, then show what to do when the status is still “requested.” The companion article can provide the same instructions in a readable format. A person offering telephone help should use the same action names.

An update should not make those instructions obsolete without warning.

When a design must change, explain what changed, preserve familiar functions where possible, and offer assistance. Let feedback influence whether the change stays.

Consistency is something the organization maintains over time—not a visual style chosen at launch.

Design for the interrupted day

Test what happens when use does not proceed perfectly.

A connection drops during a meeting. A session ends while a staff member is drafting. A person submits a request twice because no confirmation appeared. A printed copy is no longer current.

The experience should explain what was saved, what was sent, what remains incomplete, and what to do next.

Do not claim that a request succeeded when delivery is uncertain. Do not invite a second submission without checking whether the first arrived. Provide a responsible person who can reconcile the situation.

Test what happens when unfinished work is interrupted. A draft should not be treated as saved until storage and recovery have been verified. Do not publish an unreviewed family note merely to preserve it; the dated persistence issue is recorded in Appendix J.

A recoverable draft is a requirement to verify, not a feature to assume.

Plan for outages as well. Identify essential information staff need, an approved fallback process, the people responsible for contacting families, and how records will be reconciled afterward.

Paper is not automatically private or current. It needs appropriate handling, dates, and replacement just as digital information does.

Reliable access includes returning after something goes wrong.

Give the staff less to reconstruct

The technology should support the people delivering care as well as those receiving it.

Ask staff to show how the work happens now. Where do they enter the same information? What do they have to reconstruct at the end of the day? Which changes require checking before information is reused?

W3C's guidance on redundant entry addresses unnecessary re-entry within a process, while preserving exceptions such as security or information that is no longer valid. It provides one useful design reference; it does not justify carrying old information forward without checking it.[66]

Recording a group activity once can reduce repeated entry only if individual accounts remain accurate and correctable. Examine the full work, including review and

correction. Appendix J records the dated configuration; any time benefit needs local measurement.

The distinction matters. Fewer clicks may help, but inaccurate group assumptions can create correction work or misleading records.

Staff should have ways to suggest improvements, identify awkward steps, and practice changes without feeling that every hesitation is being evaluated. Record the issue in the design—not a judgment about the person encountering it.

Technology can carry useful staff knowledge into guidance and training. The organization should credit that contribution and show what changed because of it.

Remove work; do not merely move it

Apply the constraint question to the complete task. A shorter staff form may look efficient while requiring a family to enter the same information at home. Faster AI drafting may enlarge a review queue. In either case, the local improvement has not yet established a better care experience.

Follow one ordinary request across the person, family, staff, and receiving partner. Identify duplicated entry, missing information, correction work, and waits for an accepted responsibility. Ask which change would make useful support easier to obtain. Accuracy and clear sources may release more review capacity than producing more drafts.

Keep phone, print, digital, and supported routes in the same review. No route should quietly make one caregiver responsible for relaying every update. Credit the people who identify a better arrangement, provide training and coverage, and check total effort before claiming a saving. See the pathway flow measures in Appendix F.

AI can assist without becoming another set of controls

An approved AI assistant could help people use a system they do not yet know well.

It might explain where to find a resource using the organization’s current instructions, help someone phrase a question, or prepare a shorter explanation of a nonclinical process.

For staff, it could help turn a useful explanation into a draft help article, compare instructions with an updated screen, or organize voluntary feedback about recurring difficulties.

Begin with the relevant approved material, not a general request to “help the user.”

A proposed assignment might be:

Using the current interface guide and approved support information, prepare instructions for finding a family summary. Keep the actual action labels. Explain what the person can do if access fails, and identify the human support route. Mark anything the sources do not establish.

The interface owner checks that the instructions match the product. The service lead verifies contacts and response expectations. An appropriate reviewer checks language and accessibility. Private personal information is unnecessary for preparing a generic guide.

The knowledge collection should preserve sources, owners, review dates, permissions, and corrections. Research, design guidance, local facts, fictional examples, and personal context remain distinct. Chapter 13 explains how to maintain this reviewed knowledge and use it responsibly.

Uploading the book does not train a model or establish that it will follow the guidance.

Properly applied, AI can be a gift here: less repetitive preparation, more tailored assistance, and routine explanations available when questions arise. It can help someone get ready for a human conversation rather than wait in uncertainty for every basic answer.

The boundaries still need to be clear. An assistant must not invent a button, claim a request was submitted when it was not, or interpret technical difficulty as a clinical finding. It should never ask for passwords or private verification codes.

Around-the-clock AI availability is not around-the-clock professional care. State when human support is available, provide appropriate urgent routes, and make escalation easy.

A simpler screen, a printed guide, or a person on the telephone may be the better answer. AI should not stand in the way of any of them.

> **In Context — A reliable route without an app**
>
> An original fictional illustration, separate from the continuing family.
>
> A person living alone wants help arranging a home-support visit. He prefers a telephone call and a printed page. The service does not ask him to recruit a relative to manage an account.
>
> The coordinator checks the number and the times he wishes to be called, explains who will respond if the usual coordinator is away, and mails a concise confirmation after the arrangement is accepted. A later change uses the contact route he agreed to.
>
> An assistant may help staff prepare the printed information from verified records. He does not need to interact with it. The useful result is a dependable route to the service, not an account created on his behalf.

Put first use and continuing access in one plan

The practical output is a **First-Use and Multi-Channel Access Plan**.

Build it around tasks and preferences, not around a list of people who have not activated

an account.

Person or role	First useful task and chosen route	Support and boundary
Pat	Review his relevant plans directly with a person or readable summary; enjoy prepared stories on the shared television.	Include him in choices. Offer other digital access when he wants it. Keep private care information off the family activity screen.
Ellen	Find the correct contact and receive a short current summary by her preferred route.	Provide calls for agreed changes and an accessible written copy. She is not responsible for relaying every update to everyone else.
Maya	Find the approved information shared with her and prepare a question through an appropriate channel.	Use her own authorized access. Make recipients and privacy boundaries visible.
Daniel	Locate details of a responsibility he has actually accepted.	Confirm the information and change-notification route. A calendar entry does not create a new commitment.
Day Center staff	Review and share an accurate update without unnecessary reconstruction.	Provide training, protected review time, correction tools, technical help, and an outage process.
Sam and partner teams	Reach relevant, permissioned information for their own responsibilities.	Preserve separate professional roles and explicit handoffs. Do not assume every system automatically exchanges information.

For a real implementation, add the named owner, actual contact details, device and format requirements, assistance offered, fallback route, and review date.

This is a proposed planning aid, not a validated assessment.

A person can change their preferred route. Their access plan should change with them.

Resource the support behind the interface

An organization choosing technology is also choosing work it must support.

Budget for setup, training, accessibility testing, interpretation, devices where needed, connectivity, maintenance, human review, and responding to questions. Consider the work created by running digital and nondigital routes together.

Ask who provides help when the usual champion leaves or is absent. Clarify what the organization can export, in which formats, and what it can continue using if the supplier changes.

The dated Day Center materials themselves identify cost, implementation, continuity beyond one champion, and what information can leave with the organization as questions requiring explicit answers.

A demonstration should cover those realities, not only the ideal route.

Ask to see first use, a mistaken entry, a permission change, a failed connection, and an unfinished draft. Distinguish what is **proposed**, **implemented**, **tested**, and **deployed in this setting**. None of those labels automatically establishes improved care.

The same discipline applies in a health system, home-care organization, independent-living community, or Day Center. The tasks differ; the need for usable access and accountable support remains.

Community and state groups can help identify shared barriers and support local solutions. One organization may need language access; another may need connectivity or staff capacity. Shared design guidance should not conceal those differences.

Genus supplies technology. Partners retain their care, staffing, programs, relationships, and voice. A connected experience must not obscure that responsibility.

How would we know it helped?

Choose one meaningful task and establish a baseline.

For example: can an authorized family member find the current arrangement and identify whom to contact about a change?

Test it through the routes people will actually use, including assistance. Record whether the task was completed, what help was needed, where the design caused difficulty, and whether the person reached a useful result.

Distinguish **completed independently**, **completed with chosen assistance**, **not completed because of a barrier**, and **not wanted**. Those are different findings. Assistance is not failure.

For an initial four-week local review, define the population offered the process, the number who tried it, the number who provided feedback, and the version tested. Include people whose sign-in failed or who chose telephone or paper—not only those visible in the app.

Ask about time, frustration, privacy, repeated entry, and unanswered questions. Count staff work alongside family effort. A reduction in family effort may be worthwhile even when it requires staff support, but the trade-off should be visible and resourced.

Keep the stages separate: invitation, access, first useful action, continuing use, received support, outcomes, and attributable impact. The research review informing this book makes those distinctions explicit and includes burden, equity, and safety.

Willingness to recommend is not an actual referral, and a referral is not another person receiving help.

Give a named leader authority to act on the findings. Change an unclear label. Repair a failed recovery route. Restore human assistance. Pause a rollout that increases unsafe work or excludes people.

We are evaluating whether the support is reachable—not whether the family is sufficiently digital.

Models and Evidence Behind This Chapter

The following standards and research help examine the chapter's design choices. The PRISM trial concerns a particular intervention and population; it does not establish a Genus effect.

Accessibility standards and cognitive-accessibility guidance

Test the route, not just the appearance

Foundation and use. WCAG 2.2 provides testable web-accessibility requirements. W3C's additional cognitive-accessibility guidance addresses familiar patterns, clear instructions, support, and participation of users in design. It is supplemental guidance, not an additional conformance level.[62]

Where we used it. Predictable navigation, accessible sign-in, readable content, visible help, and alternatives to unnecessary re-entry.

Evidence boundary. Standards establish design requirements, not clinical effectiveness. Neither an automated check nor an attractive interface establishes that the whole experience works for the intended audience.

Local question: Can people complete the relevant task with their actual devices, abilities, preferences, and available support?

COM-B and diffusion of innovations

Investigate the barrier before blaming adoption

Foundation and use. COM-B distinguishes capability, opportunity, and motivation. Rogers' diffusion framework asks about an innovation's relative advantage, compatibility, complexity, trialability, and observable value. The research review informing this book uses these ideas to examine both family access and professional adoption.

Here, they support beginning with a useful task, allowing a supported trial, and checking whether a tool fits the person's life and the team's work.

Evidence boundary. These are explanatory and design frameworks. Their relevance does not establish that a particular onboarding process improves care. The research review informing this book distinguishes conceptual support from intervention evidence.

Local question: Is the obstacle unclear value, an unusable interface, unavailable access, lack of support, or a choice not to use the tool?

PRISM: technology with training and support

Evaluate the complete offer

Supporting trial. Sara Czaja and colleagues' PRISM randomized trial, published in the 2018 volume of *The Gerontologist*, included **300 older adults at risk of social isolation** across three U.S. sites. It compared a specially designed computer system with a binder containing similar printed information.

The technology package included equipment, internet access, training, and support. At six months, the PRISM group reported less loneliness and greater perceived social support and well-being. Those between-group advantages were not maintained at 12 months. Computer confidence and proficiency improved.

Important limits. The study excluded people with cognitive impairment and certain sensory or motor limitations. It does not establish the same effects for Pat, isolate the value of the interface from the support package, or validate Genus.[67]

Local question: What equipment, preparation, and human assistance are necessary for this particular offer to be useful?

Caregiver applications and care coordination

Potential is not the same as demonstrated benefit

Supporting review. Marjorie Kelley and colleagues' 2024 scoping review identified **34 papers representing 25 studies** of caregiver applications. The evidence was largely qualitative, pilot, or feasibility work. The review identified needs involving information, support, communication, and care coordination, but found no included study directly evaluating an integrated caregiver-app intervention for care planning and coordination among people with multiple chronic conditions.

Important limits. The literature search extended through June 2021. The finding describes that review's included evidence—not every application available now. It does not establish that caregiver technology is ineffective, but it limits claims about demonstrated coordination outcomes.[68]

Where we used it. The chapter treats app use, communication, practical help, and caregiver outcomes as separate evaluation questions.

Local question: What changes in the person's care or workload beyond gaining another channel?

Clear communication and supported first use

Demonstrate something worth doing

Practice foundation. AHRQ recommends understandable explanations, demonstrations, questions, and checks of understanding. Its materials guidance also emphasizes evaluating whether information is understandable and actionable.[6]

Where we used it. First use begins with a chosen task rather than a complete feature tour. The person can practice, ask for help, or choose another route.

Evidence boundary. This is practice guidance, not a trial of the proposed first-use plan. A technically successful action may still fail to deliver useful support.

Local question: Did the introduction leave the person able to do something they value and find help when they need it?

One thing to try

Choose one essential task in your current service.

Invite an intended user to try it using their usual device or preferred nondigital route. Explain that you are testing the design, not them. Observe without immediately taking over, while providing agreed assistance whenever needed.

Then test the route back from a problem: an expired invitation, a mistaken entry, or uncertainty about whom to contact.

Fix one point where the process makes the person work unnecessarily.

Your team's question is:

What are we asking people to learn, repeat, or manage that the design could handle more respectfully?

Reaching the information is only the beginning

> **In Context — A question worth bringing**
>
> At home, Ellen placed the current summary beside the telephone.
>
> Maya had found her permitted information. Daniel knew where to check the details of his accepted task. Pat had the next story ready for another evening with the grandchildren.
>
> The additional Tuesday remained unresolved. Sam was still responsible for reporting back through the route they had agreed.
>
> "I know where to find things now," Ellen said during their next call. "What I'm wondering about is how to explain the evenings."
>
> "What would you like us to discuss?" Sam asked.

> **In Context — A question worth bringing**
>
> “Some evenings feel harder to organize. Pat doesn’t see it quite the same way.”
>
> Pat was beside her.
>
> “I think we’re both tired of talking about what needs doing.”
>
> “That can stay in the question too,” Sam said.
>
> The technology had helped them reach the information and the person.
>
> The next opportunity was to help them prepare for a better conversation: bring together the questions they chose to share, the Day Center’s reviewed observations, and the relevant professional guidance—without pretending those sources all said the same thing.
>
> Access made the material reachable.
>
> The next principle asks how assistance can make that knowledge useful while keeping judgment and responsibility with people.

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CHAPTER 9

Care AI — Bring Human Wisdom Within Reach

At a Glance

The central idea: AI should help people make better decisions—not quietly make the decisions for them.

What you'll explore: How AI can help people organize information, prepare questions, explain approved guidance, develop content, and preserve useful experience. Follow Sam as he prepares for a family meeting without allowing a summary to erase the differences between Pat's and Ellen's perspectives.

Design and AI: Give an assistant a defined purpose, appropriate knowledge, clear rules, and a place within a human service. See how a staff member's explanation can become a reviewed article, video, question, or planning resource while retaining its meaning and authorship.

Put it to work: Create an **Assistant Role Card** and a **Reviewed-Knowledge Workflow** that identify sources, permissions, reviewers, human response routes, and how corrections become improvements.

Evidence and evaluation: Examine source-grounded generation, early caregiver-chatbot research, clinical drafting experience, and responsible-AI guidance. Evaluate accuracy, usefulness, review effort, privacy, access, and actual support—not the fluency or volume of generated answers.

> *"One of the most important potential outgrowths of AI in medicine is the gift of time."*
>
> — **Eric Topol, MD**, physician-scientist, in *Deep Medicine*, quoted by Scripps Research, March 12, 2019.[69]

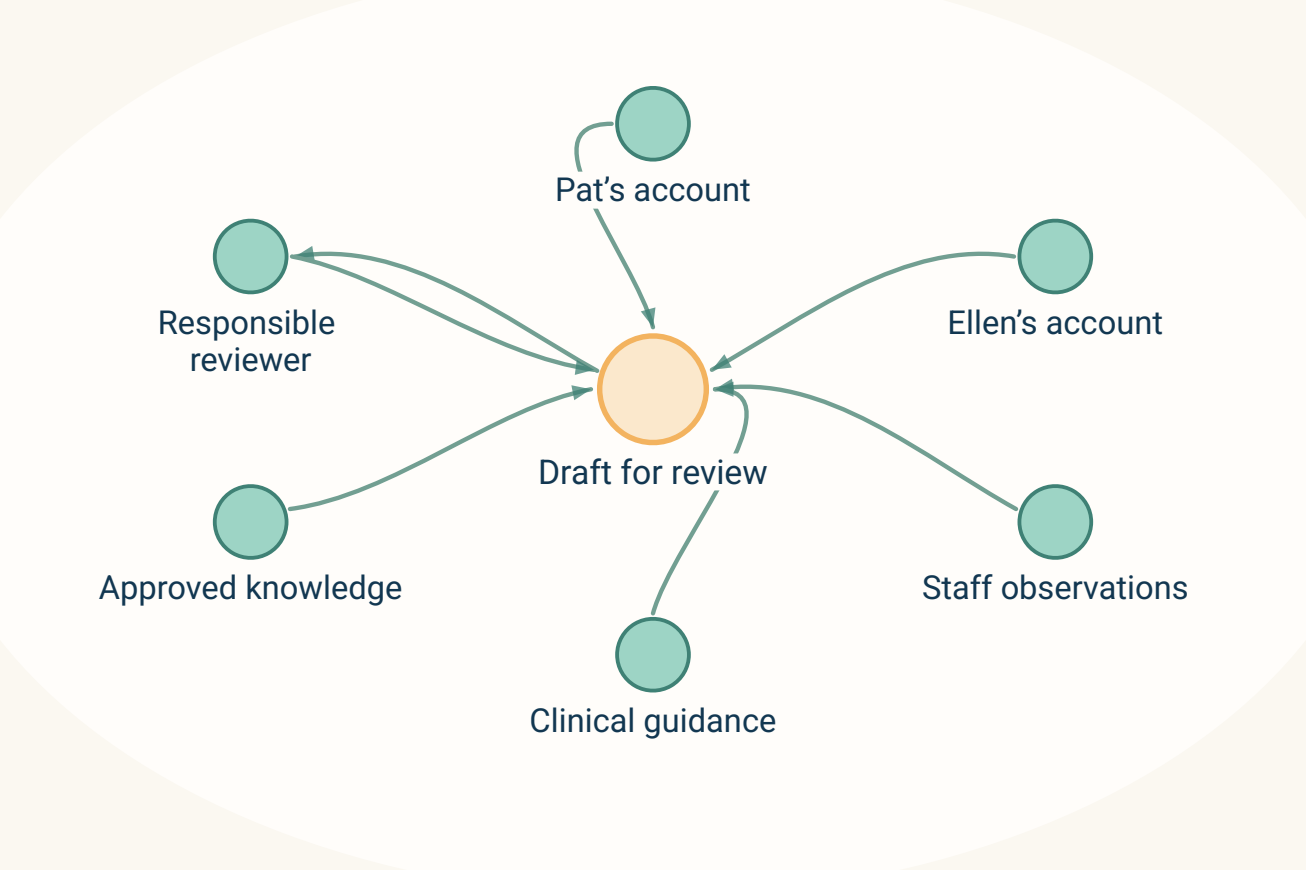


Figure 10 · A draft that keeps the sources separate. Concept illustration of preparation for human review, not a product screenshot.

Pat’s account remains a distinct source in the draft. Ellen’s account remains a distinct source rather than being merged with Pat’s. Staff observations retain their source and status in the draft. Clinical guidance remains distinguishable from observations and family accounts. Approved knowledge supplies relevant grounding for the draft. A responsible human reviewer checks the draft before it is used. The reviewer corrects unsupported statements, omissions and lost differences. AI prepares rather than makes the care decision. In this story Sam is the social worker; clinical responsibility stays with the appropriate clinicians.

Pat’s account	Ellen’s account	Staff observations	Clinical guidance
What Pat reports.	What Ellen reports.	What staff actually observed.	Approved clinical information.

AI-assisted, source-linked draft → Human review → Conversation and chosen next steps

Keep differences visible. An assistant does not decide whose account is right.

> **In Context — Getting ready to listen**
>
> Before the next meeting, Sam looked again at the question Ellen had raised.
>
> Some evenings were becoming harder to organize.

> **In Context — Getting ready to listen**
>
> Pat had described it differently. He thought they were both tired of talking about what needed doing.
>
> The Day Center had information about a different part of the day: activities Pat had enjoyed, occasions when he had chosen somewhere quieter, and the support the team had provided.
>
> There was also the unresolved request for an additional Tuesday. The latest information available to Sam did not contain a confirmation. That needed checking, not an assumption.
>
> Each item mattered. None explained all the others.
>
> Sam wanted the meeting to begin with the family's concerns, not with everyone reconstructing the record.
>
> He explained the preparation process to Pat and Ellen.
>
> "With your agreement, I can use an assistant to help organize the information we have chosen for this conversation. I will check the draft before we use it. It won't decide what the evenings mean or what support you should accept."
>
> "Will it make us agree?" Pat asked.
>
> "No."
>
> "Then it has a reasonable chance."
>
> Ellen smiled.
>
> "I just want my question to be there when we start."
>
> "That is what we are preparing for," Sam said.
>
> The useful task was not to produce a comprehensive account of the family.
>
> It was to help the people arrive ready to listen.

A gift when the purpose comes first

The original CarePhysics framework introduced Care AI as assistance intended to make care more personal and reduce repetitive work. This chapter develops that intention into specific tasks, responsibilities, and tests of usefulness—not a promise that adding AI automatically improves care.

AI should help people make better decisions—not quietly make the decisions for them.

That boundary leaves a great deal of room for useful work.

An assistant could help a social worker prepare for a conversation, a family member

formulate a question, a nurse draft an explanation, or a Day Center team turn a practical insight into training. It could help an organization compare possible approaches before investing in new content or software.

The opportunity is not simply faster writing. It is making relevant knowledge easier to work with.

When properly applied—with appropriate sources, guidelines, rules, and accountable people—AI can be a gift to a care organization. It can take on some of the repeated searching, assembling, formatting, and drafting that surrounds care, leaving people with a better starting point for the work only they can do.

That is an opportunity to test and protect.

Time saved in preparing a summary should not automatically become an expectation to handle more families. A useful explanation should not become a reason to eliminate human contact. The organization must decide what it wants the assistance to make possible.

For Sam, the purpose is a better-prepared conversation.

For Ellen, it is having her concern represented accurately.

For Pat, it includes being able to disagree without disappearing from the account.

Care AI is more than a chatbot

A conversational assistant is one way to provide help. It is not the whole idea.

Some assistance happens before anyone opens a conversation: organizing selected notes, locating approved guidance, preparing an article outline, or identifying information that needs confirmation.

Other assistance happens while someone is thinking: explaining a term, comparing appropriate options, rehearsing wording, or helping turn a broad concern into a question.

Still other work follows the encounter: preparing an agreed summary, organizing feedback, or drafting a revision for the responsible team to review.

Summarization, preparation, navigation, accessible explanations, and routes to people are useful tasks to examine. The evidence for each task differs; none should silently expand into autonomous care.

A drafting assistant also differs from a system authorized to take action.

Preparing a message does not send it. Identifying a possible appointment does not book it. Finding a service does not establish eligibility or availability.

Where a configured system can perform a bounded action, the organization must define the permission, confirmation, and record required. The assistant should never announce that something happened merely because it generated the words describing it.

These distinctions make the service easier to understand. They also help the team decide

where AI is useful and where a simpler tool—or a person—is the better choice.

Give the assistant knowledge with a clear purpose

The quality of the assignment begins before the prompt.

What information is relevant? Who supplied it? What kind of authority does it have? May it be used for this person and this purpose?

At Genus, we assembled the research and working materials behind CarePhysics to help guide our own development, training, content, and support. The dated Day Center export describes that shared reference foundation for teams, wording decisions, and AI-assisted work. This is an internal working approach, not proof that every resulting feature or answer improves care.

Other organizations can build on the same idea without adopting the same services or technology.

CarePhysics supplies questions and design principles. Your organization supplies its current services, professional guidance, terminology, values, and hard-earned experience. The people you serve help establish what fits.

Those materials should not become one undifferentiated collection.

Kind of knowledge	What it contributes	What must remain clear
Research evidence	Findings and models relevant to the question	Source, population, study design, findings, uncertainty, and limits
Design and practice guidance	Ways to explain, demonstrate, invite, support, and review	Whether it is professional guidance, an organizational rule, or a proposed design approach
Local organizational facts	Services, contacts, eligibility, hours, capacity, and responsibilities	Owner, date checked, applicable setting, and what requires confirmation
Illustrative material	Fictional scenes, sample questions, demonstrations, and draft templates	It is an example—not a real person's history, a testimonial, or an outcome
Permissioned personal context	The information appropriate to an individual task	Who may access it, why it is needed, what may be shared, and when permission or relevance must be reviewed

This separation is part of the proposed CarePhysics knowledge-bank approach. A

research result should not become a claim about a local program. A fictional scene should not become a fact about a family. A private concern should not become reusable training material.

An assistant does not need everything the organization possesses.

It needs the appropriate material for the job.

Retrieval is not training—and a source is not a guarantee

One way to support an assistant is to retrieve relevant passages from an approved collection and make them available when it prepares a response. This is often called **retrieval-augmented generation**: finding material and using it to support generated text. Research has demonstrated the approach on language and question-answering tasks; that does not establish clinical reliability.[70]

The distinction is practical.

Making this chapter available for a response is not the same as retraining the underlying model. Correcting an answer does not, by itself, mean the system will remember that correction next week. Whether conversations are stored or reused for other purposes is another question the organization must resolve.

A maintained source collection, an implemented retrieval system, and a tested care service are different things.

Even retrieved material can be wrong for the task. It may be outdated, apply to a different setting, omit an important qualification, or be interpreted incorrectly.

Ask the assistant to identify the sources supporting its statements. Then make it possible for the reviewer to inspect them. A citation that does not support the sentence is not useful evidence.

When sources conflict, the assistant should expose the conflict and refer it to the designated authority. It should not silently combine two incompatible instructions or assume that the most recent informal note overrides a clinician-approved plan.

The goal is not an impressive stack of references.

It is a traceable explanation that the responsible person can check.

Prepare a summary without settling the disagreement

> **In Context — The difference belongs in the draft**
>
> For the meeting preparation, Sam selected the information appropriate to the task. Pat and Ellen knew what would be included. Private material outside that agreement was excluded.
>
> The proposed assistant produced a short draft, with links to the selected records and their dates.

Source	What the draft should preserve
Ellen’s question	Evenings feel harder to organize. She wants help explaining what remains to be done and considering support.
Pat’s perspective	He is tired of evenings being occupied by conversations about care tasks. He wants more ordinary time together.
Reviewed Day Center information	Pat has enjoyed reading and discussion and has sometimes chosen a quieter setting. These observations concern the program day, not evenings at home.
Relevant clinical material selected for this meeting	No new clinical explanation of this particular evening concern is established in the selected material. Questions requiring assessment belong with the clinical team.
Additional Tuesday request	The latest selected record contains no confirmation. Sam must verify the current position rather than infer what happened.

In context

One sentence in the draft read:

“The family agrees that Pat’s evenings are becoming difficult.”

Sam removed it.

The family had not agreed on that description. Ellen had raised a concern about organizing the evenings. Pat had described something he wanted less of.

Sam replaced it with:

“Pat and Ellen describe different concerns about evenings. Discuss both before proposing a change.”

He also checked that the Day Center’s observations were not being used to explain something its staff had not observed.

The draft was now more useful because it held less certainty.

When the meeting began, Sam did not read the table as though it were a verdict.

“Ellen, is this still the question you want to start with?”

“Yes,” she said. “By evening, there are still little arrangements to make.”

> **In context**
>
> “And Pat?”
>
> “I would like an evening that isn’t about arrangements.”
>
> “Then perhaps we should look at which work could happen earlier, or be shared differently,” Sam said. “And whether there are separate questions for the clinical team.”
>
> The assistant had not solved the issue.
>
> It had helped keep the important parts available for the people who could discuss it.

Human review is work, not a button

A summary can be grammatically correct and still be wrong about a person.

Review must examine the sources, not merely polish the output. Has the draft attributed statements correctly? Preserved uncertainty? Included a concern that changes the meaning? Invented agreement? Turned a suggestion into an accepted responsibility?

The reviewer also checks what should not appear.

The Day Center export describes meeting preparation from staff-selected evidence, with private notes excluded by default and drafts reviewed before use. That is a documented workflow description, not independent evidence that every review catches every error.

Permission needs to be enforced before inappropriate material enters the task. Do not send private notes to an assistant and rely only on a sentence telling it not to reveal them.

A technical control that allows a note to be included does not itself establish that inclusion is authorized or appropriate.

Review also requires time and expertise. Sam can review the support-planning summary within his role. Lena confirms program information. A clinical explanation needs the relevant clinical authority.

WHO identifies **automation bias** as a risk: people may overlook errors or delegate difficult judgments because a system presents a persuasive answer. Its guidance calls for defined tasks, stakeholder involvement, and continuing assessment.[1]

Make disagreement with the draft easy. A rejected sentence is not a failed worker or a disloyal user. It may be the review process doing exactly what it should.

Turn a useful explanation into shared knowledge

AI can also help preserve knowledge that would otherwise remain in one conversation.

A staff member finds language that makes a difficult idea clearer. A family points out

why an invitation felt pressuring. A volunteer discovers an effective way to demonstrate a task. The team can examine that contribution and decide whether it belongs in a reviewed resource.

The opportunity is to capture the lesson—not automatically copy the personal conversation.

In Context — Lena's words become a starting point

After several discussions about activities, Lena explained her approach to the team.

"An invitation should leave room for a different answer. Someone can enjoy listening without wanting to lead."

A colleague asked whether that idea belonged in the family guide.

"It might," Lena replied. "But I don't want it to sound as though we can offer anything at any time."

That qualification mattered too.

With Lena's agreement, the team prepared a generic brief. It contained her explanation, the center's actual activity options, the relevant CarePhysics design guidance, and the route for families to ask questions.

It contained no private family notes.

The assistant's assignment was not "write something warm about participation." It was more specific:

Prepare a short article and demonstration outline explaining how participants can discuss activity preferences with our team. Preserve the options and limits in our approved information. Make clear that contribution is optional. Identify questions our team must answer before publication.

The first draft said that participants could always leave any activity and go elsewhere independently.

Lena corrected it. The center could offer choices, but staff still needed to provide appropriate assistance and work within the service's arrangements.

The revised wording made the support visible instead of presenting choice as the absence of responsibility.

That is a useful form of knowledge capture: a human insight, its context, its limits, and a reviewed way to share it.

The dated export describes team-refined examples and explicit drafting rules for family summaries. It provides a basis for this approach, but it does not establish that every correction automatically changes future model behavior. That requires a defined improvement process.

Let one idea work across several formats

Once the idea is reviewed, different formats can serve different needs.

A short article might begin:

There is more than one way to take part

You can tell our team what interests you and what does not. Joining a discussion, listening, trying part of an activity, or asking about a quieter option are all things we can talk through.

You do not have to lead an activity to belong here.

For example: “I would like to listen first. Could someone help me find a comfortable place?”

Staff will explain the options available and any assistance needed. Families can also share questions through the center’s stated contact route.

A video could demonstrate the conversation. Show someone asking to listen, a staff member explaining the available choices, and the person choosing. Do not let the demonstration promise an option the program cannot provide.

A feedback question might ask whether the explanation made those choices clear. It should identify who will review the answer and provide a way to request a response.

A feature-planning brief could ask how the interface distinguishes an offered activity, an expressed preference, and a support arrangement that still needs confirmation.

The same knowledge now informs content, training, and software design without becoming a product catalog.

The recognizable pattern remains: why it matters, the main idea, a demonstration, a chosen next step, questions or connection, and what follows. AI should help carry that design consistently—not make every article or message sound identical.

Clinical instructions and validated instruments require a different discipline. Do not rewrite their essential wording, conditions, or scoring merely to make them fit the template.

And sometimes the useful answer is to create less. A shorter message with a dependable human contact may serve the person better than another complete educational package.

Personalize through what people tell us

Personalized assistance begins with relevant, permissioned knowledge—not a confident guess.

Ask about language, preferred depth, format, culture, beliefs, the people someone wants involved, and what practical support is available. A person may welcome faith-related material, prefer secular guidance, or want neither introduced into this particular discussion.

Do not infer these preferences from a name, address, age, or family role.

The CarePhysics writing guidance explicitly separates cultural humility from demographic assumptions and calls for learning how this person and family want care organized.

An assistant could help adapt a reviewed explanation for a person who requests less detail, a different format, or another language. The appropriate reviewers still check meaning and suitability. Generated translation should not be treated as qualified interpretation for consequential care conversations.

Keep the facts stable while adapting the expression.

Ellen's preferred brief summary should not omit an unresolved concern. Maya's request for more detail should not grant access to information that was not shared with her. Pat's interest in reading should not become a standing assignment to lead.

Purpose comes from the person. Personalization should help them pursue it, not make the organization's preferred action more difficult to decline.

Questions do not keep office hours

A family member may remember a question after the service has closed. They may want to revisit an explanation without feeling embarrassed about asking again.

A properly configured assistant could make approved routine information available around the clock. It could help prepare questions, explain the organization's process, or offer a relevant resource within its defined scope.

That can extend support between conversations. It can also help someone arrive at the next conversation knowing what they want to ask.

Consider Ellen using an approved question-preparation tool:

"Help me explain the evening problem without making it sound as though Pat is the problem."

The assistant might offer:

"By evening, I still have arrangements to finish. I would like us to look at what could happen earlier or be shared, while keeping time for us to enjoy together."

Ellen can change it, reject it, or bring it to Sam in her own words. The draft does not automatically become a message to her children.

Or she might ask why Pat has become tired in the evening. The assistant should not diagnose from the conversation. It can explain that the available information does not establish a cause and help her contact the appropriate professional.

Around-the-clock information is not around-the-clock professional care.

State when people respond, provide the approved route for urgent concerns, and make human help available without requiring a person to persuade the chatbot that their question deserves attention.

If a request is transmitted, report that accurately. Do not say that Sam is handling it until he or the responsible service has accepted it.

The intended outcome is a useful answer or human connection—not a longer conversation with the assistant.

Give the assistant a role people can understand

Before introducing a new assistant, complete an **Assistant Role Card**.

This is an organizational planning tool, not a certification. It makes the proposed job inspectable by the team and understandable to the people affected.

Role-card element	Example: Family Meeting Preparation Assistant
Human purpose	Help people arrive ready to discuss their questions, without reconstructing every record during the meeting.
Authorized users and information	Named staff roles, approved guidance, verified local information, and selected personal material authorized for this purpose.
Permitted work	Retrieve, organize, draft questions, identify missing information, and prepare source-linked summaries.
Review and decisions	Sam reviews support-planning material; Lena confirms Day Center facts; clinical questions go to the relevant clinician.
Action limits	No independent diagnosis, treatment change, capacity judgment, family invitation, disclosure, booking, or declaration that a service occurred.
Privacy and sharing	Exclude information outside the task's permissions. Produce separate versions only when appropriate. Explain storage, access, retention, and any secondary use.
Uncertainty and help	Preserve disagreements, identify unsupported statements, and provide the actual human response route and urgent-care instructions.

Role-card element	Example: Family Meeting Preparation Assistant
Ownership and evaluation	Name the service owner, backup, review date, configuration version, benefit measures, burden checks, and conditions for stopping or redesigning.

A separate family-facing assistant needs its own card. Permission to prepare an internal draft is not permission to answer every family question directly.

The proposed role-card approach follows the book's source specification: define the task, information, permitted output, reviewer, boundaries, and response when something may be wrong.

Explain the role plainly to users. They should know when they are interacting with AI, which organization stands behind the service, and what a person has or has not reviewed.

Make corrections travel through a deliberate process

An error corrected today can help improve tomorrow's work—but only if someone carries the lesson forward.

The team needs to distinguish correcting one record from changing a reusable instruction.

Sam's correction preserves this family's different perspectives. A broader design lesson may be that the assistant needs a clearer rule against converting multiple viewpoints into agreement.

The owner can revise that instruction, prepare suitable test cases, and examine the new behavior. The updated version should be checked against both ordinary examples and cases involving disagreement, missing information, or restricted material.

Keep contributors credited. Record what changed, who approved it, and what happened when it was tested.

Do not automatically turn a family's private exchange into an example for other organizations. A generic or carefully authorized example may communicate the lesson without carrying the private story.

Likewise, "the system learns from feedback" should describe a real mechanism. It might mean revised guidance, changed retrieval, an updated template, a corrected local fact, or a separately governed model-training process. Those are not interchangeable.

The dated Day Center materials propose a register of findings, decisions, changes, and remeasurement—and explicitly say that register is maintained outside the product described there. A promise to learn is not evidence that learning occurred.

Give people the means to provide oversight

An assistant needs an organization around it.

Someone must maintain the sources, review the work, cover absences, respond to questions, investigate errors, and decide whether a task remains appropriate.

Budget for those responsibilities. Include training, language and accessibility review, technical support, security, evaluation, and the cost of corrections—not only model access.

Give reviewers practical training using fictional or otherwise appropriately authorized examples. Include omissions and plausible mistakes, not just obviously wrong answers. Test whether people can find the source and reject the draft.

Do not introduce fabricated errors into actual family records as a staff test.

Agree with technology suppliers on where information goes, who can access it, how long it remains, and whether it may be used for other purposes. Verify those arrangements for the actual workflow rather than assuming that one general privacy statement covers every use.

A more capable model or a changed source collection can change the experience. Recheck affected tasks before treating the updated configuration as equivalent to the previous one.

NIST's AI Risk Management Framework organizes this ongoing work through **Govern, Map, Measure, and Manage**. It is a risk-management framework, not proof that a particular assistant is safe or effective.[71]

The same approach can serve different settings. A health system might begin with clinician-reviewed message drafting. A home-care organization might prepare training from approved procedures. A Day Center might organize meeting questions. A community network might maintain reviewed resource descriptions.

Genus supplies technology. Partners remain responsible for their services, staff, programs, professional decisions, and voice.

AI can help reveal that a resource is missing. It cannot replace unavailable transport, staffing, respite, or clinical care with reassuring prose.

How would we know it helped?

Begin with one defined task and the process used before AI assistance.

For meeting preparation, measure the whole task: selecting information, producing the draft, checking sources, correcting it, and preparing the approved version. Fast generation is only one part.

The Day Center research materials propose five distinct evaluation layers: draft quality, human-review quality, workflow efficiency, family impact, and safety and fairness. A strong result in one does not establish the others.

For an initial local test, use a defined set of appropriately authorized cases and a stated review period. Record the model, instructions, source collection, and workflow version.

Check whether statements are supported, important information is missing, and disagreements survive summarization. Distinguish errors caught during review from errors that remain afterward.

Then ask whether the output helped. Did the family's questions appear accurately? Did the meeting address them? Was the explanation understandable? Did a requested human response actually occur?

Count the effort required from staff and families. A tool may reduce blank-page effort without saving minutes. It may save staff time while transferring work to relatives. Both differences matter.

Examine access and performance across the languages, formats, and situations the service intends to support. Include people who decline AI assistance and keep appropriate human alternatives available.

A high approval rate is not enough. It could reflect good drafts, rushed review, or overreliance. Sample approved outputs and give a named leader authority to pause or narrow a workflow when serious errors, privacy failures, or unacceptable burden appear.

Separate reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact. Willingness to recommend, actual referrals, and services received by referred people remain different questions.

We are not measuring whether the assistant sounds caring.

We are asking whether its use helps people provide and receive better support.

Models and Evidence Behind This Chapter

The following research examines components of the proposed workflow: retrieval, clinical drafting, caregiver assistance, and governance. The population and task in each source define what its results can support.

Source-grounded generation

Give the assistant relevant material to work with

Patrick Lewis and colleagues' 2020 NeurIPS paper combined a language-generation model with retrieval from an external knowledge collection. Across knowledge-intensive language tasks, the system produced improvements over comparison models, including more specific and factual generated language in the tasks studied.[70]

Where we used it: Retrieving relevant guidance and selected records before preparing a draft.

Evidence boundary: These were computational language tasks, not care encounters. The paper does not show that retrieving documents guarantees faithful summaries, correct

citations, privacy, or clinical safety.

Local question: Did the assistant retrieve the right material and use it accurately—not merely include a source label?

A purpose-built caregiver chatbot

Early acceptability is encouraging, but it is not outcome evidence

Sheung-Tak Cheng and Peter H. F. Ng's 2025 **PDC30 Chatbot** study developed an assistant around a dementia-caregiving guidebook and defined behavioral instructions. The researchers compared responses to 21 common questions and then conducted a two-week acceptability study with **21 family caregivers**.

Participants generally rated it favorably for usability and helpfulness. They had been asked to use it at least daily during the trial.[72]

Where we used it: The proposal to combine a defined role with selected caregiving knowledge.

Evidence boundary: The small, short acceptability study did not establish reduced caregiver burden, better clinical outcomes, or lasting benefit. A guidebook's prior evidence does not automatically validate a chatbot using it. The research review informing this book classifies direct caregiver-AI evidence as **Emerging**.

Local question: Is the support understandable and useful, and what remains unanswered or requires a person?

AI-drafted clinical messages

Usefulness and time saved are separate outcomes

Patricia Garcia and colleagues' 2024 study evaluated AI-drafted patient-message replies at Stanford Health Care. The **five-week, single-group quality-improvement study included 162 clinicians**; **73 completed both surveys**.

Mean draft use across clinicians was about **20 percent**. Survey findings suggested reduced perceived task burden and work exhaustion, but measured reading, writing, and reply times did not improve.[73]

Where we used it: Counting review and correction work and examining usefulness separately from speed.

Evidence boundary: There was no randomized control group, follow-up was short, and survey participation was incomplete. This was a particular clinical workflow, not a Day Center trial or evidence about Genus.

Local question: Does the assistance improve the task, reduce effort, save time, or create some combination of benefits and costs?

WHO and NIST guidance

Responsibility remains an ongoing organizational task

WHO's guidance on generative health AI identifies potential uses in administration, education, research, and care while warning about inaccurate outputs, bias, privacy risks, and inappropriate delegation. It recommends defined tasks and involvement of the people affected. NIST's AI RMF and Generative AI Profile provide structures for evaluating and managing risks across the system's use.[1]

Where we used them: The role card, source permissions, review responsibilities, testing, and authority to stop or redesign.

Evidence boundary: These are governance frameworks, not outcome studies or certifications of the proposed assistant.

Local question: Who is responsible when the answer is wrong, the information is inappropriate, or the promised human response does not arrive?

Behavioral and social-learning foundations

Use knowledge to support people's choices

COM-B helps us investigate whether the barrier is understanding, opportunity, motivation, or a combination. Self-Determination Theory keeps choice, capability, and relationships in view. Social Physics directs attention to how useful knowledge travels between people.

The research review informing this book gives these different evidence judgments: strong conceptual support for COM-B, moderate intervention evidence for Self-Determination Theory, and emerging-to-moderate support for the broader Social Physics perspective. These grades do not transfer to an AI application simply because it names the models.

Where we used them: Helping Ellen formulate a chosen question, preserving Pat's perspective, and carrying Lena's reviewed explanation into resources others can use.

Local question: Does the assistance strengthen human understanding and connection—or merely increase interaction with the system?

One thing to try

Choose one repetitive preparation task that your team understands well.

Use fictional or appropriately authorized material to prepare a source packet and an Assistant Role Card. Ask for one draft. Have the responsible person check it against the sources, including what was omitted.

Record what helped, what required correction, and the total effort.

Then complete this sentence:

"The assistant prepares _____ so that _____ can spend more attention on _____."

If the final blank describes only producing more output, reconsider the purpose.

A better question is a beginning

In Context — “That is what I meant”

During the meeting, Ellen looked at the revised summary.

“That is what I meant,” she said. “Not that every evening is bad. There are just things still waiting for me.”

Pat read his part.

“And I would like fewer meetings after supper.”

Sam kept both statements.

They began discussing which arrangements needed attention, what could be shared, and which questions belonged with the clinical team. They did not assign new responsibilities to Maya or Daniel without asking them.

The additional Tuesday remained a matter to verify through the people already responsible. It did not become confirmed because the summary was neatly organized.

Before they finished, Sam asked what had been useful about preparing this way.

“We got to the question,” Ellen said.

Pat looked at the page.

“And I survived being summarized.”

The assistant had helped with preparation. The conversation still belonged to them.

Whether this approach would continue to help—and whether it was worth the work required—needed more than an encouraging moment. It needed careful listening, appropriate measures, and a willingness to change what did not serve people.

That is the final principle.

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CHAPTER 10

Scoring — Learn What Helps

At a Glance

The central idea: Measure whether life became better—not whether people spent more time in the system—and use what people discover to improve the next encounter.

What you'll explore: How to distinguish good design, useful participation, received support, and meaningful outcomes. Learn during a conversation, invite feedback afterward, and examine what changes over time. Recognize solutions contributed by patients, participants, caregivers, volunteers, and frontline teams—not only organizational leaders.

Design and AI: Explore optional real-time assistance that can bring forward an unanswered question, relevant resource, or possible next step. Use AI as a supportive facilitator and preparation tool, not an unquestionable referee or a hidden staff evaluator.

Put it to work: Create a **Benefit–Burden–Safety Measurement Plan** and a **Shared Learning Record** that connect observations and ideas with responsible action, contributor credit, and review.

Evidence and evaluation: Examine quality-improvement frameworks, person-reported outcomes, caregiver research, and an experiment in AI-assisted communication. Retain the **Jack Scale** as a historical and proposed review tool—not a validated clinical assessment.

> *"Ultimately, the secret of quality is love."*
>
> — **Avedis Donabedian, MD, MPH**, healthcare-quality researcher, quoted by Michigan Medicine, July 29, 2016.[74]

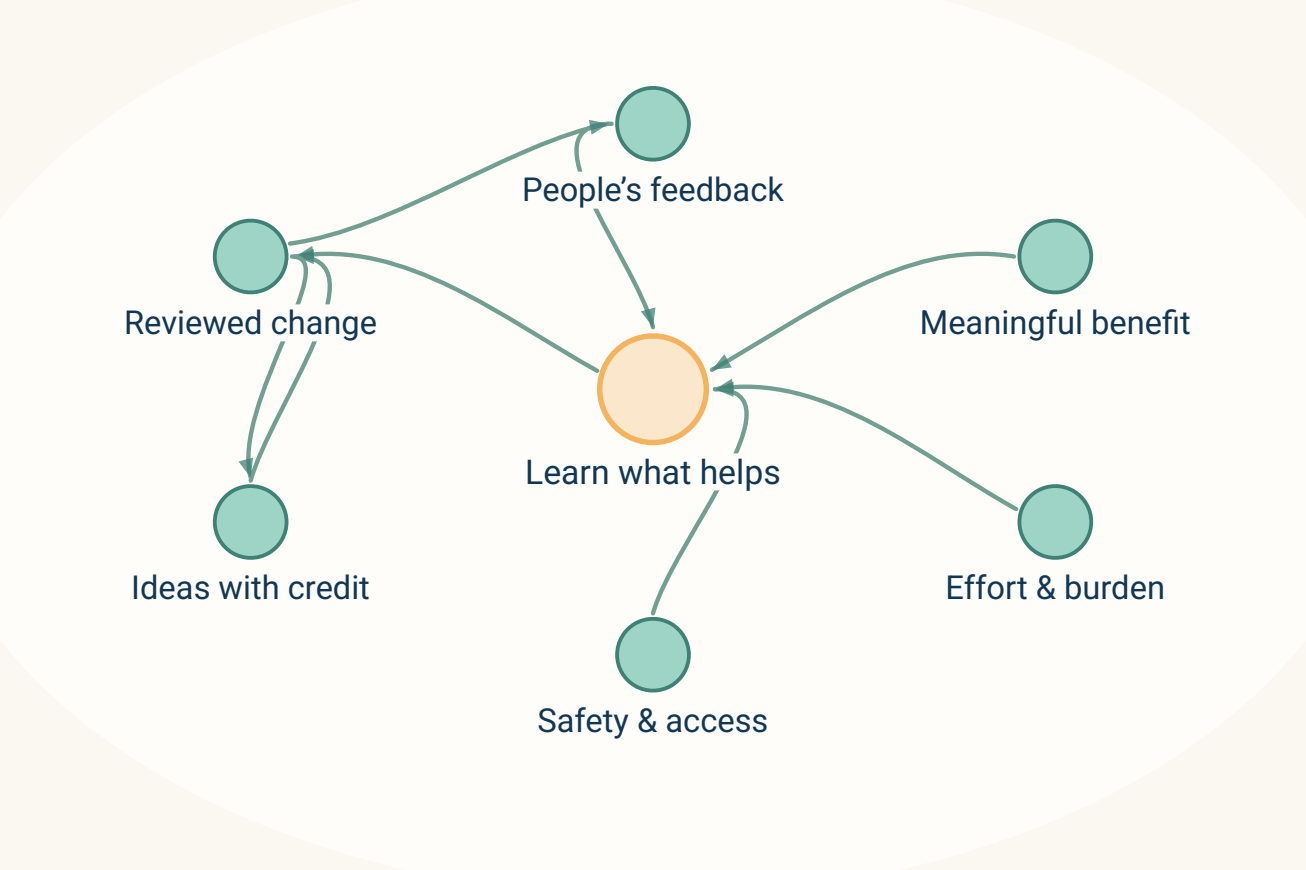


Figure 11 · Learning that gives credit

People's feedback contributes to learning what helps. Examine meaningful benefit rather than treating system activity as the result. Examine the effort and burden alongside any apparent benefit. Examine safety and access, including people who were missed. The learning informs a reviewed change to try. Ideas inform the reviewed change with contributor credit attached. After a change, ask people again what helped and what should change. Tell contributors what happened to their ideas and let them choose how they are credited. A change is not automatically caused by the intervention. The historical/proposed Jack Scale is not a validated clinical assessment.

Notice and contribute	Review and return
People receiving and providing care	Ask what helped, what was difficult, and what should change. Preserve different accounts.
Responsible reviewer	Agree a proportionate change, check benefit and burden, and keep unsuccessful findings.
Contributors	Hear what happened to their suggestion; choose how they are credited. No hidden rankings.

In Context — What made the week better?

Toward the end of their review conversation, Sam asked Pat and Ellen a question that was not about the next appointment.

“What has been most useful?”

Ellen looked at the summary.

“Knowing what is actually arranged.”

“What difference does that make?”

“On a Thursday when everything happens as agreed, I can make a plan of my own. I’m not spending the morning checking whether someone is still coming or whether the day is confirmed.”

“And the messages?” Sam asked.

“Some are helpful. But more messages wouldn’t make Thursday more dependable.”

Pat had a different answer.

“The reading group. And the people at that table.”

“Is there anything you would change?”

“The activity afterward can get too busy. I’d rather do something quieter.”

Sam wrote that down separately.

“Does that mean you don’t want to go?”

“No. It means I like one thing and would change another.”

Ellen nodded.

“That’s how I feel about some of the information. I appreciate having it. I don’t need all of it every week.”

The service could be valuable while part of it needed adjustment. Information could be useful without more of it being better.

“What happens to what we’ve said?” Ellen asked.

“That is the important next question,” Sam replied.

They had offered more than feedback for a report.

They were helping design the support.

Scoring is a way to learn, not a verdict on people

The first nine principles have brought us from understanding a person to designing encounters, connecting pathways, improving access, and using AI with a defined

purpose.

The tenth asks whether that work helped—and how to make it better.

The original CarePhysics Scoring principle examines content, communication, access, coordination, and outcomes. It also calls for feedback to influence future design. This edition retains that purpose while distinguishing a reviewer's judgment, a person's experience, and evidence of an outcome.

Measure whether life became better, not whether people spent more time in the system.

Scoring does not require putting a number on every encounter. It means being clear about what we hoped to improve, what information could help us judge it, and what we will do with the answer.

Some measures are counts: requests answered, services received, or minutes required to complete a task. Others concern experience: whether someone felt heard, enjoyed an activity, or could use the time that support provided. Stronger claims about health, strain, quality of life, or financial value require an appropriate evaluation.

The person receiving care is not the object being graded.

Nor are the family's love and the staff's commitment things to infer from their activity records.

We are evaluating the support.

Learning belongs to everyone involved

Learning should not travel in only one direction—from an organization to the people it serves.

A clinician may find a clearer explanation. A patient may identify why an instruction will not work at home. A participant may suggest a better time to offer an activity. A caregiver may reveal where an arrangement creates unnecessary work. A volunteer may discover a more welcoming way to introduce someone.

Each contribution can help the next encounter.

The Day Center source materials reflect this approach: participants, families, care teams, social workers, volunteers, pilots, and focus groups contribute to the questions and designs being developed. Their experience is not merely a reaction collected after the software is finished.

For CarePhysics, that creates three connected opportunities.

During the encounter, notice whether something needs clarification or whether a useful option has emerged.

Immediately afterward, invite the people involved to describe what helped, what was difficult, and what they would change.

Over time, examine whether the chosen changes improve the experience, reduce burden, or contribute to the intended outcomes.

AI can assist at each point. The people remain the sources of lived experience, the interpreters of important differences, and the owners of decisions.

The aim is not simply to learn faster.

It is to make more of what people know available to one another.

Name what the number actually represents

The word *engagement* can conceal several different events. Keep the distinctions visible rather than combining everything into one activity score. The research review informing this book separates reach, understanding, first action, adoption, useful participation, outcomes, burden, equity, and safety.

What we are examining	The question	What would not establish it
Design quality	Is the material accurate, relevant, accessible, and ready to try?	A polished appearance or favorable internal rating alone
Reach	Did the intended person have a reasonable opportunity to encounter it?	Counting messages prepared rather than delivered
Understanding	Can the person explain the relevant idea, choice, or next step?	Opening an article or finishing a video
First meaningful action	Did the person take a useful step they chose?	Registration with no useful task completed
Adoption	Did they begin using the relevant service or support?	A request that has not led to use
Ongoing useful participation	Does participation remain worthwhile and appropriate?	Repeated logins, attendance, or a maintained streak alone
Experience	Did the person feel respected, heard, and able to influence what happened?	Staff or AI assuming the experience was positive
Outcome	Did something important change, such as strain, function, confidence, or quality of life?	A completed process without examining the intended change

What we are examining	The question	What would not establish it
Attributable impact	How much of that change can credibly be attributed to the intervention?	A favorable before-and-after difference without considering other explanations

These are not compulsory stages everyone must complete.

A person may understand an option and reasonably decline it. A caregiver may stop using a tool because the immediate need has been resolved.

For Pat's family, the reading guide was offered. They chose to try it. They described what they enjoyed and what was confusing.

That gives the team information about use and experience. It does not establish improved cognition or a benefit caused by the technology.

The distinction does not diminish a pleasant evening. It keeps the claim faithful to what happened.

Measure progress through the pathway—not speed alone

A constraint-focused project needs to know whether the whole pathway improved. Keep operational measures alongside outcomes and balancing measures that examine unintended consequences. IHI recommends this combination; it is not a new CarePhysics score.[75]

Record time to the first substantive response, time to a confirmed arrangement, and time to the service itself as different intervals. These are lead-time measures. A service delivery rate counts defined services actually delivered per week or another stated period. It is not the same quantity as days of waiting, and it is not TOC's financial throughput-accounting measure.

Keep unresolved demand visible: how many requests remain open, how long they have been open, their stage, known reason, and responsible responder. Report completed-case waiting times alongside the age of open requests. Otherwise, those waiting longest disappear from the apparent improvement. An automatic acknowledgment is not necessarily a substantive answer.

Choose units and denominators before comparing results. Preserve clinically appropriate priority, count missing outcomes, and examine language and access differences without guessing identities. Do not improve a queue statistic by deleting requests, moving work to families, or selecting only easier cases. Necessary conversations should not be rushed to meet a rate target. See Appendix F6 for local definitions and an arithmetic example.

Learn while the conversation can still change

A question does not have to wait for the next evaluation report to be answered.

With appropriate agreement, a configured assistant could help identify an unanswered question, an unfamiliar term someone has asked about, or a proposed next step without an accepted owner. It could bring forward a relevant approved resource or suggest a clarification for the facilitator to consider.

The dated Genus Coach description includes consented real-time transcription and timely suggestions, while explicitly making family-facing use dependent on deployment and configuration. That is a documented capability description—not evidence that every conversation is accurately assessed or improved.

A useful suggestion might read:

Possible clarification: Ellen asked who will contact her if the arrangement changes. That responsibility has not yet been confirmed in this conversation.

Or:

Relevant resource: The center's approved guide explains the introductory options being discussed. Check that the version and arrangements are current before using it.

The facilitator decides whether to use the suggestion. It should be easy to dismiss, and it should not interrupt every pause.

This allows us to examine specific parts of a conversation while it is happening. Was a question raised? Was an answer offered? Was an action accepted? Does the person say the explanation helped?

Those are different from an assistant declaring that someone is reassured, confused, resistant, or trusting.

Do not treat facial expression, tone, silence, or speaking time as an authoritative measure of private feelings or comprehension. In this proposed approach, explicit statements and confirmed actions carry more weight than inferred emotional labels.

A transcript can also contain errors. People must be able to correct the record.

Real-time assistance can identify a moment worth checking. The people involved establish what that moment means.

Bring a possible solution forward without taking credit for it

> In Context — The useful idea comes from Pat
>
> *In this proposed version of the review, everyone has agreed to limited live assistance after Sam explains what it processes, who sees its suggestions, and how it can be paused. The meeting can proceed without it.*
>
> Sam and Lena were discussing Pat's request for a quieter afternoon option.
>
> "We can review the activity schedule," Lena said.
>
> Pat looked at her.

In Context — The useful idea comes from Pat

“Could you tell me the choices before lunch?”

“Would that help?”

“Yes. Sometimes people ask me what I want when I’ve already had enough of deciding.”

The assistant brought forward a brief reminder for Sam:

Pat’s proposal: Explain the actual afternoon choices earlier. Confirm the preference before moving to other arrangements.

Sam did not describe it as the assistant’s discovery.

“Pat, you’re suggesting that the timing matters—not only which activities are available.”

“Exactly.”

The assistant also located the center’s reviewed activity-options guide. Lena checked what it said against the arrangements her team could actually provide.

“We could try discussing the available choices earlier on the days you attend,” she said. “I need to check with the team how we would do that consistently.”

“And I can still change my mind?”

“Yes.”

“Then we have a promising proposal.”

The assistant could help record the suggestion and prepare the follow-up. It could not promise staffing, invent an activity, or decide that the change had worked before anyone tried it.

The useful idea came from Pat.

Lena accepted responsibility for checking feasibility.

A later conversation would establish what happened.

Ask everyone what helped

After an encounter, offer a brief opportunity to reflect while the experience is still fresh.

A patient, participant, caregiver, clinician, staff member, or volunteer may notice something the others missed.

A proposed invitation could say:

Help us improve the next conversation

You can tell us what helped, what was difficult, or what remained unanswered. Positive and critical responses are equally useful.

What should we keep?
What should we change or try?

You may answer now, respond later, speak with a person, or skip the questions. Before you respond, we will explain who receives your feedback and how to request a reply.

The organization must supply the actual recipient, response arrangements, and privacy information. These are local improvement questions, not a validated questionnaire.

An assistant could help someone organize a spoken or written answer, where that format is supported and agreed. The person should be able to check what will be shared and change wording that does not sound like them.

Do not automatically send every response to everyone who attended.

A caregiver may need a private route. A volunteer may want help reflecting on their own communication. A patient may prefer to raise a concern with someone other than the professional involved.

Staff can also be offered private, optional practice: “Help me explain this more clearly next time.” That should not quietly become a manager’s performance report.

Keep differing accounts visible. “The clinician believed the plan was clear” and “the patient remained unsure whom to call” should lead to a better explanation, not a contest over whose rating is correct.

A supportive third party, not an unquestionable referee

AI may offer another place to prepare a concern or suggest an improvement. Whether people find that more comfortable than speaking directly is something to ask—not assume.

The appropriate aspiration is **a nonjudgmental facilitator designed to treat perspectives fairly**, not an inherently neutral judge.

AI systems can produce inaccurate, biased, or incomplete statements and encourage inappropriate reliance. WHO’s guidance emphasizes defined tasks, stakeholder participation, transparent responsibility, and continuing assessment.[1]

For this application, the assistant should neither defend the organization nor automatically agree with the speaker.

It could help a caregiver say:

“I appreciate the support. I still do not know who will call if the plan changes.”

It should not convert that concern into “The organization is failing you” or “You should

be grateful.”

The service should explain who configures the assistant and who can access the feedback. An organization-operated channel must not present itself as an independent complaints authority.

When conflict, safety, or professional judgment requires a person, provide an appropriate human route. Agreement among several relatives does not make Pat’s preference disappear. A favorable average does not cancel a serious concern.

Fairness requires a process people can question.

Capture wins with context and credit

A learning system should notice what went well as well as what failed.

A participant finds a comfortable way to contribute. A patient suggests a clearer preparation checklist. A caregiver identifies a better time for an update. A volunteer demonstrates how to use a shared screen without taking over. A staff member finds words that make a difficult explanation easier to discuss.

These moments can be recognized without claiming more than they establish.

“Capture a win” should mean preserving what was useful, who contributed, and the conditions under which it helped—not collecting only flattering stories.

The dated Day Center materials describe Team Pulse as a place for wins and observations, alongside family feedback and editable updates. The description supports a contribution-and-review workflow; it does not establish that every contribution leads to improvement.

A **Shared Learning Record** can be short:

What needed attention: Pat wanted a quieter option after the reading group.
Who contributed the idea: Pat suggested discussing choices earlier.
What will be tried: Lena checks a workable arrangement with the team and Pat.
What will be reviewed: Pat’s experience, whether the choices were genuinely available, and the work required.
What may be shared: A general lesson, with permission and without unnecessary private details.

The record develops as the work happens. It should distinguish an idea from a trial, a reported benefit from a repeated finding, and a local result from evidence that applies elsewhere.

Contributor credit is itself a choice. Ask how someone wants to be acknowledged. A participant should not have to disclose a diagnosis or personal story to receive recognition.

And keep the result that did not improve. Otherwise the collection becomes promotion rather than learning.

Let the learning change the design

Feedback should be able to change a video, article, survey, message, conversation, or pathway.

The reading guide already offers an example. Ellen initially thought the optional prompts were instructions. That observation could lead the team to separate suggestions from the story and make their optional nature more visible.

Pat's suggestion concerns timing. The next improvement may be a conversation earlier in the day rather than a new piece of content.

In a separate illustrative example, a volunteer notices that families cannot easily tell which door to use. The answer might be an accurate arrival photograph, a revised message, or someone meeting visitors—not a longer welcome booklet.

Use the familiar design functions: purpose, main idea, demonstration, chosen next step, questions or connection, and what follows. Preserve recognizable structure while adapting the language, examples, format, and assistance.

Ask how culture, beliefs, resources, and local circumstances affect the experience. Do not assume one community's response identifies the right design for every other community.

Clinical instructions and validated questionnaires retain their required meaning, wording, and scoring. Clarity can be added around them without casually rewriting the instrument.

The learning cycle is practical:

Notice → ask → consider options → try a chosen change → hear from those involved → review → share appropriately → check again.

Each transition needs responsibility.

Feedback submitted is not feedback considered. A proposed solution is not a change implemented. A revised article is not evidence that the next reader understood it.

The Jack Scale: preserve the question behind the number

The **Jack Scale** belongs to the history of CarePhysics.

The framework's history credits Jack Gleason with proposing a scale from **−5 to +5**, with **zero as neutral**, to recognize that an experience may detract from its purpose as well as contribute to it.

Its underlying question remains useful:

Did this experience help, do little, or make things harder?

The Jack Scale remains a historical and proposed review tool. Clinical validation or reliable outcome prediction has not been established in the sources reviewed for this book.

An organization choosing to use it should define the specific item and what its ratings mean. Keep the reason and evidence beside the number.

“Reviewer judged the next step unclear” is useful.

“Family engagement is −2” conceals too much.

A team can record what it expects a redesigned item to improve, then compare that expectation with actual experience. Do not revise the original prediction afterward to make the design appear more successful.

Zero must not mean “we have no information.” Missing, declined, not applicable, and not yet reviewed need separate labels.

Avoid false precision. Neighboring ratings may be difficult to distinguish. Reviewer disagreement may reveal an unclear standard or differing assumptions about the audience.

A favorable total also cannot cancel a serious problem. An attractive video with an incorrect safety instruction is not ready because its other ratings are high.

Use the scale to support discussion where useful. Do not use it to rank families, infer staff compassion, determine eligibility, or claim clinical benefit.

Choose measures that can change a decision

Start with the difference the support is intended to make.

For Ellen, that may be dependable time she can use without continuing to coordinate care. For Pat, it may be a worthwhile day with choices. For staff, it may be an accurate update that does not require after-hours reconstruction.

IHI recommends examining **outcome measures**, **process measures**, and **balancing measures**. Balancing measures ask whether an improvement in one area creates problems elsewhere.[75]

For live conversation assistance, a process measure might examine whether a question received a response. The experience measure asks whether the person found the response useful. A balancing measure examines distraction, review effort, or discomfort about being recorded.

For a family update, timely delivery matters. So do accuracy, understanding, and the work required to prepare it.

A shorter interaction is not necessarily better. A useful conversation may take longer. More questions may indicate confusion—or greater willingness to speak.

Interpret the measure through the purpose, not through a general preference for higher or lower numbers.

A local question can be sufficient for improving tomorrow’s activity. A claim of reduced caregiver strain requires a more systematic approach and appropriate measurement.

When using a standardized instrument, verify the construct, respondent, setting,

language version, permissions, recall period, scoring, and interpretation. An AI rewrite does not automatically preserve its measurement properties.

An intake baseline can help begin a conversation. Repeating a measure requires an agreed process and suitable interpretation; the initial score alone cannot establish change. Appendix J preserves the dated local-intake example.

Private caregiver concerns also need an appropriate confidential route. Do not collect sensitive answers in a shared family record and rely on wording alone to prevent disclosure.

An assessment needs a response and a return point

RUSH's Caring for Caregivers (C4C) model is one public example of assessing the caregiver's own needs and returning to them over time. Its published description names caregiver-burden, anxiety, depression, health-literacy, and social-needs measures. Those measures are not interchangeable with the local four-item intake described above.[76]

For a local evaluation, name the instrument, version, language, respondent, baseline event, and follow-up dates. Enrollment, the first assessment, and completion of a support program are different starting points. Compare the same intended construct while recording any changes in the tool or delivery.

Our proposed process permits a person to decline a nonmandatory question or choose a private conversation. Record declined, not asked, and missing separately; none means zero strain. Follow the instrument's rules for incomplete responses rather than silently changing its score.

Before asking sensitive questions, establish the authorized reviewer, response time, private record, and professional escalation route. A concern requiring prompt attention must not wait for the next scheduled measurement. Appendix F turns these requirements into a planning card.

Keep missing people and different perspectives in view

Ask the person directly where they can express the relevant experience, with appropriate assistance. Label caregiver or other proxy accounts separately. Staff observations should remain observations.

A person can sit through an activity without feeling that they belong. A caregiver can appreciate a service and still find the arrangements exhausting.

Consider an **invented reporting example**: a center invites 20 households to provide feedback. Twelve respond, and nine say the guide was useful.

"Seventy-five percent of responding households found it useful" describes nine of twelve.

"Seventy-five percent of families benefited" does not.

Eight households have not provided feedback. The other three responses also need understanding. Silence is not satisfaction, and missing information is not zero.

Define the denominator—the group a percentage describes—and the unit being counted. People, households, encounters, requests, and service days are not interchangeable. Several answers from one household are not several independent households.

Offer appropriate languages, formats, times, and assistance. Include people who decline digital or AI participation. Do not infer cultural preferences or demographic characteristics from names, addresses, or communication style.

The export explicitly states that its described intake lacks demographic fields needed for some proposed group comparisons. That limits what can be concluded from those records alone.

Differences among communities may reflect resources, care needs, transport, service capacity, or access—not simply the quality of staff effort.

Distinguish a change from its cause

A family reporting less strain is important. It does not, by itself, establish what caused the change.

During the same period, relatives may have accepted responsibilities, clinical care may have changed, or the household may be going through a different stage of need.

Match the comparison to the claim.

To examine whether an evening note adds value, compare communication approaches while considering the underlying service. To examine live AI support, compare the relevant encounter process, including preparation, review, and follow-up—not an assisted meeting against an unrelated experience.

Deterioration does not automatically mean that care failed. Comfort, choice, practical support, and family capacity can matter while an illness progresses. Stability alone also cannot prove that a program prevented decline.

Use research expertise and an appropriate comparison when stronger causal claims are intended. Report uncertainty and results that are too imprecise to support a conclusion.

A familiar theory can explain why an approach is worth trying. It cannot supply the missing outcome evidence.

Nine outcome areas, not nine promised results

CarePhysics identifies nine outcome areas. Retain them as questions to examine, not a promise that every application improves all nine.

Original outcome area	A question for evaluation
Improved Culture of Care	Can people raise concerns, contribute ideas, and see respectful responses?

Original outcome area	A question for evaluation
Integration of SDOH	Do social needs, such as transport or affordability, lead to practical assistance?
Care Equity	Who can reach and benefit from support, and who remains excluded?
Community Connections	Do introductions become appropriate services or useful relationships?
Stronger Relationships	Are communication, commitments, and opportunities for disagreement improving?
Improved Quality of Life	Does something important in the person's life improve?
Reduced Burnout	What happens to staff workload and well-being —and separately to caregiver strain?
Improved Outcomes	Do relevant health, function, safety, or care outcomes change under an appropriate evaluation?
Improved Bottom Line	Is the service sustainable after implementation, staffing, review, and other costs?

Choose the areas relevant to the project. Do not administer every possible questionnaire merely to fill the table.

Keep financial perspectives separate. A saving for an organization may shift work or expense to a family. Better documentation may support a funding application without guaranteeing payment.

Keep **willingness to recommend**, **an actual referral**, and **a referred person receiving useful support** separate too.

Recognition should reward contribution, not favorable answers. Negative feedback deserves the same opportunity to influence the work. Points or participation totals must not become family leaderboards, care-quality ratings, or promised funding.

Build a Benefit–Burden–Safety Measurement Plan

Begin with one decision and one manageable process.

For example, an organization could test whether optional live assistance and brief post-meeting feedback help people leave a review conversation with their concerns represented and responsibilities clear.

Start with appropriately authorized practice cases. Then, where the organization approves a real-world test, establish a baseline and a defined review period. A two-week baseline followed by a four-week improvement test is an illustrative planning option—not a design sufficient to establish long-term clinical effectiveness.

Record the population, source materials, configuration, pathway version, reviewer, and authority to change or stop the process.

What to examine	Measure and source	Responsibility and possible action
Questions and responsibilities	In a reviewed sample, questions with an answer or accepted follow-up owner divided by questions identified. Record what remains unresolved.	The facilitator checks the record and repairs missed follow-through.
Experience and choice	Optional feedback on being heard, ability to disagree, usefulness of assistance, and preference for future encounters. Report invitations, responses, and declines.	The service lead reviews differences and changes the offer or format.
Ideas becoming improvements	Accepted improvement actions completed by their review date divided by those due; retain suggestions still awaiting a decision.	A named improvement owner records the action and returns an answer to the contributor.
Meaningful benefit	A suitable measure of the project's intended result, such as understanding, usable caregiver time, or participant experience.	The relevant professional interprets findings within their role and adjusts support.
Burden and access	Preparation, encounter, review, correction, and follow-up time; distraction and access difficulties across available routes.	The operational lead revises staffing, training, prompts, or workflow.
Safety and accuracy	Unsupported suggestions, misattributed statements, privacy errors, missed escalation, and incorrect service information.	The designated safety and service owners act promptly; serious concerns do not wait for a scheduled review.

For conversational signals, the assistant's count should not establish its own accuracy. Compare a sample with appropriate human review. Examine both misleading prompts and important matters the assistant missed.

Count the whole task. Faster drafting may be offset by checking and correction. A benefit to the team may shift work to the family.

Set review criteria in advance. A serious privacy failure is not balanced away by favorable satisfaction responses.

Let AI assist the learning without inventing it

An assistant could help organize permissioned feedback, identify missing definitions, retrieve relevant guidance, or prepare a draft improvement report.

Its assignment should make the distinctions explicit:

Using the approved definitions and authorized records, summarize what was offered, what people experienced, and what changed. Preserve disagreements and negative findings. Show denominators and missing information. Credit contributors according to their permissions. Separate proposed solutions, actions completed, and outcomes. Identify what cannot be established.

Use checked calculations and reconciled records for numerical reporting. Fluent prose does not verify arithmetic or data selection.

The dated Day Center record distinguishes booked from attended days, does not capture family-guide completion, and has no separate referral-date field on the adult day intake. An assistant must preserve those limits rather than generate the report someone hoped the records could support.

Reviewed research and design guidance can help the team develop possible responses. Current local information establishes which resources actually exist. Personal context shapes a response only within its permissions.

Keep those sources distinct, with owners, review dates, approved uses, and corrections. A correction may lead to a revised instruction, template, source entry, or workflow; it does not automatically retrain a model. The knowledge-bank companion remains a proposed way to organize this work.

Properly applied, AI can reduce repetitive assembly, capture useful experience, and give people more attention for interpretation and action.

It should not infer a hidden score of love, cooperation, kindness, or entitlement to help.

Give the organization the capacity to learn

A supportive learning process needs time, trust, and authority.

Explain what live assistance captures, what is retained, who sees suggestions, and which feedback remains private. Separate permission for the current encounter from permission to reuse a story or example. Allow people to decline or pause assistance and

retain appropriate human, telephone, paper, and accessible-language routes.

Do not promise anonymity when responses are identifiable. Explain any relevant limits on confidentiality and required safety reporting.

Practice with fictional or appropriately authorized material. Include mistakes and omissions in a training environment; do not seed false statements into real care records to test staff.

Provide time for review, technical support, interpretation, training, and responding to concerns. An invitation to contribute creates work for someone who must listen and act.

AI may make routine information or question preparation available around the clock. That is not continuous professional coverage. State actual human response hours and the appropriate urgent routes.

Let staff help shape the process. Use their ideas to improve workflow rather than interpreting every difficulty as a performance problem. Clinical accountability remains; undisclosed scoring of compassion is not a substitute for it.

The same principles apply in health systems, home care, independent living, and community programs. A patient may improve a procedure-preparation explanation; a volunteer may improve a welcome; a caregiver may identify a broken handoff. Their contributions need review appropriate to the task, not dismissal because they came from outside the professional team.

At community and state levels, share definitions and lessons without exposing private stories or ranking unlike populations. Relationships and better messages cannot replace unavailable services.

Genus supplies technology. Partners retain responsibility for care, staffing, programs, professional decisions, and follow-through.

Make the learning visible

Return to the contributor.

“You suggested this. We tried it. Here is what happened.”

Where the idea cannot be implemented, explain the reason and any alternative. Where it did not help, keep that result.

The dated export proposes a register containing the finding, decision, responsible person, actual change, date, and remeasurement. It explicitly says that this register is maintained outside the described product. A commitment to learn is not evidence that learning happened.

A learning record should therefore be able to show a decision to continue, adjust, narrow, stop, or make no change.

Sometimes the most useful improvement is removing a field, reducing a message, or restoring a conversation with a person.

The measure earns its place when it helps someone make a better decision.

Models and Evidence Behind This Chapter

The chapter combines the original measurement framework with the proposed real-time and post-engagement learning approach. The sources below support different parts of that design; none validates the complete CarePhysics application.

Donabedian's framework and improvement measures

Examine conditions, processes, and results

Donabedian's 1966 paper, reprinted in 2005, distinguishes the structure of care, the processes through which it is provided, and outcomes. It also warns against assuming that the relationships among them are established. This is methodological work, not an intervention trial.[77]

IHI's guidance complements that perspective with outcome, process, and balancing measures and repeated review over time.[75]

Where we used it: A conversation completed, a question resolved, a caregiver's experience, and staff workload receive different measures.

Local question: Did the process produce the intended value without unacceptable consequences elsewhere?

AI-assisted conversational feedback

Assistance can be useful before a response is finished

Ashish Sharma and colleagues' 2023 randomized study tested **HAILEY** with **300 peer supporters** from TalkLife. The system offered just-in-time feedback while supporters prepared written replies. The authors reported a **19.6 percent increase on their measure of conversational empathy** overall.[78]

Where we used it: The proposal to offer limited suggestions while a person still controls the response.

Evidence boundary: This was a nonclinical, text-based study—not a trial of spoken dementia-care meetings or Genus. A higher score for empathic language does not establish improved clinical outcomes, reliable emotion detection, or impartial mediation.

Local question: Does the assistance help people respond usefully while preserving their judgment and attention?

Person-reported measures

A questionnaire works through a relationship

Joanne Greenhalgh and colleagues' 2018 realist synthesis examined how patient-reported outcome measures influence communication and care. The wider synthesis included **46 papers**, with **42 informing the article**.

Measures could help people reflect and raise concerns, but could also constrain

conversation depending on their use and the response they received. The review explains mechanisms and context rather than providing one pooled effect size.[79]

Where we used it: Immediate feedback leads into dialogue and action rather than replacing them.

Local question: Did asking the question give the person a useful voice?

Caregiver outcomes

Measure the support people are meant to receive

Steven Zarit and colleagues' Daily Stress and Health study followed **173 family caregivers of people with dementia over eight consecutive days**. Caregivers reported fewer care-related stressors and more positive experiences on adult-day-service days, alongside more noncare stressors. It was a within-person observational study, not randomized attendance.[43]

Laura Gitlin and colleagues' ADS Plus trial involved **203 caregivers across 34 sites**, randomized by site to usual services or services with structured caregiver support. Adjusted depression scores were lower in the added-support group at 12 months. **22.7 percent** were lost to follow-up, the sample was predominantly female and college educated, and the attendance comparison did not meet the conventional statistical-significance threshold.[44]

Where we used them: Caregiver experience and well-being are examined separately from service activity.

Evidence boundary: Neither study establishes an effect of AI assistance, a family summary, or this proposed measurement process.

Person-centered measurement in Day Centers

Presence is not the same as belonging

Clara Scher and colleagues' 2025 e-Delphi study involved **22 practitioners and researchers** reviewing candidate measures. The panel reached consensus on selected measures of meaning and purpose, friendship, and belonging, but not on a single engagement measure.

This was expert-consensus work, not real-world validation of every selected instrument or evidence that Day Centers improve those outcomes.[45]

Where we used it: Pat's preferences and experience remain distinct from attendance.

Local question: Can the organization learn what matters without making measurement another burden?

Behavioral models, social learning, and responsible AI

Let findings change the response

COM-B helps investigate barriers. Self-Determination Theory directs attention to chosen

participation. Social Physics offers a perspective on how useful knowledge travels through relationships.

The research review informing this book distinguishes their evidence: strong conceptual support for COM-B, moderate intervention evidence for Self-Determination Theory, and emerging-to-moderate support for the broader Social Physics perspective. Those judgments do not transfer automatically to a scoring system or live assistant.

WHO's guidance adds requirements for defined tasks, stakeholder involvement, privacy, and protection against overreliance. It is governance guidance, not proof of effectiveness.[1]

Local question: Does the learning process strengthen people's agency and the support around them—or merely increase what the organization can count?

One thing to try

Choose one encounter your organization offers regularly.

Ask a person receiving support and a person providing it what helped, what was difficult, and what they would change. Offer separate responses and appropriate privacy.

Select one contribution, name an owner, and try a manageable change. An approved assistant may help organize the information or prepare options; people decide what to use.

Then return to the contributors and examine what happened.

Alongside that exercise, take one success measure you already report and ask:

What important human outcome could become worse while this number improves?

Add the question or measure that would help you see it.

Ten principles become an ongoing practice

> **In Context — "Ask me again"**
>
> Before the meeting ended, Sam read back the actions—not an overall score.
>
> Lena would check how to discuss afternoon choices earlier with Pat. The team would continue reviewing the reading guide so optional prompts looked optional. Ellen's support questions would remain part of the ongoing conversation, with private concerns handled through the appropriate route.
>
> The additional Tuesday had no new confirmed resolution. It remained an open need.
>
> "How will we know whether the afternoon change helped?" Sam asked Pat.

> **In Context — “Ask me again”**
>
> “Ask me again.”
>
> “And if it doesn’t?”
>
> “I’ll probably mention it.”
>
> Ellen smiled.
>
> “That is dependable.”
>
> Lena asked whether Pat was comfortable with the team using his suggestion as a general example.
>
> “As long as you say it’s a suggestion,” he replied. “I haven’t inspected the results.”
>
> They had not solved every problem.
>
> They had made one improvement specific enough to try, preserved the name of the person who proposed it, and agreed to find out whether it helped.
>
> The tenth principle turns CarePhysics into an ongoing practice of listening, contributing, trying, checking, and changing. The next five chapters apply these ten principles to the people and organizations doing the caring.

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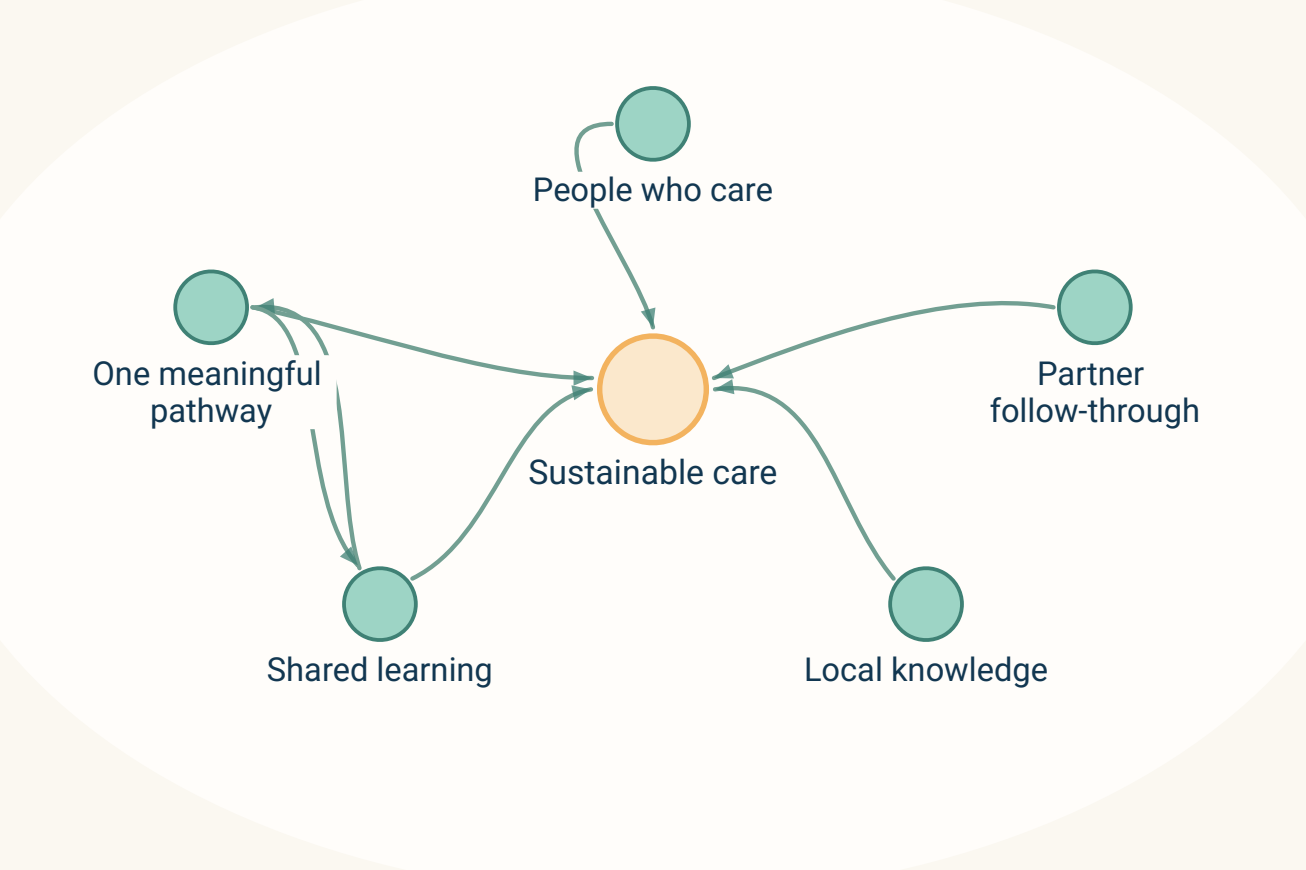
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PART III — Better Care, Learning Together



Connection map — Put the ten principles to work together

Supporting the people who care is part of making care sustainable. Partner follow-through requires understood commitments behind sustainable support. Local knowledge helps adapt shared principles to the setting. Shared learning helps people and organizations examine their support. One meaningful pathway gives the work a manageable place to begin. Shared learning informs what to try in the pathway. Experience from the pathway returns to the shared learning. These five chapters apply the ten principles; they are not five additional principles.

A useful framework has to survive an ordinary week.

The appointment changes. A family member's work schedule becomes difficult. A staff member needs help with a task they have not performed before. A volunteer notices something worth sharing. Someone receiving care wants a different choice.

The ten CarePhysics principles give us ways to understand and respond to these situations. The next five chapters bring them together.

These are **applications of the ten principles, not additional principles**. We will examine how to support the people who care, build community relationships that follow through, adapt shared knowledge to local circumstances, learn across organizations, and begin with one meaningful pathway.

The focus moves from what makes an individual encounter useful to what makes good care sustainable.

That requires more than clear messages. Families need practical support. Staff need time, training, workable processes, and appropriate coverage. Volunteers need roles they can carry confidently. Organizations need resources and partners whose commitments are understood.

Design remains central. An invitation to ask for help should lead to a person who can respond. Training should prepare someone for a real task. A family plan should reduce uncertainty rather than give one person another document to maintain.

AI can assist with preparation, explanation, practice, and learning. With appropriate knowledge and rules, it can help carry useful experience forward. The people and organizations still need to provide the care behind the words.

We begin with a question that should appear in every support plan:

Who is supporting the people on whom this plan depends?

CHAPTER 11

Support the People Who Care

At a Glance

The central idea: A care plan that depends on one exhausted person carrying everything is not a strong care plan.

What you'll explore: How respite, shared responsibilities, practical training, and future planning can support families without transferring the hidden work to someone else. Follow Ellen as dependable help makes room for her own life, while Pat remains involved in decisions. Examine what staff and volunteers need to provide that support sustainably.

Design and AI: Create clear invitations, realistic commitments, task-specific demonstrations, and accessible routes to questions. Explore how an approved AI assistant could prepare options, help people practice, and organize reviewed information—without assigning responsibilities, inferring distress, or replacing human care.

Put it to work: Build a **Shared-Care and Backup Plan** for the family and a separate **Staff and Volunteer Support Plan**.

Evidence and evaluation: Examine adult day services, structured caregiver support, implementation research, and workforce evidence. Measure usable relief, sustainable responsibilities, confidence, access, and total workload—not merely services booked, materials delivered, or training completed. RUSH C4C adds a publicly documented caregiver-support workflow; its reported observations are not treated as causal outcomes.

> *"We know how to support families caring for an older adult. But that knowledge is not easily accessible to the families who need it."*
>
> — **Laura N. Gitlin, PhD**, caregiving researcher, in *NIH News in Health*, December 2017.[80]

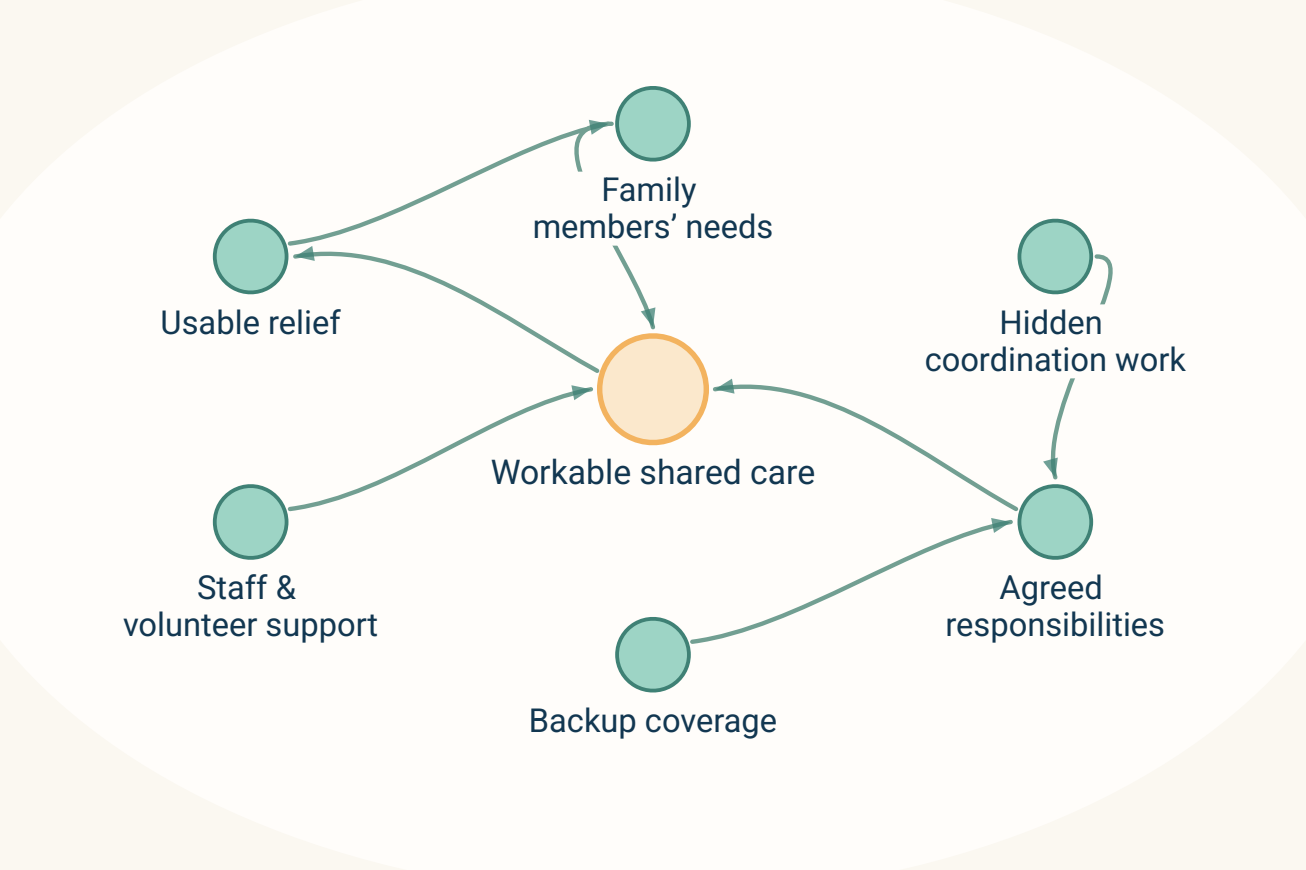


Figure 12 · Support includes the work around care

Listen to family members' separate needs when planning workable shared care. Include the hidden preparation, travel and coordination in agreed responsibilities. Bounded, accepted responsibilities contribute to workable shared care. Backup coverage supports agreed responsibilities when arrangements change. Staff and volunteers need time, training, roles and workable conditions behind the plan. Check whether the shared-care arrangements produce usable relief in practice. Ask the person whether that relief fits their own needs and life. Relief is something to examine, not something established by a booking or a completed training module.

The visible task	The support that makes it workable
An agreed responsibility	Prepare, travel, deliver, communicate changes, and close the loop.
Shared care	Name the owner, boundaries, resources, and backup; do not default every gap to the caregiver.
Time of one's own	Ask whether the arrangement provided usable relief, not only a booking.

In Context — Time that belongs to Ellen

The continuing family and team scenes are fictional illustrations. They show proposed care arrangements and design choices, not documented cases or measured product outcomes.

When Maya called that evening, she began with a different question.

“Did you have lunch with your friend?”

“Yes,” Ellen said. “We talked about her for a change.”

“Was that good?”

“It was very good. I’d forgotten how much she has going on.”

Pat was reading nearby.

“Did you bring back anything interesting?”

“Several things. None of them appointments.”

“That sounds promising.”

The Day Center had given each of them something different. Pat had people to talk with and an activity he wanted to attend. Ellen had time that was not organized around the next care task.

But when she later met with Sam, she did not describe the week as solved.

“The days at the center help,” she said. “It’s everything around them that still takes some working out.”

“What is still landing with you?”

“The meals. The calls. Remembering what we need to ask. Sometimes I’m not doing something, but I’m still making sure someone else is.”

Sam asked which part she most wanted to change.

“Evenings,” Ellen said. “By then I would like us to be finished arranging things.”

Pat looked up.

“I would support that proposal.”

They were not asking for a life without responsibility.

They were asking whether responsibility could be shared in a way that left them more room to be husband and wife.

Support has to reach the people expected to give it

Our approach includes family relationships, resources, education, and capacity within whole-person care. That means asking not only what support the person needs, but what the people around them can realistically provide.

A care plan that depends on one exhausted person carrying everything is not a strong care plan.

The same question belongs inside an organization.

Does the plan depend on a staff member staying late to complete the record? On a volunteer accepting responsibilities beyond their preparation? On a manager being available whenever something goes wrong?

Goodwill matters. It should not conceal an unsupported arrangement.

Family caregiving, paid professional work, and volunteering are different roles. They involve different obligations, skills, boundaries, and resources. We should not treat them as interchangeable.

But each deserves a similar design question:

What must we provide so this person can carry their agreed responsibility without being left alone with the rest?

Love should not require Ellen to absorb every uncertainty. Professional commitment should not require Lena's team to make an under-resourced process work through personal sacrifice.

Support becomes practical when it changes the work, the resources, or the responsibility —not only how someone is encouraged to feel about it.

Respite is more than an empty space on the calendar

For this chapter, *usable respite* means time during which appropriate support has actually been provided and the caregiver can use that time for something of their own choosing.

The distinction is important. A service may be booked without being received. Attendance may require substantial preparation, travel, and coordination. A caregiver may remain unsure who is responsible if something changes.

Ask about the whole arrangement.

Ellen might use the time for her own appointment, a friend, household work she chooses to do, or rest. None needs to be more productive than another to count.

The Daily Stress and Health study found that caregivers reported fewer care-related stressors on adult-day-service days, but more stressors unrelated to care. Its findings support examining what happens during the time provided rather than assuming that every service hour becomes rest.[43]

Pat's experience remains equally important. Ellen's relief should not depend on persuading him to tolerate a poor fit. His enjoyment should not erase her need for help outside program hours.

When those needs conflict, discuss the conflict. Explore the support available rather than making one person responsible for protecting the other from disappointment.

The additional Tuesday requested in earlier chapters illustrates that boundary. Until the responsible people confirm an arrangement, it is not respite Ellen can rely on. An open request should remain visible as an unmet need.

Make the hidden work discussable

Do not begin by handing the caregiver an exhaustive form asking them to document everything they do.

Start with a manageable part of the week.

“What happened between getting home yesterday and going to bed?”

Listen for the work inside the answer: noticing, deciding, arranging, doing, confirming, and responding when something changes.

Someone else may drive to an appointment while Ellen still checks the time, prepares the information, contacts the driver, and asks whether the visit happened. The visible task has moved; much of the coordination has not.

NIA’s guidance on sharing caregiving responsibilities recommends discussing needs together, choosing tasks that fit people’s abilities and interests, recognizing limits, and revisiting arrangements as circumstances change.[81]

Our application is to make the scope of an offer clear.

“I can help with dinner” is a beginning.

“I can plan, bring, and clear up dinner on these four evenings, within the food requirements we agree” describes something the family can consider.

Not every task can be handed over. Some require professional expertise, preparation, permission, or a relationship the person receiving care accepts. Some should be removed because they are unnecessary. Others reveal a need for services beyond what the family can provide.

The aim is not equal task totals.

It is an arrangement that respects everyone’s circumstances and reduces the need for one person to keep the whole plan functioning.

A commitment can be generous and bounded

> ### In Context — A smaller promise that includes the work
>
> At the next family conversation, Daniel offered to handle Wednesday dinner for the following four weeks.
>
> “I can plan it, bring it, and clear up,” he said. “Let’s agree on what works for you both.”
>
> “Does that include deciding what we’re having?” Ellen asked.

In Context — A smaller promise that includes the work

“Yes. Unless you have a request.”

Pat had one.

“Nothing that requires a presentation.”

Daniel smiled.

“I was planning food.”

Maya offered something different.

“I can help prepare the questions for the planning conversation you’ve mentioned. Once you decide whom you want to speak with, I can make that one contact next week, with your permission.”

Sam checked the scope.

“Not taking over all the family planning?”

“No,” Maya said. “I can do this part.”

“That would help,” Ellen replied.

Daniel also agreed to tell them promptly if a Wednesday became impossible and to work with them on an acceptable alternative. The family did not automatically assign that alternative to Ellen.

They would review the arrangement after four weeks.

A single medical-appointment ride from an earlier chapter had not become a standing transport commitment. One planning call had not made Maya responsible for every future decision.

The new offers were useful because people understood what had—and had not—been accepted.

Build the Shared-Care and Backup Plan

A **Shared-Care and Backup Plan** can extend the agreement the family already uses. It does not need to become another competing record.

Begin with what Pat and Ellen want the support to protect. Record only the responsibilities and information needed to make that support dependable.

Part of the plan	What should be clear
What matters	Pat’s preferences, Ellen’s support needs, and the ordinary activities they want to preserve

Part of the plan	What should be clear
Accepted responsibility	The person, task, dates, and limits—including who makes the arrangements and confirms completion
Preparation and permission	Relevant instructions, skills, access, and information-sharing authority
Backup	Who has actually agreed to help, what they can provide, and which arrangements still need confirmation
A changed situation	Who should be contacted, what can safely wait, and the approved route for a concern requiring prompt attention
Review	Who maintains the plan, when it will be discussed again, and how anyone can request a change

A name in the backup column is not enough.

Has that person agreed? Are they available? Do they know what the task involves? Can they provide the required assistance? Does the person receiving care accept the arrangement?

For a service, verify eligibility, availability, cost, and the support it can provide. A contact for investigating help is not yet a substitute caregiver.

Where no suitable backup exists, write that plainly and assign responsibility for exploring it. Do not make the document look complete by writing “family” or “community support.”

The clinical team remains responsible for clinical guidance. Sam can help coordinate the agreed support discussion within his role, but he does not become the owner of every task.

The grandchildren have a different place in the plan: enjoyable contact, stories, games, and affection with adult support. They are not backup caregivers, safety monitors, or responsible for keeping their grandparents well.

Give the caregiver a conversation of their own

Ellen should not have to translate every personal need into a benefit for Pat.

“How are you managing?” is a different question from “How is Pat doing?”

Offer an appropriate private setting to discuss the caregiver’s health, strain, relationships, practical concerns, and the support they would welcome. Explain who can

see the information and what any limits on confidentiality mean.

Do not collect a sensitive answer in a shared family record and assume that discretion in a summary will protect it. Use an appropriately governed private route where the system's permissions do not provide the necessary separation.

Support may include a conversation, skills training, navigation, peer contact, counseling, or help reaching the caregiver's own healthcare professional. Choose with the person and confirm that the service exists.

A group is not the right answer for everyone. Some people prefer an individual conversation, a trusted community connection, or practical assistance before discussing feelings.

The research review informing this book makes the underlying distinction clear: guilt, cost, access, exhaustion, trust, and family circumstances are different barriers. More information is not an adequate response to all of them.

In the ADS Plus trial, the added support included education, validation, problem-solving, referrals, and caregiver self-care strategies delivered by trained staff over time. It was not simply a handout advising people to take a break.[44]

That is the organizational question here: what support follows the invitation to speak?

Caring for Caregivers: identify, understand, assist

RUSH University Medical Center's **Caring for Caregivers (C4C)** program makes caregiver support an explicit part of healthcare. Its public resources describe identifying caregivers, assessing their circumstances, and connecting them with assistance—including skill-building, Planning for What Matters sessions, and care-team planning. The program was developed with philanthropic support, including the RRF Foundation for Aging and The John A. Hartford Foundation, and has worked with IHI on wider implementation.[8]

In the published model, Planning for What Matters Sessions are brief psychotherapy delivered by a designated clinician. A general planning conversation, an activity discussion, or an AI-generated prompt is not the same clinical service. Partners must identify the qualified professional and actual support available before using that name.[76]

We can learn from that structure without treating a Day Center as a complete clinical C4C service. The following is a CarePhysics adaptation for a partner-supported caregiver pathway.

Identify. Recognize the person doing the caring and invite them into support in their own right. Being listed as a relative or emergency contact does not tell us what they carry or what help they want. Explain the offer, the private route, and the appropriate alternatives.

Understand. Give the caregiver space to describe their health, strain, practical needs, understanding, and available support. Qualified people select and interpret suitable assessments where indicated. Ask what would make life more manageable for the

caregiver, not only what would make them more useful to someone else.

Assist. Agree on a response with an accepted owner and an achievable next step. That may involve practical help, professional skills support, a planning conversation, a relevant community service, or the caregiver's own clinician. Check whether help was received and whether it addressed the stated need.

Follow-up is part of the work. The 2025 C4C case study describes follow-up one and three months after completion, or at other predetermined times; RUSH's implementation resource allows a schedule suited to the adopting system. Those are examples, not a universal baseline/one/three/six-month requirement. A local plan should state both the timing and the event from which it is counted.[82]

Protect time, training, interpretation, response capacity, and coverage for the people providing this support. If a service is unavailable, keep the need open and explain who will investigate another route. A completed assessment should never become the organization's reason to stop asking whether help followed.

Protect the caregiver's private account

A public Center for Health Care Strategies profile of RUSH's implementation describes caregivers registering as patients with their own electronic records. That is a useful example of recognizing their separate needs. It is not evidence that a shared family record in another system provides the same protection.[83]

Our proposed design distinguishes three uses of information. The **private caregiver record** holds sensitive disclosures and assessments for the caregiver and appropriately authorized professionals. The **shared support plan** carries only the information agreed and appropriate for that purpose, such as a request for practical help. The **family-facing Daily Summary** concerns the participant's day and authorized follow-up; it does not automatically inherit the caregiver's private answers.

Explain the actual confidentiality limits and access arrangements before collecting the information. Protect it at collection and retrieval, not only when a summary is published. An assistant preparing a family meeting should not receive private caregiver material merely because it has been told not to mention it.

Check printed packets, exports, notifications, search results, meeting drafts, and personalized tips as well as the main screen. Even a helpful-sounding suggestion can disclose something private by implication. A "Caring for yourself" heading in a shared note is not permission to draw on a confidential assessment.

Where those boundaries cannot yet be enforced, use an approved, separately restricted process for sensitive assessment. Do not promise a private route that depends entirely on someone remembering to remove a paragraph. Appropriate professionals remain responsible for urgent concerns and for explaining any lawful limits to confidentiality.

Supporting the family does not mean giving the whole family access to everything each person has shared. The practical checks appear in Appendices B, C, F, and J.

Make tomorrow discussable without taking over today

Future planning belongs alongside current support, but it should not arrive as a demand to settle every difficult question at once.

Pat can begin with what matters to him, whom he wants involved, and what he wants explained. Ellen can raise concerns about her own capacity. Maya and Daniel can describe what they are able to undertake.

NIA's planning guidance encourages discussing preferences early and continuing the conversation as circumstances change. It treats planning as preparation for future decisions, not a single form that anticipates every situation.[84]

An initial conversation might identify questions for the appropriate professionals:

"What kinds of support might we need to consider later?"

"What should we understand about who can make which decisions?"

"Which legal or financial arrangements should we review with a qualified professional?"

The family need not answer those questions themselves. An assistant should not produce a legal decision, determine Pat's decision-making ability, or infer that a diagnosis transfers authority to relatives.

Maya's agreed role is to help prepare and arrange a conversation—not decide its outcome.

Planning should also leave room for needs exceeding the current arrangement. A higher level of support is not evidence that the family did not care enough. Nor should anyone promise that one program will keep every person at home indefinitely.

The purpose is to make future choices more informed while preserving participation now.

A useful outcome of an early planning conversation may be a short question list and an accepted professional contact—not a completed legal document. Keep questions about costs, assistance, future care, and decision-making arrangements distinct. Ask what can be shared, and check whether the intended professional conversation actually happened. Chapter 1 and Appendix B offer a practical concern-to-follow-through aid.

Staff need workable conditions, not another message about resilience

The support around Ellen depends partly on Lena's team.

If the team cannot prepare, take breaks, ask for help, or finish essential work within a workable day, a better family-facing experience may rest on hidden staff effort.

Begin by asking staff where the work becomes difficult.

What gets repeated? Which responsibilities are unclear? What happens when someone is absent? What information is missing at the moment it is needed? Which tasks require more practice, and which require more people?

> **In Context — The earlier conversation needs a place in the day**
>
> Lena brought Pat's suggestion to the team: discuss actual afternoon choices before lunch.
>
> A staff member raised a practical concern.
>
> "We can do that, but we need to know which options we can offer. Otherwise we'll promise one thing and change it later."
>
> Another colleague pointed to an existing preparation conversation.
>
> "Could we confirm the options there, instead of creating another checklist?"
>
> Lena agreed to try that approach. The person leading the activity would confirm the available choices, and the existing preparation conversation would identify who would discuss them with Pat.
>
> They would review both his experience and the work the change created.
>
> Nobody was asked to squeeze a new task into the day and call it a small favor.
>
> The team had helped design the response.
>
> This is one application of the lesson from Chapter 10. A participant's suggestion and a staff member's operational knowledge can improve the same experience.
>
> Neither contribution replaces the other.

Make training something people can use

A training library is a resource. It becomes practical support when people have time to use it, assistance with questions, and an opportunity to practice.

Teach the actual task.

A family member learning a consequential care skill needs appropriate professional instruction, demonstration, practice, and a check of readiness—not merely a completed video. A staff member preparing for a difficult conversation may benefit from rehearsal with a colleague. A volunteer needs clear boundaries and a named person to contact.

The Day Center materials describe short paired huddles and branching simulations, including practice around dignity, communication, safety, and documentation. The huddle's chosen personal commitments are not collected or compared. These are documented training designs, not proof of competence or improved outcomes in every setting.

Protect the difference between practice and required competency assessment. People should know which is occurring, who sees the result, and what support follows.

Do not require staff to do "optional" learning in personal time while implying that declining signals a lack of commitment. Plan appropriate paid preparation and coverage.

Training cannot create capacity that does not exist. A respectful way to explain a service limit is useful. It does not remove the need to address that limit.

Give volunteers a clear and supported place

A volunteer may bring warmth, language skills, local knowledge, creativity, or time for a conversation. Those contributions deserve preparation and support.

Begin with a bounded role: welcome participants, help with an activity, prepare materials, or offer agreed companionship.

Explain what the volunteer may do, what requires staff assistance, which information they may access, and who will respond when they have a concern. Do not let an informal favor expand into medication decisions, personal-care duties, or responsibilities beyond the person's preparation and the service's arrangements.

A volunteer who asks for help should not feel they have failed.

Offer a brief debrief when useful. They may have noticed a confusing entrance, an activity instruction that does not work, or something a participant would like to try. Carry those ideas into review with permission and credit.

Purpose makes contribution meaningful. It must not become pressure to accept more than someone can sustain.

Volunteer confidence, role clarity, staff preparation, workload, and implementation costs deserve attention alongside participant outcomes.

When one person is carrying too much, examine the arrangement around them. Constraint-focused improvement should remove unnecessary work or supply missing support, not make exhaustion more productive. The caregiver's own well-being matters regardless of its effect on the service, and the private C4C-informed conversation remains separate from an operational review. See R2.5.

Build the Staff and Volunteer Support Plan

Keep this plan separate from the family's care information. Staff well-being and private concerns do not belong in a participant's shared record.

Support area	Organizational commitment
Workload and coverage	Identify the work, protect essential preparation and breaks, provide absence coverage, and address demand beyond capacity
Training and practice	Provide task-specific instruction, supported rehearsal, appropriate competency checks, and time to learn

Support area	Organizational commitment
Clear responsibility	Name who receives questions, handles exceptions, and makes decisions beyond someone's role
Personal support	Explain confidential professional-support routes and their limits; do not require public disclosure of distress
Voice and improvement	Invite staff and volunteer ideas, credit contributors, explain decisions, and test changes without hidden personal rankings
Review	Examine total workload, after-hours work, access to support, unresolved concerns, and whether the plan survives changes in personnel

Appreciation belongs in this plan, but it is not a substitute for the other commitments.

A thank-you means more when a person can also take a break, obtain help, and see an unnecessary task removed.

Design invitations that offer help—not homework

The content surrounding support should make the offer easier to use.

A caregiver message can begin with the person's situation rather than a list of recommended behaviors:

Support for your week

We can help you look at one part of the week that feels difficult to carry.

That might be an arrangement, a question about available support, a skill you would like to practice, or something you would prefer to discuss privately.

You do not need to prepare a complete account. You can begin with: "This is the part I would like help with."

We will explain what support is available, what needs checking, and who will follow up. You can choose a conversation, receive information, or take more time.

Before using this invitation, add the real responder, contact route, availability, privacy arrangements, and what happens after a request.

The supporting formats should have different jobs. A short video can demonstrate a bounded offer of help. An article can explain practical choices and service limits. A tile can collect the relevant material and a question route. A call can address an individual concern.

A feedback question can ask, “Did this reduce the work you were carrying, or create something else to manage?” Explain who reviews the answer and how to request a response.

Keep familiar labels and expectations across these formats. Consistent meaning does not require identical wording, as the communication approach used here emphasizes.

Adapt language, format, timing, and examples with the people involved. A caregiver working shifts, a family without reliable transport, and a household seeking faith-related support may need different arrangements. Ask rather than infer.

An urgent concern follows its appropriate route immediately. A validated instrument retains its required wording and scoring. An invitation to rest should not end with another required activity.

AI can help remove the work around support

An assistant could help Ellen prepare the question she wants to ask, Maya organize a limited planning task, or Lena’s team turn a useful explanation into reviewed guidance.

The opportunity begins with the work already identified—not with a requirement to use AI.

In a proposed workflow, Sam selects the approved guidance, verified local resources, and personal information authorized for the task. The assistant prepares options. Sam checks whether they reflect the actual agreements and what the services can provide.

Suppose a draft says:

“Maya will coordinate future care planning.”

That is not what she accepted.

The corrected version says:

“Maya will help prepare the agreed questions and make one approved contact next week. Further responsibilities have not been assigned.”

The draft has become useful by staying within the commitment.

For staff, an assistant could assemble current materials for a huddle, prepare a demonstration outline, or organize voluntary suggestions. It could retrieve a relevant explanation during agreed coaching and help someone reflect afterward. It should not score compassion, infer burnout from a voice, or present itself as an impartial authority in a family disagreement.

A practical assignment might be:

Using CarePhysics and our approved local guidance, help us identify one part of this support process that creates repeated work. Prepare options that respect the person’s preferences, staff roles, resources, and privacy. Distinguish accepted commitments from suggestions. Identify who must review each option and how we could test whether it reduces burden.

Keep research, design guidance, current service facts, fiction, and permissioned personal context distinguishable. Retain source owners, review dates, allowed uses, and corrections. The book is a reference for that work; uploading it is not model training or proof of reliable performance.

With reliable knowledge, clear guidelines, practical rules, and accountable people, AI can be a gift: less routine assembly and more attention for the person.

Families may also revisit approved routine information or prepare questions outside office hours. State when human help is available and make that route easy to reach. Around-the-clock AI access is not continuous professional care.

Private caregiver or staff concerns must not automatically become shared summaries or training examples. For generic content development, use generic examples rather than private records.

Measure the whole task against the local baseline, including checking, corrections, and work outside scheduled hours. A drafting tool does not necessarily measure or reduce the time required to finish the work.

What the organization must provide

A support initiative needs more than educational content and a coordinator's name.

Confirm service capacity, staffing, costs, accessible formats, language assistance, training, privacy, and coverage. Assign an owner who can change the process when it adds work or leaves needs unanswered.

Do not solve Ellen's coordination burden by transferring it without agreement to Maya. Do not solve family uncertainty by making frontline staff continuously available. Do not rely on one enthusiastic leader to hold the entire arrangement together.

The same principles apply beyond dementia care.

A person supporting a relative through rehabilitation may need a professionally taught skill and an affordable way to attend appointments. A home-care worker may need reliable supervision between visits. A volunteer in an independent-living community may need clear boundaries around assistance and a prompt staff response.

Community and state groups can help identify recurring shortages and resource appropriate services. They should not assume that a resource listed in a directory is available to every household.

Genus supplies technology. Partners retain responsibility for their care, staffing, programs, relationships, and voice.

Relationships can reveal a missing service. They cannot replace it.

How would we know it helped?

Use the measurement discipline from Chapter 10 without making the support plan another reporting burden.

Choose one manageable change, establish a baseline, and name the review period and owner. A short local test can identify practical problems; it does not establish lasting clinical benefit.

For the family plan, distinguish tasks accepted from tasks completed. In the defined review period, record completed agreed tasks out of those due, and keep cancellations, unresolved needs, and unknown outcomes visible.

Then ask whether the arrangement reduced the caregiver's work. Did someone else handle preparation and changes, or only the visible task? Did the caregiver gain usable time? Did the person receiving care find the arrangement acceptable?

For staff, examine preparation, documentation, review, corrections, and after-hours work. For volunteers, ask about role clarity, confidence, and access to assistance. Do not treat training completion as proof that someone can perform the task.

Keep educational delivery, understanding, booked and attended days, and initial versus repeated assessment distinct. A support process needs evidence for the particular result it claims; see the dated field limitations in Appendix J.

Use suitable measures for formal claims about caregiver strain or workforce well-being, preserving their wording, privacy requirements, and interpretation.

Include people using telephone, print, interpretation, or personal assistance. Report how many were offered support, used it, and provided feedback. A family unable to afford or reach a service should not be recorded simply as uninterested.

Keep reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact separate. Willingness to recommend, an actual referral, and another person receiving help are also different results.

Most importantly, give the findings somewhere to go. If the new process increases duplicate work, exposes private information, or depends on unsafe coverage, change or pause it.

We are asking whether the support became sustainable—not whether people became better at enduring its absence.

Models and Evidence Behind This Chapter

This chapter applies the CarePhysics principles through fictional arrangements and proposed support plans. The studies below examine caregiver support and workforce interventions in their stated settings.

COM-B, autonomy, and social support

Match the help to the actual need

COM-B directs attention to capability, opportunity, and motivation. Self-Determination Theory emphasizes autonomy, competence, and relatedness. Here, they inform task-specific preparation, feasible roles, and the right to limit or decline a responsibility.

Our commissioned review grades COM-B strongly as a conceptual framework and the broader Self-Determination Theory intervention evidence as **Moderate**. It describes several specific family-role applications as **Plausible** or supported by mechanisms rather than direct feature trials.

Where we used them: Daniel and Maya choose bounded responsibilities; a resource gap is not answered with another motivational message.

Local question: Did the support make a chosen responsibility manageable, or merely make it harder to refuse?

Adult day services and daily caregiver experience

Examine what the service day makes possible

Steven Zarit and colleagues' Daily Stress and Health study, published in the 2014 volume of *The Gerontologist*, followed **173 family caregivers of people with dementia over eight consecutive days**. Caregivers reported fewer care-related stressors, more positive experiences, and lower anger on service days, alongside more noncare stressors.[43]

Evidence boundary: This was a within-person observational study, not randomized attendance. It concerns daily experience, not proof that every center reduces long-term strain or that a digital tool produces the effect.

Where we used it: Ellen's usable time is evaluated directly rather than inferred from a booking.

Local question: What did the caregiver gain, and what preparation or coordination remained?

ADS Plus

Support the caregiver alongside the participant

Laura Gitlin and colleagues' multisite trial included **203 caregivers across 34 adult day-service sites**. Sites were randomized to usual services or services plus trained-staff support involving education, validation, referrals, problem-solving, and self-care strategies.

At 12 months, adjusted caregiver depression scores were lower in the added-support group. **22.7 percent** were lost to follow-up; the sample was predominantly female and college educated. The attendance comparison did not reach the conventional statistical-significance threshold.[44]

Evidence boundary: The trial tested a structured, multicomponent program over time—not a brochure, occasional check-in, or AI companion.

Where we used it: The caregiver receives a conversation and support process of their own.

Local question: What trained human support follows the invitation to ask for help?

RUSH C4C: a defined pathway for caregiver support

Carbonell, Mariani, and Golden's 2025 organizational case study describes caregiver support that can be adapted across organizations. It reports reductions in caregiver depressive and anxiety symptoms and caregiver burden at one- and three-month follow-up after intervention. These are encouraging uncontrolled observations. They do not establish that C4C caused the changes or that Day Center attendance, an AI assistant, or a Genus implementation would reproduce them.[76]

Where we use it: recognition of the caregiver's own needs, an organized support pathway, and planned reassessment. R1 separates this implementation model from the controlled caregiver-intervention studies; our proposed privacy and follow-through requirements remain requirements to verify locally.

Implementation research

A program must fit the people delivering it

Gitlin and colleagues' 2025 analysis examined implementation in **16 ADS Plus sites serving 102 caregivers**. Some caregiver outcomes differed by implementation level at three and twelve months, but not six months.

Sites were not randomized to implementation levels. Missing and irregular documentation made it difficult to distinguish incomplete delivery from incomplete recording. The authors also identified training and local-fit challenges. The paper disclosed that Gitlin co-founded a company entitled to fees for ADS Plus training.[85]

Evidence boundary: These associations do not show that more documentation causes better care. The commissioned review classifies this implementation evidence as Emerging.

Where we used it: Staff participate in adapting the work and receive preparation, coverage, and review time.

Local question: Can the team deliver the essential support under its actual working conditions?

Workforce interventions

Change the work as well as supporting the worker

As supplementary evidence, Maria Panagioti and colleagues' 2017 systematic review and meta-analysis included **19 studies, 20 comparisons, and 1,550 physicians**. Interventions produced small average reductions in burnout, focused on emotional exhaustion. Organization-directed approaches had larger average effects than physician-directed approaches.[86]

Evidence boundary: The studies included randomized and controlled before-and-after designs, with different interventions and settings. The subgroup comparison does not establish which change will work in a Day Center, and the findings cannot simply be transferred to volunteers or family caregivers.

Where we used it: The staff-support plan addresses workload, coverage, role clarity, and work processes—not only individual coping.

Local question: What has the organization changed about the conditions creating the difficulty?

Shared responsibility and future planning

Prepare without deciding everything at once

NIA's guidance recommends identifying needs, discussing who can undertake which tasks, recognizing limits, and revisiting the plan. Its advance-care-planning guidance emphasizes conversations about preferences and preparation for future decisions. These are practice resources, not trials of this chapter's tools.[81]

Where we used them: Accepted responsibilities remain specific, and planning questions go to the relevant professionals.

Local question: Does the plan preserve the person's voice and reduce uncertainty without placing every unanswered question on one relative?

One thing to try

Choose one recurring part of care that depends heavily on one person.

Ask that person to describe a recent example—not to reconstruct their entire week. Identify the work of noticing, arranging, doing, confirming, and handling changes.

Together, select one responsibility to share, one unnecessary step to remove, or one resource gap to address. Name the person who will act and when you will review the result.

Do the same with one staff member or volunteer involved in the service.

Your team's question is:

Have we offered support—or made it possible for someone to set part of the work down?

Shared care should leave room for ordinary company

> **In Context — Dinner includes clearing up**
>
> On the first Wednesday of the new arrangement, Daniel brought dinner.
>
> Pat inspected it.
>
> "No presentation?"
>
> "Not unless you ask."
>
> Afterward, Ellen began gathering the plates.

In Context — Dinner includes clearing up

“I included that part,” Daniel said.

She stopped.

“So you did.”

Pat returned to the table with his book. Ellen sat beside him while Daniel cleared up.

“What are you reading?” she asked.

Pat turned the cover toward her.

“Something with very few appointments.”

The arrangement had not solved the whole week. It had completed one agreed piece of work without Ellen having to direct it.

That was enough to notice—and something to review before assuming it would remain workable.

Families can share meals, calls, and other responsibilities. Staff and volunteers can be better prepared and supported. But some parts of care still depend on separate organizations keeping their commitments.

A family cannot supply a missing service simply by communicating more clearly.

The next chapter examines what happens at those boundaries: who accepts responsibility, who responds when an arrangement fails, and how a community learns to follow through.

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CHAPTER 12

Build a Community That Can Follow Through

At a Glance

The central idea: A community resource becomes care only when someone can actually receive it.

What you'll explore: How hospitals, clinical practices, social workers, Day Centers, transportation services, and other partners turn separate capabilities into dependable support. Follow Pat and Ellen when a confirmed ride does not arrive. Learn to distinguish responding to today's problem from changing the arrangements that allowed it to happen.

Design and AI: Give partners shared meanings, clear responsibilities, and usable response routes without requiring them to become one organization or use one system. Explore how an approved AI assistant could prepare handoffs, identify missing confirmations, retrieve relevant options, and help people learn from an interrupted service.

Put it to work: Create a **Partner Handoff Agreement** that identifies who acts, what information may travel, how acceptance and delivery are confirmed, and what happens when the usual arrangement fails.

Evidence and evaluation: Examine referral guidance, navigation research, transportation evidence, and social-learning models. Measure received services, unresolved needs, family effort, access, and partner workload—not referral volume alone.

> *"By a system I mean that the diverse people actually work together to direct their specialized capabilities toward common goals for patients."*
>
> — **Atul Gawande, MD**, surgeon and writer, Harvard Medical School commencement address, May 26, 2011.[87]

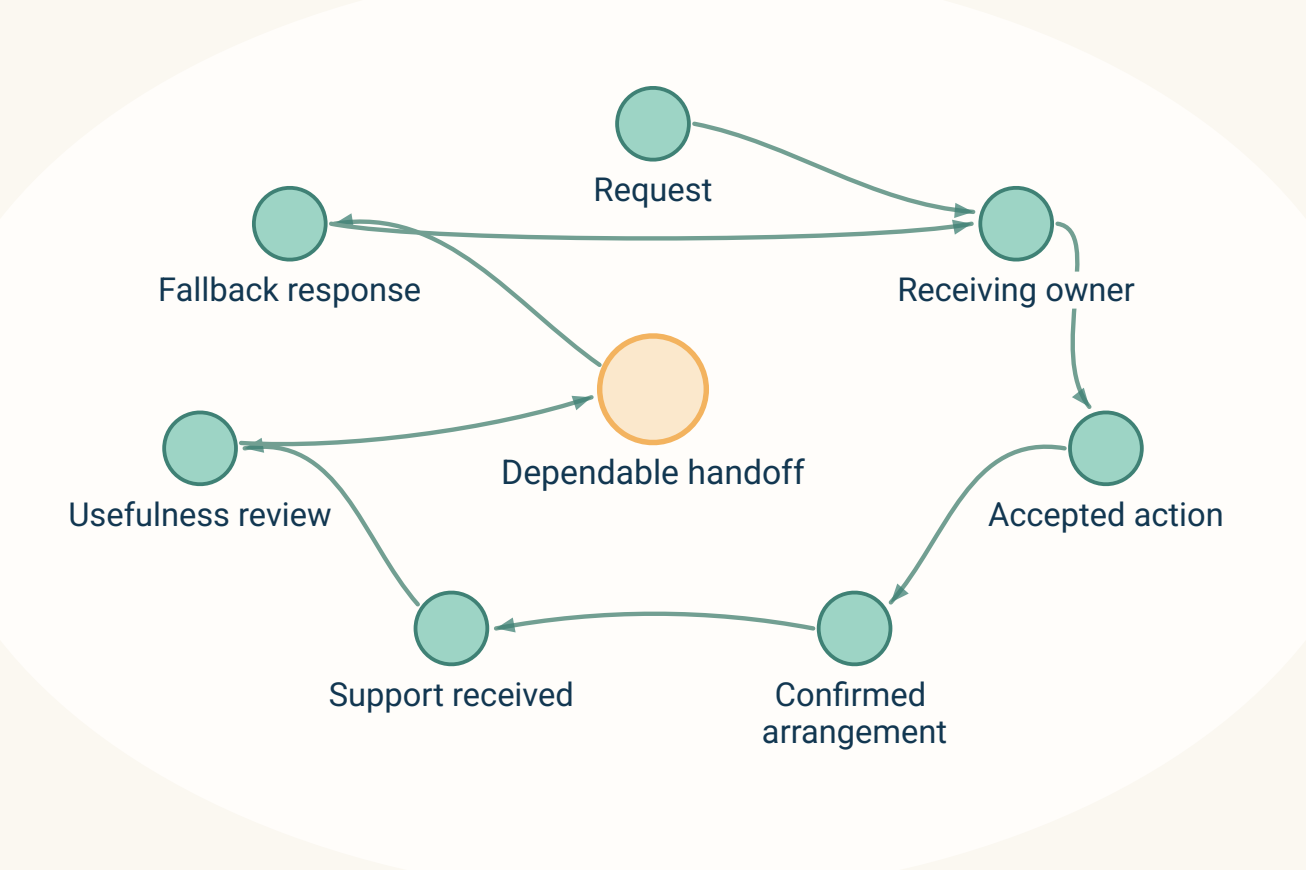


Figure 13 · The handoff, made visible

A request must reach an identifiable receiving owner. The receiving owner accepts a defined action; receipt alone is not acceptance. The accepted action is arranged and confirmed. Check whether the confirmed arrangement actually delivered support. Review the usefulness of the support received. The review informs how to make the handoff more dependable. A dependable handoff includes a planned response when the usual route fails. The fallback routes the problem to a responsible person rather than leaving the family with another number. The arrows describe responsibilities to confirm, not automatic movement from referral to care received.

Stage	What must be confirmed
Sent → received	The intended service received the request and relevant authorized information.
Accepted → arranged	A named role accepts a defined action, with timing and an alternative when needed.
Delivered → reviewed	Support actually occurred; the person can say whether it was useful. Keep unmet needs open.

In Context — The ride that did not come

The continuing family and partner scenes are fictional illustrations. They demonstrate proposed arrangements, not documented cases or claims about a particular transportation service.

It was one of Pat’s confirmed Thursday Day Center days. The transportation service had separately confirmed the trip.

The pickup window had passed.

Pat sat at the kitchen table with his coat over the chair. Ellen checked the information beside the telephone.

“Should I put this back on?” he asked.

“Not yet.”

“I may finish the book before we get there.”

Ellen called the Day Center.

Lena checked the attendance plan. Pat was expected. That told her nothing about where the vehicle was.

“Where are you both now?” she asked.

“At home.”

“Is there anything you need help with while we check?”

“We’re all right. We’re waiting.”

Lena confirmed the transport details Ellen had received.

“I’ll speak with the dispatcher. I’ll call you by ten, even if I don’t have a replacement arrangement.”

Ellen began looking for another number.

“You don’t need to call the other services while I check,” Lena added. “I’ll tell you what I find, and we can discuss what works for you and Pat.”

Pat looked toward the telephone.

“Tell them I was looking forward to the photographs.”

Ellen repeated his message.

The missed ride was not merely a transportation problem.

Pat was missing people and an activity he had chosen. Ellen’s time was becoming uncertain again. The Day Center had prepared for someone who could not reach it.

Several organizations were connected to the family.

At that moment, connection was not enough.

The space between organizations is part of care

In Chapter 5, we examined how community makes belonging and support possible. In Chapter 7, we connected encounters into a pathway. Chapter 11 asked whether the people carrying responsibilities had enough support themselves.

Now we examine what happens where those responsibilities meet.

The original CarePhysics Community principle includes family members, caregivers, and community partners working around the person. That collaboration becomes practical only when the organizations understand what they are agreeing to provide.

A community resource becomes care only when someone can actually receive it.

A hospital may recognize a need. A navigator may find an appropriate service. The service may accept a referral. Yet the person can still be left without help because an appointment, ride, document, payment arrangement, or response has not been secured.

This chapter is not about adding more organizations to a directory.

It is about helping the partners already involved make commitments they can understand, deliver, and repair.

Their shared purpose should be stated in terms the person would recognize. For Pat and Ellen, that includes a worthwhile day, appropriate support, and time Ellen can use without continuing to coordinate every detail.

The purpose belongs to them. The partners contribute different parts of making it possible.

Respond to the person before reviewing the process

When an arrangement fails, begin with the present situation.

Where is the person? What support are they relying on? Is there a concern requiring immediate professional attention? What has actually happened, and what remains unknown?

A missed community service should not be interpreted as a clinical emergency solely because a record is incomplete. Equally, a clinical concern should not wait in a routine referral queue. The responsible people must use the appropriate response route.

Then establish who will coordinate the immediate response and when the person will hear again.

> **In Context — An answer, even when it is not the hoped-for answer**
>
> Lena called before ten.
>
> “The assigned vehicle cannot make the trip. The transport service is checking alternatives, but they have not confirmed one that meets today’s arrangements.”
>
> “So we should keep waiting?” Ellen asked.

> **In Context — An answer, even when it is not the hoped-for answer**
>
> “Only if you and Pat want us to continue checking. I cannot promise when a suitable ride would arrive.”
>
> Pat wanted to know how much of the day remained.
>
> They discussed it together. No suitable alternative could be confirmed in time for the visit to remain useful to them.
>
> Ellen stayed home with Pat and changed her own plans.
>
> Lena explained what she would do next. She would record that the service had not been received because the confirmed transportation failed. The center would review any related charge through its normal process and tell the family the result. With their permission, she would also involve Sam in the follow-up.
>
> “This should not be recorded as though you decided not to come,” she said.
>
> “I didn’t,” Pat replied. “I was dressed for it.”
>
> The response had not restored the morning.
>
> It had stopped asking the family to wait without an answer and made the failure something the organizations had to address.
>
> That matters. Honest recovery does not always produce an immediate replacement. It should produce clarity, appropriate assistance, and responsibility for what remains unresolved.
>
> A video, an encouraging message, or an optional activity at home cannot be reported as equivalent to the service that was lost.

A handoff includes responsibility—not only information

AHRQ’s TeamSTEPPS guidance describes a clinical handoff as transferring relevant information together with clearly understood responsibility and authority. It includes acknowledgment, questions, uncertainty, and contingency plans. Its clinical context should remain visible when adapting the idea to community services.[88]

A transport provider does not inherit clinical responsibility for Pat because it accepts a ride. A Day Center does not become responsible for every need at home because Pat attends.

The agreement concerns a defined part of the support.

What assistance has been accepted? Where does it begin and end? Who receives the person or information next? What must be confirmed before responsibility changes?

For a transport arrangement, “door-to-door” may still leave important questions unanswered. Does it include assistance from the agreed entrance? Who meets the person at the destination? What happens if that person is unavailable? How is the return

journey handled?

Ask about the individual's needs rather than inferring them from a diagnosis.

AHRQ's referral guidance also recommends agreements between services, direct information exchange, and a process for confirming completion rather than relying on patients to carry information between professionals.[89]

The proposed CarePhysics application extends that discipline across the relevant community partners: an accepted responsibility should have a defined scope, a responder, and a way to establish what occurred.

Close the communication loop—and check the service

There are two different things to confirm.

First, did the receiving person understand and accept the message?

AHRQ's closed-loop communication guidance describes an exchange in which the recipient provides feedback and the sender verifies understanding.[37]

Second, did the intended service happen?

A dispatcher can correctly understand a request and still be unable to provide the trip. A clinic can receive a referral while no appointment is available. A navigator can explain the next step while the underlying need remains unmet.

Keep the stages distinct:

Requested → received → accepted for a defined action → scheduled or confirmed → delivered → reviewed for usefulness.

A waitlist, a declined request, an inability to contact someone, and an unavailable service need their own descriptions. They are not interchangeable failures of participation.

"Completed" should identify what was completed.

The introduction may be complete while assessment remains pending. The assessment may be complete while the service remains unavailable. The administrative record may be closed while the person still needs help.

The communication approach used here puts the distinction plainly: need, role, permitted information, current stage, and ownership of the next action must remain visible.

For Pat's missed morning, the trip had been confirmed but not delivered. Recording the cancellation did not resolve the lost Day Center time or Ellen's interrupted plans.

Agree on the ordinary day and the difficult one

The **Partner Handoff Agreement** is this chapter's practical output.

It is an operational planning aid, not a substitute for the partners' contracts, clinical instructions, or appropriate legal and privacy review. Begin with one recurring handoff

rather than attempting to settle every relationship in the community.

The agreement makes the following elements explicit: purpose, permission, minimum necessary information, fit, status language, responsible people, expected response, failed-handoff route, and closeout.

Agreement element	What the partners must establish
Shared purpose and service scope	What the person wants to accomplish, what each partner provides, and what falls outside that service
Fit and availability	Eligibility, assistance requirements, hours, capacity, costs, and what must be verified for this particular request
Named responsibilities	A person responsible on each side, appropriate coverage, and a clear point at which the next responsibility is accepted
Information and permission	What needs to travel, why, who may receive it, the approved route, and how errors or changes are corrected
Confirmation	What counts as acceptance, booking, arrival, delivery, and completion; which facts require direct confirmation
Response expectations	When an acknowledgment or decision is due and how the family will hear, using the route they chose
Failure and urgent needs	What happens after silence, cancellation, staff absence, an unavailable service, or a safety concern; who investigates alternatives
Return communication	How the person, relevant family members, and referring partner learn what happened without receiving unrelated private information
Review and resources	Who examines recurring problems, funds and staffs the work, approves changes, and tests whether they helped

Replace role labels with actual names and coverage arrangements in the working agreement. “The team” is not a sufficient answer when everyone could reasonably believe someone else is acting.

Do not transfer unlimited coordination to Sam. His role in bringing people together does not make him the transport dispatcher, clinical decision-maker, or owner of every unresolved task.

A dependable partnership distributes responsibility explicitly.

Learn why the failure happened

> **In Context — The partners compare their accounts**
>
> At the agreed review, the transport coordinator explained what the provider's record showed.
>
> The trip had been accepted. When the assigned vehicle became unavailable, dispatch began searching for another. The change had not triggered a prompt call to the family or the Day Center.
>
> The center's attendance plan still showed that Pat was expected.
>
> Sam asked the partners to separate the two problems.
>
> "One was the unavailable vehicle. The other was the missing update. They may need different solutions."
>
> Ellen described what the delay had meant at home.
>
> "I didn't know whether to make another plan. I thought leaving the phone might make us miss the ride."
>
> Pat added his own request.
>
> "Tell me when I can stop waiting. I can choose something else to do."
>
> The transport coordinator agreed that a service interruption should trigger a human update while the search for an alternative continued—not only after a replacement had been found.
>
> Lena's team would identify the person covering transport-related calls during arrival time. They would also agree how to check an expected arrival without assuming that every absence was caused by transport.
>
> The partners would test the revised process before treating it as dependable.
>
> Nobody had to decide that a driver or staff member did not care enough.
>
> They needed to identify the missing action, give someone the authority and capacity to perform it, and check the result.
>
> That approach does not remove accountability. It makes the responsibility specific enough to examine and change.

The transport example also shows why the goal of an improvement must be named. A

replacement vehicle could restore the trip; an earlier update could reduce uncertain waiting even when no vehicle is available. Both matter. A constraint analysis should distinguish these purposes rather than dismiss communication because it cannot supply transport. See Chapter 7's constraint-focused design example.

Match the support to the barrier

A better reminder would not have repaired this morning. Pat and Ellen were ready.

COM-B helps explain why the distinction matters. The barrier may concern understanding, ability, opportunity, motivation, or several things together. The research review informing this book warns against treating a service-access problem as a shortage of motivation.

Ask what needs to change before selecting the response.

If the person does not understand the referral, explain it.

If they are uncertain whether the service fits, offer a conversation or appropriate introduction.

If the route is unaffordable, inaccessible, or unavailable, investigate the resource problem.

If the person no longer wants the service, respect that decision while discussing any relevant alternatives.

AHRQ's social-needs guidance recommends asking whether people want assistance, maintaining current community information, establishing referral agreements, and following up with the service provider. It also allows people to choose self-referral rather than a direct introduction.[10]

Support should be proportionate. Some people want to make their own arrangements. Others welcome help with one step or with the whole introduction.

The purpose is not to make navigation compulsory. It is to ensure that choosing assistance actually supplies assistance.

Design the handoff people will experience

A partner agreement is the working document behind the service. Families need a clear account of the part relevant to them.

For an agreed Day Center trip, an illustrative confirmation could use familiar headings:

Your Day Center visit and travel arrangements

What is confirmed
Your service day and transport arrangement are listed separately, with the agreed date, pickup window, destination, assistance, and return plan.

Who can help

The transport contact manages the trip. The Day Center contact manages your arrival and the day's program. Their actual numbers and availability appear here.

If something changes
The responsible service will contact you through the route you chose. You can also call the agreed first contact. The organizations will clarify who is following up rather than asking you to make every call.

What happens next
The appropriate people confirm arrival and the return arrangements. Tell us if the plan no longer fits or if you need a different explanation or format.

This wording must be completed from verified local arrangements. Do not promise a response process that nobody has accepted.

The content around it can perform different jobs.

A **tile** can hold a short video, article, practical questions, and the contact information. A **video** can demonstrate an arrival handoff and one exception, such as the expected staff member being unavailable. An **article** can explain assistance, service limits, and costs in more detail. A **telephone call or virtual meeting** can address individual requirements. A brief **feedback question** can ask whether the arrangement worked and identify who will respond.

Keep the purpose, main idea, demonstration, chosen next step, question route, and follow-through recognizable across those formats. Urgent information comes first; nobody should have to watch an introduction before learning that a ride has been canceled.

The family's contact route is a way to obtain help—not a requirement that they detect every service failure.

Share enough information—not the whole life

Different partners need different information.

A transport provider may need verified locations, relevant assistance requirements, contact arrangements, and who will meet the person. That does not automatically justify access to private family conversations or an entire clinical record.

The Day Center may need updated professional guidance relevant to its service. A volunteer helping with a welcome needs a role-appropriate briefing, not unrestricted account access.

Establish the information flow before adding more connections.

Explain the intended sharing, verify the relevant authorization, and use approved channels. Record which information has been confirmed and when. Give people a route to correct it.

A connected platform does not make every participating organization entitled to every field. A person's permission for one introduction is not blanket permission for unrelated sharing, research, or training.

Nor is removing a name always enough to make a distinctive story safe to circulate.

For partnership improvement, use the minimum case information necessary for the review. Generic design exercises can use fictional examples without personal records at all.

The communication guide's design rule is helpful here: make the experience understandable while keeping organizational roles, permissions, and handoffs explicit. Apparent simplicity should not hide responsibility.

Local differences belong in the agreement

Two communities can share a commitment to dependable support and require different arrangements.

One may have several transport providers. Another may have a limited service covering long distances. A program may offer interpretation directly or need to arrange it. A family may have a reliable internet connection, a basic telephone, or neither.

Ask about language, culture, beliefs, care needs, timing, and preferred involvement rather than assigning a communication style from demographic information.

A person may want a trusted community or faith organization involved. Another may prefer direct contact with the provider. Those preferences should shape the introduction without changing the facts or service limits.

Waymouth and colleagues' qualitative research identifies interacting barriers to home- and community-based services, including infrastructure, awareness, cultural and language differences, and caregiver circumstances. It supports looking beyond a single explanation for non-use. It does not establish how common every barrier is in a particular community.[42]

The practical response may be a different contact method. It may also require money, staff, equipment, or a service that is not presently available.

Relationships help people discover what is missing. They cannot substitute for the missing resource.

Give AI a useful place between the partners

An approved assistant could help with the repeated work around a handoff: assembling permitted information, checking for missing fields, locating current guidance, drafting updates, and preparing questions for a review.

It could compare the records made available for a particular task:

Day Center record: Pat was expected.
Transport record: The trip was confirmed, then disrupted.
Family report: No vehicle arrived within the agreed window.
Not established: A replacement journey was delivered.

That draft helps because it preserves the distinction between sources.

The assistant must not create the missing arrival event, infer that the family canceled, or mark the need resolved because the transport provider closed its booking.

Nor should we assume it can access the partner's records. Each connection, permission, and available field must be verified.

The dated Day Center export explicitly states that information does not automatically return to a referring practice. Its incident records identify owners and due dates, but the described workflow does not include a completed-at timestamp for measuring time to closure. Those limits remain relevant even when an assistant can write an excellent summary.

A useful planning assignment might be:

Using the approved partner agreements and current service information, draft a handoff for this defined need. Identify the information each recipient needs, the responsibility being requested, the confirmation required, and the response if that confirmation does not arrive. Mark every unresolved assumption. Do not treat a proposed action as an accepted commitment.

The transport lead checks transport facts. Lena reviews the center's responsibilities. Sam reviews the navigation task within his role. Clinical questions remain with the appropriate clinicians.

The workflow is familiar: retrieve relevant knowledge, add verified local context, prepare options, review, test, and revise. Keep research, design guidance, local facts, fiction, and permissioned personal information distinguishable, with sources, owners, dates, and corrections. Supplying the book does not train the model or establish reliable performance.

With reliable knowledge and clear rules, AI can be a gift to this work: less repeated assembly, clearer preparations, and more attention available for resolving the actual need.

Families may also revisit approved routine information outside office hours. The assistant must distinguish that availability from human dispatch or professional coverage and provide the actual route for urgent help.

Let contributors improve the connection

Chapter 10's learning approach belongs in the partnership too.

With appropriate agreement, limited live assistance could help a review group keep an unanswered question visible or retrieve the relevant agreement. Afterward, patients, participants, caregivers, volunteers, and staff can be offered separate opportunities to describe what helped and what should change.

The assistant can organize those contributions. It is not an independent judge of who was right.

Pat's request to know when he can stop waiting is a design contribution. Ellen's account identifies the uncertainty imposed on the household. The dispatcher understands

operational constraints. Day Center staff know what arrival support requires.

Bring those perspectives together without flattening them into one satisfaction score.

Credit useful ideas according to the contributor's preference. Keep private comments separate from shared meeting records. A general learning example should not expose the family whose experience prompted it.

The dated Day Center materials describe staff wins, observations, family feedback, and paired practice activities. They are examples of ways to invite contributions—not evidence that a particular partnership improved.

Before changing the process, practice it with a fictional interruption: the vehicle is unavailable, the usual contact is absent, or the digital channel fails.

Ask whether the new process leaves a responsible person holding the next action. Then test it in the actual setting and return to the contributors with what happened.

Fund the work between organizations

A partnership can fail even when every organization supports its purpose.

Someone must maintain contacts, check availability, receive changes, review information, investigate exceptions, and answer families. Those activities need time and coverage.

Do not send a community organization more referrals without discussing its capacity to respond. Do not require it to enter the same information into several systems without examining the workload. A well-intended referral campaign can increase the queue without increasing available care.

Agree who pays for coordination, interpretation, training, and required data work. Examine the costs of cancellations and backup arrangements. Do not assume that software fees cover the human service.

A coordinator needs authority to resolve the defined problem or reach someone who can. A backup must be more than a second name that has never been asked.

Partners also need room to decline work they cannot safely or appropriately provide. Honest limits make better planning possible.

The same approach applies beyond Day Centers. A rehabilitation clinic and home-care service need to know which professional guidance has been accepted. A primary-care practice and a community food program need to distinguish a referral from food actually received. An independent-living community and an outside care provider need clear responsibilities at the beginning and end of a visit.

Community and state groups can help establish shared definitions, convene partners, and identify recurring capacity gaps. They should not turn unlike organizations into a league table or treat greater referral volume as proof of better care.

Genus supplies technology. Partners retain responsibility for their services, staffing, programs, professional decisions, and voice.

When the community cannot yet provide the service

Consider a fictional community where several households want an appropriate service, but no provider has capacity at the times required. Improving the invitation cannot create those places. The partnership records the unmet demand, checks suitable alternatives with each person, and assigns a service-planning or funding owner to examine the larger gap.

People waiting receive an honest update and an appropriate route for needs that cannot wait. They are not recorded as uninterested, and a family is not made responsible for inventing a substitute. This is also local knowledge worth sharing: the constraint may require a resource decision beyond the authority of the navigator.

How would we know the partnership helped?

Choose one recurring handoff and establish a baseline.

For example, review confirmed transport arrangements connected with a defined program over a stated period. Agree whether the unit is one journey, a return trip, or a full service day. Report those units consistently.

Then test a manageable change over an agreed review window. A short local test can identify operational problems; it cannot establish long-term health or financial effects by itself.

A small measurement plan could examine:

Question	Measure and decision
Did the accepted service occur?	Completed agreed journeys divided by journeys due, with cancellations, changes, and unknown outcomes reported separately. The transport lead reviews failures.
Did people receive timely information?	Disruptions with a verified update within the agreed response window divided by all identified disruptions. The partners revise notification and coverage where needed.
Did the intended care become usable?	Confirmed Day Center days actually attended, with reasons for nonattendance retained. Transport completion alone does not answer this question.
What happened to unresolved needs?	Requests still awaiting acceptance, alternatives, or a decision, including how long they have remained open. A named coordinator reviews the next action.

Question	Measure and decision
What did the process require?	Family calls, waiting and coordination time; staff preparation, duplicate entry, review, and after-hours work. Operational leaders address burdens the new process creates.

Ask Pat and Ellen about the experience through the routes they prefer. Did they know what was happening? Could they reach a person? Did the arrangement provide worthwhile participation and usable time?

A local feedback question is not automatically a validated instrument. Use appropriate tools and expertise for formal claims about caregiver strain, quality of life, or other health outcomes.

Keep people who could not access the service in the evaluation. Separate a chosen decision not to use it from inability to obtain suitable assistance. Include language, geography, accessibility, cost, and other relevant differences where information can be collected appropriately.

Use the dates the question actually requires. Intake-to-first-day time is not referral-to-first-day time. Where a required date was not recorded, report the gap rather than relabeling another field. Appendix J contains the dated product example.

Keep reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact separate. Willingness to recommend, actual referrals, and services received by referred people are different events too.

Review failures without hiding them inside averages. An improved average among completed requests can conceal people still waiting.

Finally, give someone authority to change, narrow, or stop the process when it creates unsafe work, excessive burden, or misleading information.

Models and Evidence Behind This Chapter

The source-derived foundation is the Partner Handoff Agreement and the distinction between information exchange and received support. The studies below help examine particular components. The navigation and transportation trials are supplementary external evidence, not evaluations of CarePhysics or Genus.

Referral agreements and closed-loop communication

Confirm responsibility as well as receipt

AHRQ's *Make Referrals Easy* guidance recommends relationships and agreements between services, clear information exchange, help with barriers, and follow-up on whether referrals were completed. Its social-needs guidance extends that work to community resources and the person's choice about accepting help.[89]

TeamSTEPPS adds a related clinical communication principle: the receiving person acknowledges the handoff and has an opportunity to clarify the information and responsibility.[88]

Where we used it: The agreement names the action, recipient, confirmation, and response when the usual route fails.

Evidence boundary: These are practice frameworks and guidance. They do not demonstrate that the proposed agreement prevents missed services.

Local question: Does each transition have an accepted responsibility, or only a record that information was sent?

In-person service navigation

Assistance can add value beyond a resource list

Laura Gottlieb and colleagues' 2016 trial enrolled **1,809 caregiver–child families** in primary and urgent care at two safety-net hospitals. Allocation was randomized by day. Families received either written resource information or in-person navigation with follow-up calls.

At four months, the navigation group reported a greater reduction in social needs and greater improvement in parent-reported child health. Follow-up information was obtained from **1,054 participants—58.3 percent** of those enrolled.[90]

Where we used it: A resource introduction can include practical human assistance rather than leaving every step to the family.

Evidence boundary: This was a pediatric study with self-reported outcomes and substantial missing follow-up. It does not establish the same effects for older adults, dementia care, or an automated referral process.

Local question: What assistance makes this referral more usable for the people receiving it?

Transportation assistance

An offer is not the same as a workable solution

Krisda Chaiyachati and colleagues' 2018 pragmatic trial included **786 Medicaid-insured adults** at two Philadelphia primary-care practices. Participants were allocated by the weekday of a reminder call, rather than individually randomized, to usual reminders or reminders plus an offer of free rideshare transportation.

Missed appointments occurred in **36.5 percent** of the offer group and **36.7 percent** of the control group, with no statistically significant difference. Among 288 people reached in the offer group, 57 used the service.[91]

Evidence boundary: This tested a particular urban rideshare offer, not an assisted transport service for people living with dementia. The findings do not show that transportation is unimportant; they show that this delivery model did not improve attendance in that setting.

Local question: Does the transport option fit the person's actual needs, preferences, and circumstances?

Access to home- and community-based services

Investigate the system around the person

Molly Waymouth and colleagues' 2023 qualitative study analyzed **35 interviews** with service providers, administrators, and advocates. It identified barriers at community, infrastructure, interpersonal, and individual levels, with implications for rural access and inequities.[42]

Where we used it: The partnership examines service capacity, language, practical access, and caregiver circumstances alongside information.

Evidence boundary: These were stakeholder interviews, not a representative prevalence survey or a controlled intervention trial.

Local question: Which problem requires a clearer explanation, and which requires a different resource or service arrangement?

COM-B, social learning, and network support

Put relationships to work without mistaking them for capacity

COM-B helps identify the barrier before choosing a response. Social Physics emphasizes discovering useful information and having relationships through which to interpret and use it.

The research review informing this book grades the broader Social Physics perspective **Emerging-to-moderate** and the proposed community-navigator application **Moderate/Plausible**. It also warns that social learning can spread mistakes. These judgments do not validate a particular partner network.

Where we used it: Partners exchange practical knowledge, verify what each can provide, and learn from family and frontline contributions.

Local question: Did the relationship help someone receive appropriate support—not merely another recommendation?

One thing to try

Choose one partner to whom your organization refers people regularly.

Together, review a small set of recent handoffs, using information you are authorized to examine. Determine what was requested, who accepted the next responsibility, and what the person actually received.

Then rehearse one interruption: the service is unavailable, the usual contact is absent, or a confirmation does not arrive.

Revise the first place where both organizations could reasonably believe the other is acting. Name the person who will test the change and return the finding.

Your team's question is:

When the usual plan fails, does the person receive another number—or a responsible response?

Follow-through should leave more room for the day

In Context — A day, not another project

On a later confirmed Thursday, the transport service and Day Center used the revised arrangements.

The trip was confirmed by the people responsible for it. The driver and receiving staff completed the agreed arrival handoff. Pat joined the program, and the return happened as arranged.

Ellen did not have to verify every stage herself.

At the next check-in, Lena asked how it had felt.

"I went to meet my friend," Ellen said. "I wasn't making calls from the table."

Pat had something else to report.

"We still disagree about the building in that photograph."

"What do you think it was?" Sam asked.

"A bakery."

"And the others?"

"Unnecessarily uncertain."

The completed day was worth noticing. It was not proof that the partners would never encounter another problem.

The failed morning remained in the record, along with what had changed and what the team still needed to test. The separate request for an additional Tuesday remained a separate matter.

Lena now had a clearer way to explain the service's arrangements. The transport team had contributed operational knowledge. Pat and Ellen had shown what uncertainty felt like from the receiving side.

Some of that learning could help another organization.

But another community might have different services, languages, resources, and responsibilities. Copying the form would not be enough.

The next task is to preserve what is useful while allowing the people who use it to make it their own.

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CHAPTER 13

Shared Tools, Local Wisdom

At a Glance

The central idea: Share useful knowledge without erasing the judgment, relationships, and local understanding that make it useful.

What you'll explore: How a health system, care organization, Day Center, or community group can combine CarePhysics with its own experience and resources. Follow Lena's team as a thoughtful welcome becomes a reviewed resource another organization can adapt. Learn what should remain consistent, what should change locally, and what must never be copied without permission.

Design and AI: Build a small knowledge collection that connects research, practical guidance, current service information, and approved examples. Use it to prepare articles, videos, surveys, messages, training, and pathways—with clear sources, review responsibilities, and routes for corrections.

Put it to work: Create an **Organization Knowledge and Configuration Brief** and one complete, reusable knowledge entry.

Evidence and evaluation: Examine evidence-based practice, local opinion leadership, adaptation research, and responsible-AI guidance. Evaluate whether the knowledge improves understanding and useful support, how much work maintaining it requires, and whether local adaptations preserve essential facts and safeguards.

> *"Good doctors use both individual clinical expertise and the best available external evidence, and neither alone is enough."*
>
> — **David L. Sackett**, physician and clinical epidemiologist, "Evidence-based medicine," 1997.[92]

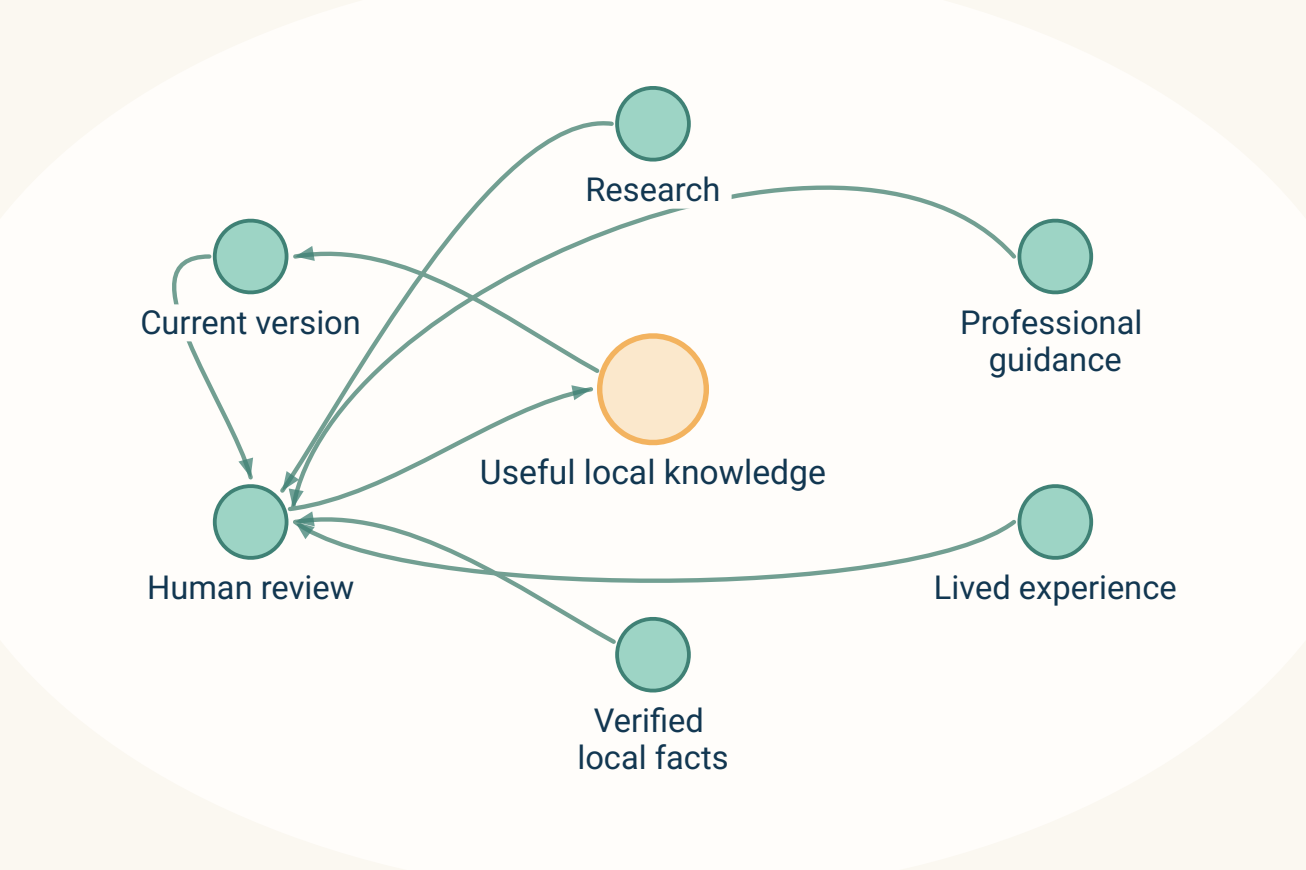


Figure 14 · Shared knowledge, local judgment

Bring research into human review with its source and limits. Bring the relevant professional guidance into the review. Bring lived experience into the review without treating it as equivalent to research evidence. Verified local facts allow reviewers to check practical fit. Accountable human review prepares knowledge for local use. Maintain a current version of the knowledge in use. Source or version changes return to review, including what depends on them. Shared knowledge does not erase local ownership, contributor credit or professional responsibility.

Knowledge	Its role in the work
Research and professional guidance	Preserve findings, populations, methods, limits, and source dates.
Local facts and design choices	Confirm actual services, resources, permissions, and who acts.
Personal context	Use only what is appropriate and authorized; do not put private encounters into a common library.
Human review	Resolve conflicts, credit contributors, test the application, and revise.

In Context — “Could you write down that part?”

The continuing family and team scenes are fictional illustrations. The resources and workflows describe proposed applications, not documented outcomes or universally available software capabilities.

A new team member had watched Lena welcome a family to the Day Center.

Afterward, she asked where to find the introduction Lena had used.

“The guide is in the resource folder,” Lena replied.

“I found that. I meant the part before the guide.”

Lena thought for a moment.

The visitor had asked whether coming to look around meant agreeing to attend. Lena had answered that question before explaining the program. She had asked what the person hoped to see and whether they preferred to begin with a conversation or a short look around.

None of it had required an elaborate speech.

But it had required choices.

“You didn’t start with the schedule,” the colleague said.

“They weren’t asking about the schedule yet.”

“Could you write down how you decide where to start?”

Later, another community organization asked whether Lena’s team had introductory material it could use.

Sending the document would be easy.

Sharing the useful part required more thought.

The other organization had different rooms, different staff, different services, and different arrangements for first visits. Some of Lena’s wording would fit. Some would make promises the other team could not keep.

What needed to travel was more than a script.

It was the reason behind the script—and a way for another team to make it true in its own setting.

A shared framework should not create identical care

The original CarePhysics manuscript describes a framework that brings an organization’s values, expertise, and resources into its engagements and pathways. It also recognizes the contributions of families, patients, caregivers, clinicians, and other professionals to that work.

This chapter makes that relationship practical.

Share useful knowledge without erasing local judgment, ownership, or the community's voice.

The ten principles provide common questions. They do not supply every local answer.

A health system needs its own clinical guidance and professional responsibilities. A home-care organization needs to explain what its workers provide in someone's home. A Day Center needs to describe its actual program. A community network needs current information about services people can reach.

Even within one organization, different people may need different explanations, formats, or assistance.

The aim is neither complete uniformity nor constant reinvention.

It is a dependable foundation that people can adapt thoughtfully.

At Genus, the research and working materials behind CarePhysics are used to inform development, content, training, and support. The August 31, 2026 export describes a shared knowledge foundation for development teams, wording decisions, and AI-assisted work. That is an internal working approach—not evidence that every resulting feature or answer improves care.

The same opportunity is available to other organizations: bring your own wisdom into a reviewed collection and use the relevant parts of this book to help examine and apply it.

You do not need to reproduce Genus's voice or adopt every tool to begin.

Preserve the purpose; adapt the expression

Before sharing a resource, identify what must remain intact and what another organization should reconsider.

For Lena's welcome, the purpose is to help someone explore the service without feeling that decisions have already been made for them.

The essential commitments include speaking directly to the person, explaining the scope of the visit, presenting actual options, and providing a way to ask questions.

The wording, setting, length, and delivery may change.

One team might begin with a telephone conversation. Another might offer a planned in-person introduction. A person may prefer to read beforehand, bring someone they trust, or ask questions privately.

Those differences need not weaken the approach. They may make it usable.

But changing the expression is different from changing the promise.

An informational visit must not quietly become enrollment. A request must not be presented as a confirmed service. "Someone will respond" needs a person and a realistic response arrangement behind it.

The communication approach used here makes this distinction central: consistency means preserving the underlying meaning, qualifications, and next step across channels —not repeating identical wording.

The unfamiliar-remote analogy applies here too. We want recognizable controls and ways to find help, not identical lives on the other side of the screen.

Keep the way through familiar. Adapt the support people find there.

Make practical wisdom explainable

A useful contribution may begin as something a person does almost without thinking.

Ask them to slow it down.

What did they notice? What question did they ask? Why did they choose that response? When would they do something different? What preparation or assistance made the encounter possible?

For Lena, the knowledge is not simply, “Use a warm greeting.”

It is that the visitor’s first concern may determine where the explanation should begin. A question about commitment deserves an answer before an account of activities. Someone asking about access needs practical information before being invited to imagine a pleasant day.

Capture exceptions too.

The approach may need to change when someone has an urgent concern, requires interpretation, wants privacy, or needs a clinical explanation outside the staff member’s role.

Invite contributions from everyone who experiences the service. Patients, participants, caregivers, volunteers, and frontline staff may identify different parts of the same problem.

Their experience gives us information to investigate. It does not automatically establish a general rule.

> **In Context — The family identifies what mattered**
>
> Lena asked Pat and Ellen what they remembered about their introductory visit.
>
> “Knowing I could look first,” Pat said.
>
> “Look at the rooms?”
>
> “Look at the whole arrangement. Without everyone deciding I’d joined.”
>
> Ellen remembered another part.
>
> “You told us what you could answer and what still needed checking.”
>
> Lena asked whether those ideas could help the team prepare its introduction for

> **In Context — The family identifies what mattered**
>
> other families.
>
> “Share the part about being asked,” Pat said.
>
> “Not your private information,” Lena replied.
>
> “Good. The book group has enough material.”
>
> Their feedback could inform a general design lesson without turning their family history into a training case.
>
> Lena’s team would record the contribution and the permission attached to it. If another organization used the resulting resource, it should know that participants and families helped shape the approach—not assume the insight came from the software.

Build a small collection around real questions

A knowledge bank does not need to begin with hundreds of documents.

Begin with a question the team encounters often:

How do we help someone understand what an introductory visit does—and does not—mean?

Gather only what helps answer it.

That may include a relevant CarePhysics section, approved communication guidance, the organization’s actual first-visit arrangements, a reviewed explanation from staff, and a fictional demonstration.

Keep those materials distinguishable.

Research addresses what has been studied. Design guidance proposes how to structure an experience. Local facts establish what the organization provides. An example shows what a conversation might look like.

Private personal context belongs under separate permissions, not inside the shared resource collection.

Organize knowledge-bank entries around human needs and design decisions, with sources, limitations, local facts, owners, review dates, and a way to test usefulness.

A proposed entry could look like this:

Knowledge-entry field	Example: Welcoming someone without deciding for them
Question and purpose	Help a person understand the introductory options and choose whether to explore further.
Relevant foundations	Holistic Care, Awareness, Behavioral Influence, Communications, and Community; the applicable sources remain attached.
Practice insight	Answer the concern the person brings before presenting the whole program. Identify this as a proposed practice to test, not a guaranteed result.
Verified local facts	Available introductory arrangements, eligibility process, costs, accessibility, contacts, and who can confirm a next step.
Demonstration	A clearly labeled fictional conversation showing an invitation, a question, a choice, and one exception.
What may change	Language, examples, format, pace, location, timing, and appropriate assistance.
What must remain	Accurate service information, meaningful choice, privacy, professional boundaries, and responsibility for follow-up.
Ownership and reuse	Named author or contributors, local reviewer, version, review date, permitted audiences and uses, and correction route.
How to test it	Can intended users explain what the visit involves and whom to ask? What effort, confusion, or pressure does the resource create?

This entry is not a new clinical instrument or another intake form. It is a working aid for the people designing and delivering support.

The collection should include a source's important qualifications near the usable guidance. A confident summary separated from its limitations is easy to reuse incorrectly.

It should also distinguish "not reviewed" from "reviewed and not suitable." Those are different reasons not to use an item.

Let culture and community shape the application

Local wisdom includes language, relationships, customs, beliefs, service history, and what people consider respectful. It also includes transport routes, working hours, costs, and the practical conditions of an ordinary day.

These are things to learn—not labels to assign.

AHRQ's cultural-humility guidance recommends recognizing each person's expertise about themselves, examining organizational assumptions, and asking rather than inferring preferences from identity or appearance.[13]

A person may want family members involved from the beginning. Another may want a private introduction. Someone may welcome faith-related support; someone else may prefer a secular setting or not want that subject introduced at all.

Record relevant preferences in the person's terms and with appropriate permission. Do not create an automatic script for everyone assigned to the same cultural group.

Language needs its own planning. Ask about preferences for conversation and written material, arrange appropriate assistance, and use reviewed translations. Consequential care conversations require qualified language support rather than assuming a generated translation or an available relative is sufficient.[14]

The organization's resources also change the design.

Consider three **illustrative adaptations** of the same introductory approach.

A health system may use it to explain a community referral after a clinical visit. Its version must distinguish the clinical recommendation from the receiving organization's acceptance and service assessment.

A home-care organization may use it to prepare for a first visit at home. Its version needs to explain who will arrive, what the worker can help with, privacy expectations, and what happens if the arrangement changes.

A Day Center may use it to introduce the environment and program. Its version needs current information about activities, support, attendance requirements, and arrival arrangements.

All three can preserve the same purpose: informed exploration with a dependable route to questions.

None can simply change the logo on the other's document.

Know who can settle a conflict

A shared collection will eventually contain information that does not agree.

An older welcome page may describe drop-in visits. A current service procedure may require appointments. A staff member may recall an exception. An AI draft may combine all three into a promise that sounds generous and is not reliable.

Define who can resolve the question.

For clinical instructions, the appropriate clinical authority reviews the conflict. For service facts, the responsible program owner confirms the arrangement. For information-sharing questions, the designated privacy or governance lead determines the authorized route. A design preference cannot overrule those responsibilities.

Do not tell an assistant simply to use the newest document. A recent informal message may not supersede an approved instruction.

> **In Context — A sentence that went too far**
>
> The team's draft invitation included:
>
> "Come by whenever it suits you, and we will show you around."
>
> Lena stopped at that sentence.
>
> "We need to arrange the visit. Otherwise we may not have someone available to welcome them properly."
>
> The colleague preparing the guide changed it.
>
> "Contact the team to arrange an introductory visit. We will explain the available times and any assistance we need to prepare."
>
> The wording was less effortless.
>
> It was also something the team could stand behind.
>
> That correction belongs in the knowledge entry, along with the reason. It can help the next reviewer recognize the same problem before publication.
>
> Where authority remains unresolved, hold the affected content and use the approved human route. Do not smooth over the conflict to keep the resource moving.

Use AI to prepare the work around judgment

A reviewed collection gives an assistant a better starting point. It does not make review unnecessary.

For the welcome resource, the team could ask:

Using the approved sources and current local arrangements, prepare an introductory article, a short demonstration outline, and an optional question set. Preserve the distinction between asking for information, visiting, assessment, and enrollment. Identify the source for factual statements, mark missing information, and show which parts another organization would need to replace or verify.

The proposed workflow is:

Define the need → retrieve relevant approved material → add verified local context → prepare options → review → try with intended users → revise.

Use the reviewed knowledge to prepare a response, not to decide in advance what the person must want.

Keep a reusable entry complete enough to stand on its own: the source and date, the task it can inform, the difference between evidence and proposal, the local facts still needed, the permitted audience, the reviewer, and essential reasons to stop or escalate. A shortened excerpt should not become an instruction after its limits and responsibilities have been left behind.

Creative expression can be adapted within those boundaries. The practical menu in Chapter 6 helps a local team choose a demonstration, photograph, story, question, or other form that fits its audience without inventing personal history or a therapeutic promise.

The assistant can reduce repetitive assembly. It can help a team find relevant guidance, prepare alternative explanations, identify inconsistent terminology, and organize a review.

It can also help preserve the connection between a piece of content and the reason it was designed that way.

But an assistant may retrieve the wrong passage, omit a qualification, or generate a statement the sources do not support. WHO's guidance identifies inaccurate or biased outputs and overreliance as risks, while supporting well-defined tasks and involvement of the people affected.[1]

Review should therefore check both what appears and what is missing.

The person responsible for the program verifies the service facts. An appropriate professional reviews clinical material. A content reviewer checks clarity and accessibility. Intended users help determine whether the result makes sense in practice.

The assistant prepares. Those responsibilities remain with people.

Distinguish a collection, retrieval, and training

A source-linked collection and an AI system that reliably retrieves from it are separate things.

Putting files in a folder does not establish that an assistant can find the appropriate passage, distinguish versions, or respect the permissions attached to them. Uploading this book does not train the underlying model or guarantee that it will apply the framework correctly.

A reviewed knowledge collection, a working retrieval system, and evidence of better care are three different things. Each needs its own verification.

Test the actual configuration.

Can it identify the current local source? Does it expose uncertainty? Does it keep fiction

separate from facts? Does it refuse to invent a response time when none has been approved?

Permissions must be enforced before restricted information is made available for a task. A sentence instructing an assistant not to disclose something is not a substitute for appropriate access controls.

An organization can begin with ordinary approved documents and human review. More elaborate retrieval or publishing functions can be added when their value and requirements are understood.

The knowledge-bank companion described in this book remains proposed. It should help organizations structure the work—not be presented as a completed service they already have.

Make one source set useful in several ways

Once approved, the welcome entry can inform a collection of materials without requiring every person to use all of them.

The article can explain the purpose and practical arrangements:

Your introduction, at your pace

An introductory conversation can help you decide whether our service is worth exploring further.

Begin with what matters to you. You may want to understand the activities, assistance, costs, or what a first visit involves.

For example: “I would like to see the setting before deciding whether to attend. What introductory options do you offer?”

Our team will explain the options currently available and what needs to be arranged or assessed. Asking for information is not an agreement to enroll.

Use the contact information provided with this guide to ask a question or request another format. We will explain who responds and what happens next.

Before use, the organization inserts its verified contact and response arrangements.

The video demonstrates rather than reads the article aloud. A staff member addresses the visitor directly, answers a concern, and explains a real option. Include an exception: the requested visit time is unavailable, so the team discusses another arrangement without pretending the service can accommodate everything.

Use consented footage or clearly labeled demonstration scenes.

The survey asks what remains unclear and which support would help. Explain who receives the answer, offer a human route, and allow the person to skip it. It is an improvement question, not an enrollment test.

The message offers only the relevant piece: “Here is the information you asked about

before your call.” It does not automatically enroll someone in a stream of unrelated content.

The pathway connects those elements with an actual contact, call, meeting, or visit. It identifies who responds when a question arrives. A tile can bring related material together; the pathway makes the next responsibility visible.

The pattern remains familiar: why it matters, the main idea, demonstration, chosen next step, questions or connection, and what follows. Urgent instructions lead with the urgent action. Validated questionnaires retain their required wording and scoring. Recreation may end with enjoyment rather than another task.

The benefit of reuse is not producing more material.

It is avoiding the need to rediscover the same reasoning each time while leaving room for the current person and situation.

Credit the contribution without taking the story

A reusable lesson does not need the full encounter that produced it.

Pat’s request to be asked before decisions are made can inform a welcome guide. The guide does not need his diagnosis, home circumstances, or private family concerns.

A volunteer’s demonstration can become a training example with their agreement. That does not authorize recording every future interaction.

A staff member can contribute an explanation without accepting responsibility for maintaining every version indefinitely.

Specify the permitted use. Does the contributor agree to internal training, public education, adaptation by other organizations, or a named quotation? Who reviews an edited version? How should credit appear?

Permission to use a service is not permission to use a person’s story. Nor is attribution a substitute for permission to reproduce material.

Where a generic example can serve the purpose, use one and identify it as fictional. Do not present a generated scene as a testimonial or a reconstructed memory.

The export’s proposed knowledge commons includes an important boundary: contributed guidance may shape wording and emphasis, but it must not add facts about a person. It also preserves the center’s option to decline contributed material.

That applies to funders and technology suppliers as well as care professionals.

A contribution should earn its place through relevance and review, not through the contributor’s influence over funding or purchasing.

Updating a source means updating what depends on it

Approval is not permanent.

A contact leaves. A service changes. New evidence qualifies an earlier claim. A

participant points out that a phrase has an unintended meaning.

Give each entry a review owner, a backup, a review date, and reasons for earlier review. The appropriate interval depends on what is likely to change and the consequence of being wrong.

Maintain a simple record of where the entry is used: articles, videos, tiles, training, scripts, pathways, and approved assistant resources.

When a material fact changes, identify the affected versions. Withdraw outdated guidance from active use, replace or clearly mark it, and contact the people who need to act differently. Printed copies and exported documents need attention too; updating a central file does not recall them.

Preserve the historical version for appropriate records without allowing it to appear current.

After updating an AI source set, test whether the configured assistant still retrieves or repeats the withdrawn instruction. Do not assume that editing the original document immediately changes every cached answer or previously prepared draft.

These are proposed maintenance requirements—not features to assume a platform already provides.

Local editing and cross-organization reuse depend on the actual authoring tools, permissions, and release process. Verify which changes a partner can make directly and which require technical work. Appendix J preserves the dated implementation limits; they should not be inferred from a proposed knowledge-bank design.

This chapter describes the stewardship an organization needs. The available tools must be checked against it.

Keep the benefits of assistance connected to people

With reliable knowledge, clear guidelines, practical rules, and accountable review, AI can be a gift to this work.

It can help turn a useful staff explanation into a draft resource, prepare local alternatives, and identify what needs checking. It can help a family revisit approved routine information or prepare a question at a time that suits them.

That assistance should give people more room for human attention—not create an expectation that every available minute produces more content.

Around-the-clock information is not around-the-clock professional care. State actual response hours, provide the appropriate urgent route, and make reaching a person straightforward.

Optional live assistance and post-encounter feedback, described in Chapter 10, can also contribute to learning. A useful idea may come from the clinician, patient, participant, caregiver, volunteer, or staff member.

Before reusing it, separate the lesson from the private encounter, confirm permission,

and have the appropriate person review it. The assistant is not an inherently neutral judge of which account should prevail.

Feedback may improve a source, a template, a prompt, a service arrangement, or the decision not to offer something. Those changes should be recorded explicitly. “The system learns” should describe a real process, not a hope that every correction automatically changes future behavior.

Maintain a record of the finding, the decision, the actual change, and remeasurement. Assign ownership even when this record must be kept outside the software. Appendix J distinguishes the proposed learning process from the functions described in the dated export.

Create an Organization Knowledge and Configuration Brief

This chapter’s practical output brings the decisions together.

It should be short enough for the people maintaining the collection to use, but specific enough that another reviewer can identify what is authorized.

Area	What the brief establishes
Purpose and audience	The human need, intended users, local setting, and what the collection is meant to help people understand or do
Shared commitments	Evidence, dignity, choice, accessibility, familiar structure, privacy, and accountable follow-through
Approved knowledge	Sources, evidence types and limits, local facts, professional guidance, approved examples, and material excluded from the collection
Local configuration	Services, contacts, languages, formats, timing, access assistance, capacity, and partner responsibilities
Authority	Who approves each kind of content, resolves conflicts, and covers an absent owner
Reuse and privacy	Contributor permissions, credit, permitted audiences, restrictions, and separation of personal records
AI role	Permitted tasks and sources, required review, human response routes, and actions the assistant cannot take

Area	What the brief establishes
Maintenance	Versions, review dates, change triggers, dependent resources, withdrawal, correction, and notification
Evaluation	Baseline, intended benefit, burden and safety checks, denominator, review period, and authority to revise or stop

The brief is a proposed planning tool, not certification that the knowledge or technology is reliable.

It should also make the arrangement sustainable when the person who started it is absent.

A collection that only Lena knows how to maintain has preserved documents without fully sharing the knowledge.

Resource the work behind the collection

Someone must select sources, check permissions, verify local facts, review drafts, prepare accessible formats, test materials, and maintain updates.

Budget for that work.

Provide staff with time to contribute and review—not an expectation to write resources at home. Involve intended users in ways that respect their time and circumstances. Keep practice and contribution separate from hidden performance scoring.

A trusted colleague can help explain a new approach, but no organization should depend entirely on one champion. A Cochrane review found that local opinion-leader interventions probably improved professional adherence to evidence-based practice, while effects on patient outcomes remained uncertain. The evidence supports examining how knowledge is introduced, not assuming that an enthusiastic advocate guarantees results.[93]

At community or state level, shared resources can reduce the need for every team to begin alone. Local organizations still need authority to assess fit, identify gaps, and decline unsuitable material.

A shared library cannot create an interpreter, an available appointment, transport, or staffing. When the proposed experience depends on a resource that is missing, record that requirement rather than editing it out of the explanation.

Genus supplies technology. Partners retain their care, staffing, programs, relationships, and voice. The legal ownership or governance of a broader shared collection requires its own documented arrangements; it should not be inferred from a product description.

How would we know it helped?

Choose one recurring task, such as preparing a first-visit explanation.

Record the existing process, then test a reviewed source-linked resource over a defined period. A four-week local test is an illustrative starting point, not a study design sufficient to establish long-term benefit.

Measure more than how quickly the first draft appears.

Can reviewers trace factual statements to the appropriate source? Are local arrangements accurate? Does the explanation preserve choice? Can the intended reader identify the next step and the person who responds?

Count all preparation and maintenance work: searching, drafting, checking, correction, translation review, publication, and responding to feedback.

For a defined sample, report how many items were reviewed and how many contained unsupported or outdated information. Keep significant errors visible rather than averaging them into a favorable overall score.

Test a change as well. Can the team find and replace the materials affected by a deliberately changed **fictional test fact**, without introducing errors into live care information?

Ask about access and burden. Who could not use the format? Who preferred a conversation? Did the revised guide reduce confusion or simply move the explanation work to the family?

Separate reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact. Willingness to recommend, actual referrals, and services received by referred people remain different questions.

AHRQ's materials guidance supports evaluating understandability and actionability with intended users rather than relying on appearance or readability alone.[26]

Record what changed because of the findings, including a decision to remove material or stop an unhelpful workflow.

A large library is not the outcome.

A better starting point—accurate, usable, maintained, and worth the effort—is.

Models and Evidence Behind This Chapter

The research and guidance below help examine the proposed knowledge-bank and local-adaptation approach. They address evidence-informed judgment, adaptation, professional learning, and responsible assistance—not the effectiveness of the complete design.

Evidence-based practice

Neither research nor experience should stand alone

Sackett's 1997 discussion describes evidence-based medicine as combining research evidence with clinical expertise and attention to the individual patient's circumstances, rights, and preferences. It is a conceptual account of practice, not a trial of a knowledge bank.[92]

Where we used it: Research, local professional judgment, and the person's priorities inform different parts of a decision.

Evidence boundary: This chapter extends that discipline to organizational content and support design. It does not turn a local preference into clinical evidence.

Local question: Are we using both relevant evidence and the knowledge needed to apply it appropriately?

Local opinion leaders

Knowledge often needs a credible human route

Flodgren and colleagues' 2019 Cochrane review included **24 randomized studies** of local opinion-leader interventions. Eighteen studies contributed to the main estimate: a median adjusted absolute improvement of **10.8 percentage points** in professional adherence to evidence-based practice, with **moderate-certainty evidence**.

All studies were conducted in high-income countries, and the targeted professionals were usually physicians. Evidence about patient outcomes was **very low certainty**; costs were not reported.[93]

Where we used it: Staff explain, demonstrate, discuss, and help adapt knowledge rather than merely receive a folder.

Evidence boundary: The review did not test this welcome guide, a Day Center knowledge bank, or AI-generated content.

Local question: Who helps people understand and use the resource, and what changes beyond distribution?

FRAME: documenting adaptations

Make local changes inspectable

Shannon Wiltsey Stirman, Ana Baumann, and Christopher Miller's 2019 paper developed the expanded **Framework for Reporting Adaptations and Modifications**, known as FRAME. Its development drew on literature, qualitative interviews, and stakeholder refinement.

It asks what changed, when, by whom, why, and whether the change preserves the intervention's essential elements.[94]

Where we used it: The proposed record distinguishes a change in wording or delivery from a change in service content or responsibility.

Evidence boundary: FRAME is a reporting and research framework—not proof that adaptation improves outcomes. The chapter's knowledge-entry tool is not a validated

substitute for it.

Local question: Can another team understand exactly what we changed and why?

Cultural humility and understandable materials

Adapt with the audience, not merely for it

AHRQ recommends learning from people about their preferences and circumstances, providing appropriate language support, and assessing whether materials are understandable and actionable. These are practice resources, not trials of the proposed collection.[13]

Where we used them: Language, examples, format, involvement, and assistance are discussed with intended users while facts and responsibilities remain clear.

Local question: Does the adaptation reflect what people told us, or what we assumed about them?

Social Physics, autonomy, and responsible AI

Help knowledge travel without taking over the decision

The research review informing this book uses Social Physics to examine discovery and social learning, while warning that people can share mistakes as well as useful ideas. It grades the broader perspective **Emerging-to-moderate**. Self-Determination Theory adds attention to chosen participation, with **Moderate** intervention evidence in the review.

WHO's AI guidance supports defined tasks, stakeholder involvement, privacy, and human responsibility while warning about inaccurate outputs and inappropriate delegation. It is governance guidance, not evidence that this assistant improves care.[1]

Where we used them: Contributors retain a voice, organizations can decline material, and AI helps prepare reviewed options rather than deciding what everyone should adopt.

Local question: Does sharing increase people's ability to understand and choose—or simply spread the same answer farther?

One thing to try

Choose one explanation, demonstration, or practical approach your team finds useful.

Ask its contributors what makes it work, when it does not fit, and what another team would need to know. Obtain permission for the intended reuse.

Create one knowledge entry with its sources, local facts, limits, owner, and review date.

Then ask a colleague unfamiliar with the approach to use the entry to prepare a small draft. Review what they misunderstood and what the entry failed to explain.

Your team's question is:

Could someone use this knowledge well without needing the original contributor to explain everything again?

Sharing the resource begins another question

In Context — “The question can travel”

When the other organization received Lena’s material, it received more than the invitation.

The packet explained its purpose, the sources used, the choices that should remain with the visitor, and the local facts that needed replacing. It included the review history and a contact for questions about the approach.

The receiving team had a different first-visit arrangement. It would begin by telephone and offer an in-person introduction when the appropriate staff were available.

Lena reviewed their questions.

“The wording will be different,” her colleague said.

“It should be,” Lena replied. “Their service is different.”

Later, she told Pat and Ellen that the general lesson was being considered elsewhere.

“What lesson?” Pat asked.

“Ask what someone wants to understand before deciding where the introduction begins.”

“That seems worth taking along.”

“They will need to try it with their own participants,” Lena said.

“Of course,” Pat replied. “We haven’t met them.”

The resource had traveled. The judgment had not been outsourced.

Now a new question remained: what would the next organization discover when it used the adapted approach?

Jordan’s forthcoming shared-learning conversation would need those answers—including what did not work, what required more support, and whose experience had not yet been heard.

A resource shared is a beginning.

Learning across communities requires knowing what happened after it arrived.

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

Return to text 1 · Return to text 2

13. Agency for Healthcare Research and Quality (2024). Consider Culture, Customs, and Beliefs: Tool 10. Health Literacy Universal Precautions Toolkit, 3rd edition. Source

Return to text 1 · Return to text 2

14. Agency for Healthcare Research and Quality (2024). Address Language Differences: Tool 9. Health Literacy Universal Precautions Toolkit, 3rd edition. Source

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26. Agency for Healthcare Research and Quality (2024). Assess, Select, and Create Easy-to-Understand Materials: Tool 11. Health Literacy Universal Precautions Toolkit, 3rd edition. Source

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92. Sackett DL (1997). Evidence-based medicine. Seminars in Perinatology. 21(1):3–5. DOI: 10.1016/S0146-0005(97)80013-4. Source

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93. Flodgren G, O'Brien MA, Parmelli E, Grimshaw JM (2019). Local opinion leaders: effects on professional practice and healthcare outcomes. Cochrane Database of Systematic Reviews. CD000125. DOI: 10.1002/14651858.CD000125.pub5. Source

Return to text 1 · Return to text 2

94. Wiltsey Stirman S, Baumann AA, Miller CJ (2019). The FRAME: an expanded framework for reporting adaptations and modifications to evidence-based interventions. Implementation Science. 14:58. DOI: 10.1186/s13012-019-0898-y. Source

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CHAPTER 14

From Local Experience to Shared Learning

At a Glance

The central idea: The most valuable findings often reveal not who failed, but where the system makes useful care unnecessarily difficult.

What you'll explore: How families, frontline teams, organizations, and communities can learn from one another without treating every difference as a ranking. Join Jordan as participating organizations examine transportation problems, unanswered requests, and the experience of using shared resources. Learn to distinguish an encouraging example from a finding another community can responsibly apply.

Design and AI: Use common definitions, clear explanations, and appropriate information sharing to make findings understandable. Explore how an approved AI assistant could organize feedback, identify questions, retrieve relevant knowledge, and prepare locally adapted options while preserving privacy, uncertainty, and contributor credit.

Put it to work: Create a **Shared Learning Brief** that records what was offered, who could use it, what happened, what it required, and what should be tried next.

Evidence and evaluation: Examine collaborative improvement, structured comparisons, social learning, and responsible reporting. Measure whether learning changes support—not merely whether organizations exchange reports.

> *"Everyone in healthcare really has two jobs when they come to work every day: to do their work and to improve it."*
>
> — **Paul B. Batalden, MD, and Frank Davidoff, MD**, "What is 'quality improvement' and how can it transform healthcare?", 2007.[95]

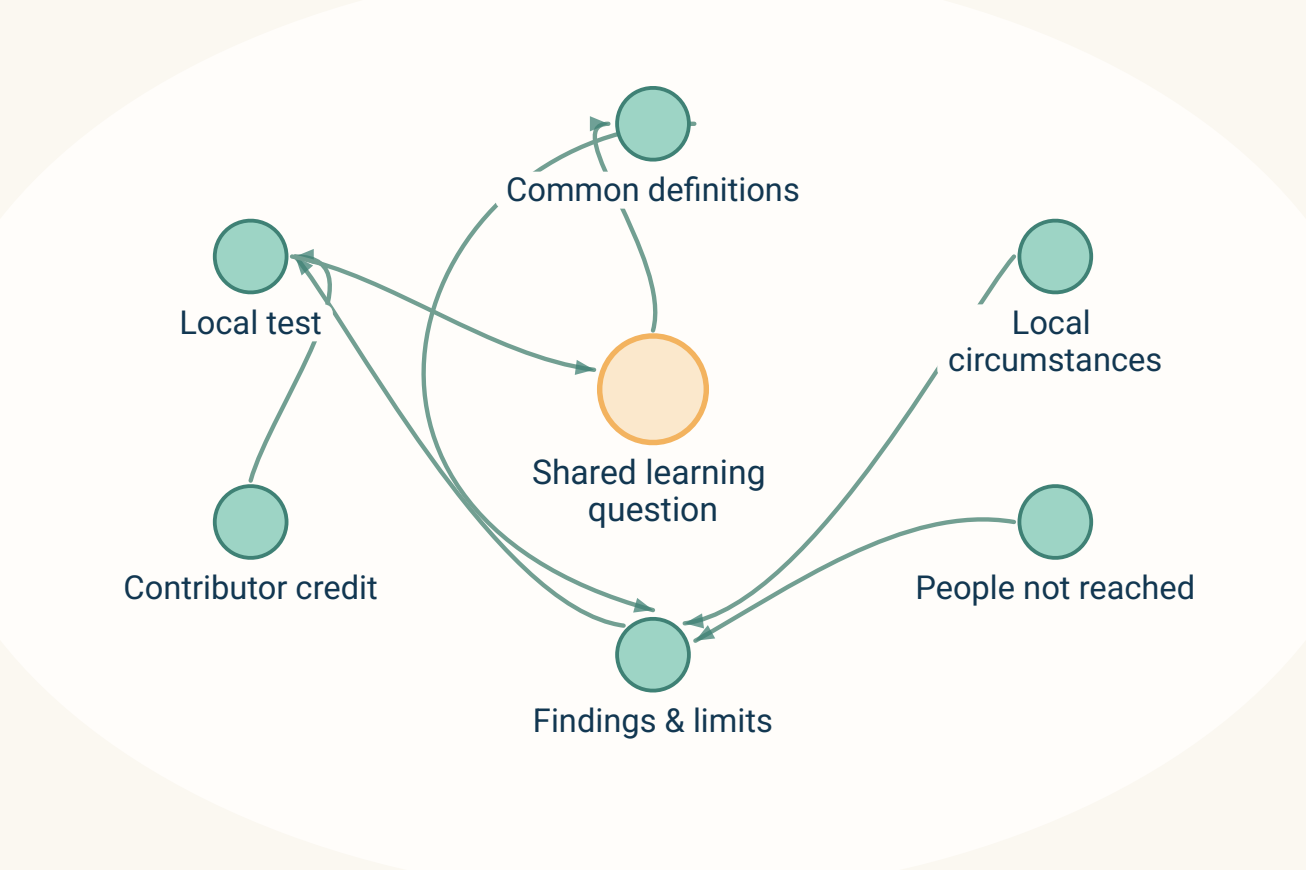


Figure 15 · A lesson travels with its context

Agree common definitions around the shared learning question. Common definitions help establish whether findings can reasonably be compared. Local circumstances qualify the meaning of findings. The experience of people not reached belongs beside the findings. Findings and their limits inform a proposed local test. Carry contributor credit with the idea being tested. Return learning from the local test to the shared question. An encouraging example does not establish that the same result will transfer to another setting.

From one setting	To another
A local experience	Record the people, need, setting, actual change, result, effort, and uncertainty.
A reviewed lesson	Share permitted knowledge with its sources, limits, and contributor credit.
A new application	Check local fit, resources, and responsibilities; test rather than assume the same result.

In Context — “What did the next organization learn?”

The continuing family and regional-learning scenes are fictional illustrations. They are not reports of measured results from actual organizations or a deployed regional platform.

Lena’s welcome resource had reached another organization.

That was worth noticing. It was not yet an answer to whether the resource helped.

Before the next shared-learning conversation, Lena asked Pat and Ellen whether the general lessons they had agreed to contribute still represented what they wanted understood.

“Ask people what they want to know,” Pat said.

“And tell them what still needs checking,” Ellen added.

Their private care information would not accompany the lesson.

Jordan, who helped participating organizations learn together, was preparing a meeting about access to community support. The group had agreed to review appropriately prepared service summaries and general lessons—not open individual family records.

Lena brought two subjects: the welcome approach and what the team had changed after a confirmed ride did not arrive.

Another organization brought a different concern. Families were receiving information, but staff did not know whether the requests for a conversation were reaching the right person.

On the first page of the meeting materials, several reports used the phrase *referral completed*.

“What does that mean in each report?” Jordan asked.

“For us, it means we spoke with the family,” one representative said.

“We use it when the person attends,” another replied.

Lena looked at the page.

“Those are both worth knowing. They aren’t the same thing.”

Jordan set the comparison aside.

“Then our first job is to understand the accounts we’re comparing.”

The group had not discovered which organization was doing best.

It had discovered why it could not yet answer that question.

Sharing is the beginning of learning

Chapter 10 examined how to learn from an encounter and improve a local process.

Chapter 13 showed how to preserve useful knowledge so another team can understand and adapt it.

This chapter asks what happens after that knowledge travels.

Was the resource used? What did the receiving organization change? Did the intended people find it useful? What support was needed? What happened differently?

The most valuable findings often reveal not who failed, but where the system makes useful care unnecessarily difficult.

Shared learning connects community, feedback, and continued refinement across organizations while keeping recorded activity distinct from demonstrated benefit.

A shared-learning group is not simply a larger dashboard.

It is an arrangement through which people can bring questions, compare appropriately, discuss possible explanations, try changes, and return with what happened.

The learning can move in both directions. A regional group may help a local team find a useful approach. A participant's observation may reveal a problem that several organizations have overlooked.

Purpose gives this work a boundary. We are not collecting information because it might someday be interesting. We are trying to make a particular part of care more useful, reachable, or dependable.

For Ellen, that may mean fewer calls to establish whether a service is arranged. For Pat, it may mean reaching the people and activities he wants to see.

Those purposes should remain recognizable even when the discussion moves to a regional meeting.

Choose the shared question before collecting the reports

Begin with a need that participating organizations recognize.

"Improve engagement" is too broad to guide the first comparison.

"Help people who request an introductory conversation receive a useful response" identifies something the group can examine.

So does:

"Help people with confirmed transportation reach the service they have chosen, and receive a timely human response when the trip is interrupted."

These are related questions, but they require different information and possibly different solutions.

Ask the people experiencing the problem to help define it. Include those receiving care, caregivers, staff, volunteers, and partners responsible for relevant services. They may not describe the difficulty in the same terms.

A navigator may see an uncompleted referral. A caregiver may describe a week of

unanswered calls. A provider may describe requests it lacks capacity to accept.

Each account helps establish what must be investigated.

COM-B provides a useful discipline here: before choosing a response, consider whether the barrier concerns understanding, skills, opportunity, motivation, or a combination. The research review informing this book specifically cautions against sending more reminders when the actual problem is cost, transport, exhaustion, or unavailable support.

The shared question should also identify who can act on the answer.

If a group can revise an article but has no authority over transport, it can improve the explanation and document the remaining gap. It should not present the clearer article as a solution to the missing ride.

Make the measures mean the same thing

Before comparing percentages, agree what is being counted.

A person, household, referral, journey, visit, and service day are different units. A return trip may involve two journeys but support one attended day. Several contacts may concern one unresolved request.

For each shared measure, write down its definition, starting event, ending event, time window, data source, and what happens when information is missing.

The dated Day Center materials call for shared definitions of instruments, denominators, and time windows before centers compare findings. They describe this as a document the field can use—not a feature that must wait for new software.

A small definition set might distinguish:

Shared term	What must be established
Request received	The service received a specific request, with an actual receipt date.
Human contact completed	An appropriate person and the intended recipient had the agreed conversation—not merely that a message was sent.
Service accepted	The responsible provider accepted a defined action, subject to any conditions still identified.
Service received	The agreed support actually occurred. A booking alone is insufficient.
Need still unresolved	Appropriate support has not been secured, even if one provider answered or declined.

Shared term	What must be established
Usefulness reported	The identified respondent described the experience, using the stated question and time period.

These are proposed working definitions. Partners should refine them for the task without changing their meaning silently between reports.

Do not manufacture a missing starting date. Intake, referral, acceptance, and attendance are different events. A regional report cannot rename one as another to make a measure appear complete. Check the field definitions and coverage before comparing services.

When definitions differ, retain the separate results until they can be compared appropriately.

A blank comparison is more honest than a precise comparison of different things.

Put the circumstances beside the result

Even shared definitions do not make different organizations interchangeable.

One center may serve people over a large geographic area. Another may have transport nearby but insufficient program capacity. One team may have interpretation available during introductions; another may need to arrange it. The support needs of the people referred may also differ.

Ask what was available, what was offered, and what was actually delivered.

Record the relevant pathway and content versions. A comparison becomes difficult to interpret if one team used a new welcome guide, another changed its staffing, and a third changed its eligibility process during the same period.

SQUIRE 2.0, a reporting framework for healthcare improvement, emphasizes the importance of explaining the local setting, the reasons for a proposed change, and how the change was studied. These are supplementary reporting principles—not evidence that the proposed CarePhysics network improves care.[96]

> **In Context — Similar numbers, different problems**
>
> Jordan asked the group what might explain differences in access besides the quality of a welcome message.
>
> “Distance,” a transport representative said.
>
> “Whether there is a place available after the conversation,” another participant added.
>
> “Whether we recorded everyone who asked,” Lena said. “Not only those who completed intake.”

> **In Context — Similar numbers, different problems**
>
> They examined the service conditions beside the reports.
>
> One organization wanted to test an earlier telephone introduction. Another already called promptly but could not offer enough suitable places. A third needed to establish whether requests made outside office hours reached the following day's responder.
>
> The group did not choose one message and send it everywhere.
>
> It identified different next actions.
>
> That is the practical value of comparison: not deciding who deserves praise before understanding the work, but finding a question worth investigating.
>
> Differences can reveal an approach worth learning from. They can also reveal unequal resources, incomplete records, or a mismatch between the service and the people seeking it.
>
> Do not use context to excuse every failure. Use it to identify which change could plausibly help.

Learn from the people who never reached the service

A service can look successful when the report includes only people able to use it.

Ask what happened to those who requested information but did not reach a conversation, were found ineligible, could not afford the service, could not travel, withdrew, or chose something else.

Keep *unknown* separate from *declined*.

A person who understands an option and decides against it has made a decision. A person who wants the service but cannot obtain it faces an unmet need. The research review informing this book preserves that distinction and warns against equating continuing digital activity with benefit.

Offer appropriate ways to hear from people without repeatedly pursuing those who do not want contact. Ask permission for follow-up and respect the route they prefer.

Language, culture, beliefs, family arrangements, disability, work schedules, and resources may shape the experience. Ask how; do not infer the answer from a name, neighborhood, or group label.

When comparing reported experiences, keep the respondent clear. Pat's account, Ellen's account, and staff observations are not interchangeable. Standardized instruments require suitable versions, consistent administration, and appropriate interpretation. An improvised translation or AI rewrite is not automatically equivalent.

Collect only the additional information justified by the evaluation and its permissions. Missing demographic information cannot be inferred from names, appearance, address,

or unrelated records. State which comparisons the available record cannot support.

A shared-learning group should ask who is missing from the discussion as well as who is missing from the data.

Make room for solutions from every direction

The strongest proposal may come from someone without a management title.

A patient may identify a confusing preparation step. A participant may explain why the timing of a choice matters. A caregiver may recognize that several organizations are all asking the same question. A volunteer may find a more comfortable way to demonstrate a tool. Staff may know which task repeatedly extends beyond the shift.

Provide routes for those contributions before, during, and after a shared-learning meeting.

An optional conversation, short written response, accessible survey, or agreed voice note can serve different people. Explain who receives it, what it may influence, and whether the contributor wants a reply or acknowledgment.

Do not require people to attend a long regional meeting to have a useful idea considered. Where participation requires time, travel, interpretation, or substitute support, plan and resource those needs.

With agreement, limited real-time AI assistance could help a facilitator retain an unanswered question or retrieve an approved resource. Immediate post-meeting feedback could help participants describe what helped and what remained unresolved.

Neither process should become hidden evaluation of staff or a mechanism for deciding which person is right. An organization-operated assistant is not an independent referee.

Credit contributions with permission. A general lesson can travel without the private encounter that produced it.

Pat's contribution in an earlier chapter was that he wanted to know when he could stop waiting. The regional group can examine the design question—how people receive a dependable update during a disruption—without receiving Pat's household records.

A contribution deserves attention because it may improve care, not because the contributor agrees to become a public story.

Protect the people while sharing the lesson

Shared learning does not require universal access to individual records.

For many questions, organizations can begin with agreed definitions, locally checked totals, descriptions of their process, and carefully prepared general lessons.

More detailed analysis may require controlled access to additional information. Establish the purpose, authorization, access, retention, review, and permitted reporting before moving it.

Information prepared for direct care is not automatically appropriate for regional analysis, publication, supplier development, or model training.

Removing names is not a complete privacy method. NIST's de-identification guidance emphasizes evaluating disclosure risks and choosing an appropriate data-sharing model; tools that merely mask personal information may not provide sufficient protection.[97]

For this proposed collaboration, the privacy reviewer should examine whether combinations of details, small groups, or repeated reports could reveal a person. The appropriate response may be to withhold a breakdown, use a broader description, or keep the analysis in a restricted setting.

Do not invent a universal "safe" group size. The context and information matter.

A public report needs a different level of detail from a restricted working discussion. Exact quotations, unusual circumstances, and recognizable stories require particular care.

Privacy should not become an excuse to ignore inequity. It is a reason to design a responsible way to investigate it, with appropriate expertise and involvement from the people affected.

Give AI the preparation work—not authority over the conclusion

Jordan's group may have several kinds of material to consider: approved local briefs, data definitions, general feedback, current resource information, and relevant research.

An approved assistant could help organize those materials before the meeting.

It might identify that two reports use different starting dates, that a claim of reduced workload lacks time data, or that a proposed solution depends on a service unavailable in one community. It could retrieve relevant CarePhysics guidance and prepare questions for human review.

A useful assignment would be:

Using the approved local briefs, definitions, and research, prepare a comparison of what was offered and what happened. Preserve differences in populations, resources, timing, and measurement. Show missing information and alternative explanations. Identify suggestions contributed by people receiving or providing care. Propose questions and possible adaptations—not rankings or causal conclusions.

Each organization checks the facts attributed to it. A qualified analyst checks calculations and comparisons. The relevant service leaders assess feasibility. The privacy reviewer checks what may be shared. Jordan facilitates the discussion but does not inherit every professional responsibility.

> **In Context — The draft makes the uncertainty visible**
>
> The assistant's first comparison used the heading:
>
> "Successful referral approaches."

In Context — The draft makes the uncertainty visible

Jordan changed it to:

“Approaches being examined.”

One organization had reported completed conversations. Another had reported attended visits. Neither comparison yet established which approach produced better access.

Lena asked the assistant to show the source behind a claim that the revised introduction reduced staff work.

There was no time measure in the approved brief. Staff had described the guide as useful, but the total preparation and review effort had not been measured.

They kept the reported usefulness.

They removed the time-saving claim.

The corrected draft gave the meeting a better starting point because it did not pretend to know the answer.

AI can also help after review: draft a revised article, prepare a demonstration outline, or organize a local test. It can capture a useful explanation and reduce repeated assembly.

With reliable knowledge, clear guidelines, practical rules, and accountable people, that assistance can be a gift. It leaves more of the meeting for interpretation, ideas, and decisions.

The workflow remains **retrieve → add verified local context → prepare options → human review → test → revise**. Keep research, design guidance, local facts, fiction, and permissioned personal information distinct. Uploading the book is not model training, and a corrected draft does not automatically change future system behavior.

An assistant may make approved routine explanations available outside office hours. It should state when human help is available and provide the appropriate urgent route. A shared-learning channel is not an emergency or care-coordination service.

This chapter proposes a shared-learning arrangement. Check actual reporting boundaries, partner permissions, and the authority to combine data before implementing it; automated regional analysis is not assumed. Dated examples and planned functions remain separate in Appendix J.

Create a Shared Learning Brief

A **Shared Learning Brief** helps another organization understand the result without needing access to the original people or records.

It should be readable enough for a partner meeting, with methods and supporting detail available to reviewers. Organize the brief around these questions: what was offered, who could access it, what was used, what changed, what burden occurred, what remains uncertain, and what will be tested next.

Brief section	What it should make clear
The human question	What difficulty or opportunity prompted the work, and whose priorities shaped it?
The setting	Who was served, who was not reached, and which services, resources, languages, and access conditions mattered?
The approach	What content, encounters, support, and staff preparation were actually provided? Identify versions and local adaptations.
The comparison	Baseline, time window, units, definitions, data sources, missing information, and any comparison group or alternative approach
The findings	What changed, what did not, and what people reported—keeping process, experience, outcomes, and attribution separate
The cost and burden	Family effort, staff time, training, travel, review, technical work, and any safety or access problems
The interpretation	Plausible explanations, limitations, disagreements, and what the evidence does not establish
The next decision	Continue, adapt, test further, narrow, stop, or address a resource gap—with a named owner and review point
Sharing and credit	Contributors, sources, permissions, funding or supplier interests, and the version approved for reuse

This is a proposed planning and reporting tool, not a validated assessment.

A brief can conclude that the original idea was not useful. It can report that families liked the explanation but still could not reach the service. It can identify a promising result that requires further testing.

Do not force every brief to end with an expansion recommendation.

Return the learning in forms people can use

The people who contributed should not need to read a technical report to discover what happened.

Use a familiar explanation: what prompted the review, the main finding, an example, what will change, how to ask a question, and what follows.

In an **illustrative update about the transport process**, the team might say:

What we are changing about interrupted journeys

People told us that waiting without an update made it difficult to decide what to do next.

The partners have agreed to test an earlier human update when a confirmed journey is disrupted, even when a replacement has not yet been found.

The update should explain what is known, what remains uncertain, and who is checking the next option.

This does not create additional transport capacity. We will examine whether the change improves clarity, what work it requires, and which needs remain unmet.

You can ask about your own arrangements through the service contact provided. Feedback on the revised process goes to the named review lead.

A video could demonstrate the new conversation, including the case in which no suitable replacement is available. An article could explain the partnership's actual responsibilities. A short survey could ask whether the update arrived and whether it helped. A tile could collect those materials; a pathway could connect them with the appropriate call and follow-up.

These formats should carry the same facts while performing different jobs. The communication approach used here calls for consistency of meaning, qualification, and next step—not identical wording.

Adapt language, format, examples, and assistance with local users. Keep critical service information accurate. Preserve validated instruments rather than rewriting their questions to match a preferred style.

Most importantly, do not use a better explanation to disguise a resource shortage.

Try what travels—do not assume it transfers

A finding at one organization can justify interest elsewhere. It does not establish the result the next organization will obtain.

Identify what appears essential to the approach and what can be adapted. Then document what was actually changed.

For a shared welcome resource, the common purpose may be informed exploration

without pressure. One local version begins with a call; another begins with a planned visit. Each needs its own service facts and response capacity.

Compare the intended experience, not superficial resemblance.

For a learning test, state the expected benefit and a burden or safety concern in advance. Use repeated observations and an appropriate comparison for the strength of claim intended. Obtain the relevant professional, privacy, and research review when the design requires it.

A small improvement test can reveal a confusing message or an unowned task. It cannot by itself establish that an intervention reduces hospital use or caregiver strain across a state.

When a result is uncertain, say whether the main problem is limited data, inconsistent implementation, an unsuitable measure, or findings that do not favor the approach.

“No clear improvement” does not always mean “proven ineffective.” It also does not justify a claim that success is merely waiting to be confirmed.

The receiving organization needs the unsuccessful attempts and the costs as much as the attractive example.

Make the collaboration sustainable

The opening quotation is an invitation to improve the work, not an instruction to add an unpaid second shift.

Provide time for preparation, interpretation, testing, and review. Fund accessible participation, language assistance, necessary technical work, and appropriate recognition for contributors.

Ask smaller organizations what reporting they can sustain. A group with the most polished data may simply have more analytic staff. Do not make production of an elaborate report the price of having its needs heard.

Agree how decisions are made, how disagreements are recorded, and who can stop an unsafe or burdensome test. Disclose funding and supplier interests. A funder can contribute knowledge without receiving a private channel to shape what families read.

The dated materials explicitly propose voluntary contribution, local choice, and reporting null findings alongside wins—even when the contributed material comes from a funder.

At regional or state level, learning may point toward changes in service hours, transportation, workforce preparation, language access, or funding. Those require responsible resource decisions, not an algorithm allocating support according to unadjusted scores.

The same approach can serve health systems, rehabilitation programs, home-care organizations, and independent-living communities. The shared question may differ; the need to understand what happened and what it required remains.

Genus supplies technology. Partners retain their care, staffing, programs, relationships, professional decisions, and voice.

A learning network should strengthen that responsibility, not obscure it.

How would we know shared learning helped?

Evaluate the collaboration as well as the local projects.

A resource shared is an output. Another organization trying it is adoption. A sustained, useful change is a further result. Improved experience or health requires its own evidence.

Choose a small set of measures with a baseline, denominator, time window, source, and owner.

For example, among agreed improvement actions due during a review period, how many were carried out and examined again? Report actions delayed, abandoned, or still unresolved. Count the staff and family effort required to reach those decisions.

Then follow the relevant human outcome. Did a requested conversation occur? Did a confirmed service arrive? Was the caregiver's time usable? Could the participant influence the day? Did a clearer process reduce uncertainty without creating excessive work?

Include organizations that withdrew and their reasons. A collaboration may lose a participant because its purpose no longer fits, because reporting is too costly, or because capacity has changed. Do not silently remove those experiences from the account.

Retain the nine CarePhysics outcome areas as questions to evaluate: culture of care, integration of social needs, care equity, community connections, stronger relationships, quality of life, reduced burnout, improved care outcomes, and organizational sustainability. They are not nine guaranteed effects of sharing information.

Keep willingness to recommend, actual family or partner referrals, and received services separate. Track available capacity beside demand. More referrals into an unchanged queue may increase unmet need.

Repeated reports also require careful interpretation. An apparent improvement may reflect a changed population, season, recordkeeping process, or service elsewhere. Use appropriate analysis rather than treating every before-and-after difference as the effect of the shared approach.

Finally, ask whether contributors heard what happened to their ideas.

A network that gathers experience without returning useful learning has completed only part of its work.

Models and Evidence Behind This Chapter

The CarePhysics outline supplies the chapter's purpose and proposed Shared Learning Brief. The following sources support particular design questions. The improvement-

collaborative review, SQUIRE reporting framework, and de-identification guidance are supplementary external foundations, not evidence that a CarePhysics network has been tested.

Improvement as shared work

Include the people who experience and provide care

Batalden and Davidoff's 2007 editorial describes improvement as a combined effort involving professionals, patients, families, researchers, planners, and others. It also emphasizes leadership, support, and learning how to test changes. This is a conceptual account, not an intervention trial.[95]

Where we used it: Contributions can come from patients, participants, caregivers, volunteers, and frontline teams, while organizations provide the resources needed to act.

Local question: Who can influence the work—and who is expected only to supply information?

Quality-improvement collaboratives

Collaboration can help, but its label does not establish effectiveness

Susan Wells and colleagues' review, published in 2018, included **64 studies** meeting its design criteria: **10 cluster-randomized trials, 24 controlled before-and-after studies, and 30 interrupted time-series studies**. The search covered research through December 2014.

The studies covered varied settings and populations. **Eighty-three percent reported improvement in at least one primary measure**, but many inadequately described implementation and important local conditions. That percentage is not a pooled effect size or an expected success rate for a new collaboration.[98]

Evidence boundary: The review does not establish that sharing a dashboard, holding meetings, or adding AI improves care.

Local question: What did the collaboration help its members change, and what happened when they changed it?

Comparing alternatives under common conditions

Test ideas rather than relying on confident predictions

Katherine Milkman and colleagues' 2021 megastudy compared **54 four-week digital programs among 61,293 members of a U.S. fitness chain**.

Forty-five percent of the programs significantly increased weekly gym visits during the intervention, by 9–27 percent. Only 8 percent produced statistically detectable changes after the four-week intervention. Forecasts did not reliably identify the strongest approaches.[99]

Where we used it: Shared definitions, comparable time periods, and deliberate tests

make differences more informative.

Evidence boundary: This was exercise research, not dementia care or community-service navigation. The research review informing this book rates the experiment **Strong** in its own setting; that grade does not transfer to a proposed care pathway.

Local question: What would distinguish a promising idea from a result worth carrying forward?

SQUIRE 2.0

Explain the setting and the limits with the finding

Greg Ogrinc and colleagues developed SQUIRE 2.0 through evaluation, consensus work, and pilot testing. The reporting guidance emphasizes the rationale for a change, the context in which it occurred, and how the intervention was studied.

It distinguishes undertaking improvement from studying whether and why the change worked.[100]

Where we used it: The Shared Learning Brief includes the setting, actual intervention, methods, unintended effects, missing information, and limitations.

Evidence boundary: A reporting framework improves the questions a report addresses; it does not establish the effectiveness of the intervention being reported.

Local question: Could another team understand the result well enough to judge whether it applies?

Social learning and responsible AI

Let knowledge travel with its qualifications

The research review informing this book gives the broader Social Physics perspective an **Emerging-to-moderate** judgment. It emphasizes discovery and interpretation through relationships while warning that social learning can also spread mistakes.

WHO's guidance addresses inaccurate outputs, bias, privacy, overreliance, and stakeholder participation. NIST's AI Risk Management Framework organizes ongoing work through **Govern, Map, Measure, and Manage**. These are governance foundations, not proof of an assistant's effectiveness.[1]

Where we used them: AI prepares comparisons and possible adaptations; people verify the sources, preserve differences, and decide what to test.

Local question: Does the assistance help the group understand its evidence—or make an uncertain conclusion sound more convincing?

One thing to try

Choose one finding your organization is considering sharing.

Before presenting it as an approach others should adopt, ask a partner to identify **three**

explanations for the result other than “our approach is better.”

Then examine which explanations the available information can address.

Prepare a short Shared Learning Brief, identify one locally appropriate next test, and decide who will report what happened—including an unchanged or burdensome result.

Your team’s question is:

What would another organization need to know before this finding could help its people?

A shared lesson needs somewhere to begin

> In Context — One question carried forward
>
> After the regional conversation, Lena explained the next step to Pat and Ellen.
>
> “The group is looking at how people receive a human response when an arrangement changes. Different services are checking different parts of the process.”
>
> “Will there be another form?” Ellen asked.
>
> “Only where it answers something we cannot already establish—and participation in feedback remains your choice.”
>
> Pat looked at the brief.
>
> “Have they worked out what ‘completed’ means?”
>
> “They are being more specific.”
>
> “That should keep them occupied.”
>
> The group had not announced that one center had solved access. It had agreed on a clearer question, better definitions, and a way to examine possible changes.
>
> At the next planning meeting, Jordan brought the discussion back to what the partners could actually provide.
>
> “We have enough ideas for a very large project,” Jordan said. “Which need can we address with the people, support, and responsibility we have?”
>
> Shared learning now becomes an invitation to act: choose one meaningful situation, make the support dependable, and learn enough to decide what belongs next—not launch everything at once.

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

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95. Batalden PB, Davidoff F (2007). What is “quality improvement” and how can it transform healthcare? Quality and Safety in Health Care. 16(1):2–3. DOI: 10.1136/qshc.2006.022046. Source

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96. Ogrinc G, Davies L, Goodman D, Batalden P, Davidoff F, Stevens D (2016). SQUIRE 2.0 (Standards for QUality Improvement Reporting Excellence): revised publication guidelines from a detailed consensus process. BMJ Quality & Safety. 25(12):986–992. DOI: 10.1136/bmjqs-2015-004411. Source

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97. Garfinkel S (2023). De-Identifying Government Datasets: Techniques and Governance. NIST Special Publication 800-188. DOI: 10.6028/NIST.SP.800-188. Source

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98. Wells S, Tamir O, Gray J, Naidoo D, Bekhit M, Goldmann D (2018). Are quality improvement collaboratives effective? A systematic review. BMJ Quality & Safety. 27(3):226–240. DOI: 10.1136/bmjqs-2017-006926. Source

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99. Milkman KL, Gromet D, Ho H, et al. (2021). Megastudies improve the impact of applied behavioural science. Nature. 600:478–483. DOI: 10.1038/s41586-021-04128-4. Source

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100. Ogrinc G, Davies L, Goodman D, Batalden P, Davidoff F, Stevens D (2016). SQUIRE 2.0 (Standards for QUality Improvement Reporting Excellence): Revised Publication Guidelines From a Detailed Consensus Process. American Journal of Medical Quality. 31(1):65–72. DOI: 10.1177/1062860615605176. Source

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CHAPTER 15

Begin with One Meaningful Pathway

At a Glance

The central idea: Begin where the need is real, the responsibility can be named, and the result can be observed.

What you'll explore: How to bring the ten principles into one manageable project rather than launch an entire collection of features. Join a health-system team and community partners as they plan a better first connection for people returning home with cognitive concerns under evaluation. Define the population, practical support, responsibilities, and boundaries before inviting anyone to participate.

Design and AI: Prepare a small set of useful materials and encounters: an explanation, a contact, a conversation, and a reviewed next step. Use AI to help organize approved knowledge, draft alternatives, rehearse the experience, and capture learning while people retain care decisions and accountability.

Put it to work: Complete a **First Pathway Project Charter**, walk through the proposed experience, and establish reasons to continue, change, pause, or expand.

Evidence and evaluation: Apply care-transition guidance, behavioral models, and small-cycle improvement methods. Examine understanding, completed human connections, received support, access, and total effort—not the appearance of a successful launch.

> *"We can do more together than separately. Thematic focus and rapid action matter."*
>
> — **Donald M. Berwick, MD**, physician and healthcare-improvement leader, in an Institute for Healthcare Improvement interview, October 14, 2021.[101]

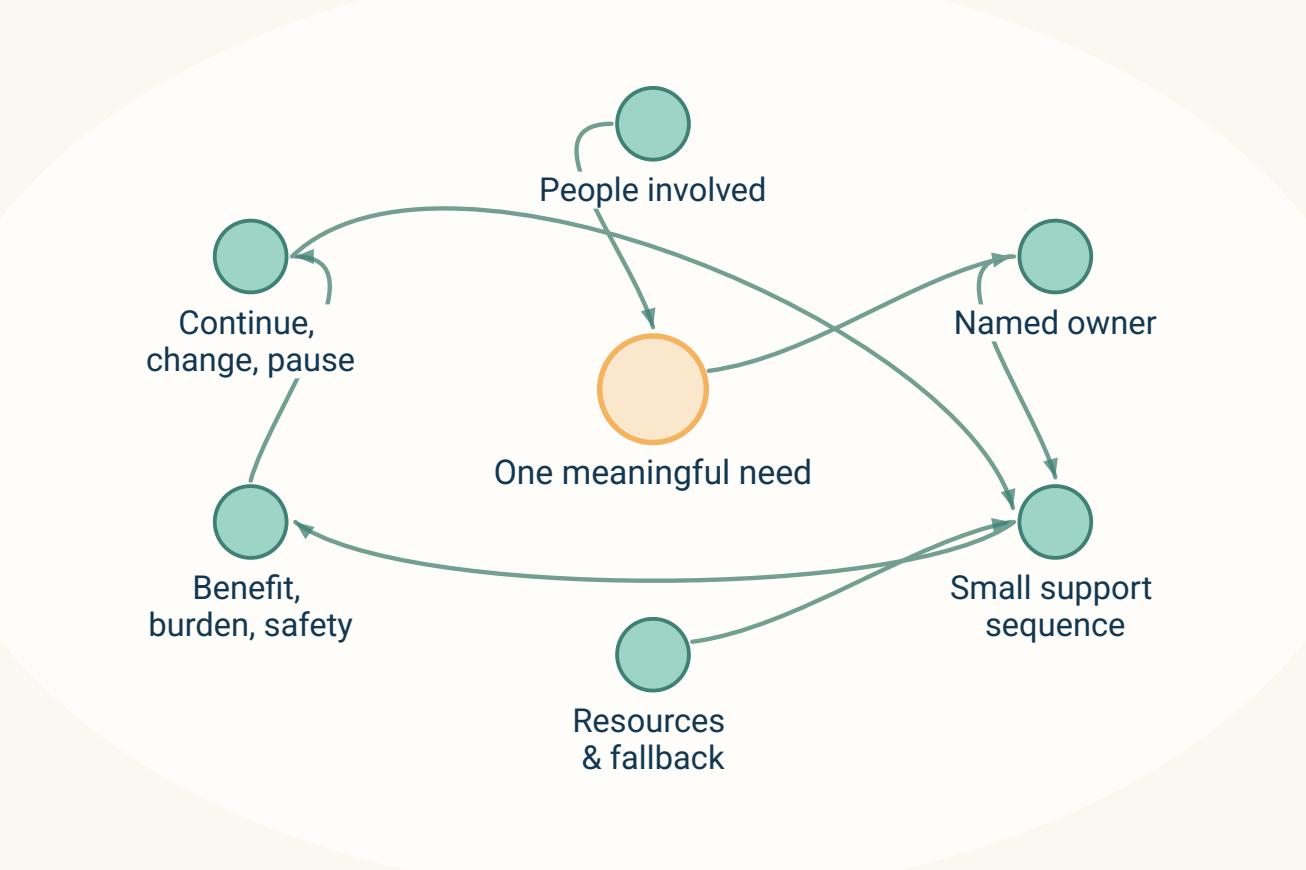


Figure 16 · Begin with one complete pathway

People who will live and deliver the support help define one meaningful need. The chosen need has a named owner and explicit responsibility. The owner prepares a small, complete support sequence. Resources and a fallback make the sequence deliverable when circumstances change. Try the sequence and examine benefit, burden and safety. The measures inform a decision to continue, change or pause. That decision changes the sequence or whether it proceeds. This is a testable project proposal, not a promise of benefit or an instruction to expand automatically.

Choose	Make it real
One meaningful need	Understand the person’s purpose and the support they actually want.
One workable arrangement	Provide the people, information, resources, response route, and backup.
One responsible test	Define evidence, benefit, burden, safety, access, and who can revise the work.

In Context — “Start where we were”

Sam brought a one-page description to a conversation with Pat and Ellen.

Casey’s hospital team and a community partner were considering a small project. They wanted to make the first steps after returning home easier to understand and less dependent on a family finding every answer alone.

“Would you be willing to look at the idea?” Sam asked.

Pat put down his book.

“How many pages?”

“One.”

“That is an encouraging start.”

Ellen read the proposed purpose.

“This says support for families dealing with memory concerns.”

“Yes.”

“Do they already have to know what is happening?”

“No. The clinical questions would remain with the healthcare team. The community conversation would help people discuss everyday support.”

Ellen looked at Pat.

“That would have mattered to me. I wasn’t sure which questions had to wait.”

“And I wasn’t sure everyone understood they were still questions,” Pat said.

Sam asked what they would put first.

“Tell people who they can speak with,” Ellen replied. “And whether that person is actually expecting the call.”

Pat had another request.

“Start where we were. Not where we are now.”

The team would not ask a new family to begin with a diagnosis, a Day Center application, or a detailed plan for the coming year.

It would begin with uncertainty, a person’s own priorities, and a human connection worth making.

Begin with something complete enough to help

By this point, CarePhysics offers many possibilities.

A team could prepare educational tiles, organize a resource collection, arrange shared conversations, support family responsibilities, improve handoffs, introduce AI

assistance, and build a learning process.

Trying all of them at once is not the only way to take the framework seriously.

Begin where the need is real, the responsibility can be named, and the result can be observed.

This final chapter focuses on one population, one meaningful need, a small set of content and communication patterns, available partners, practical response capacity, and a few measures. Expansion depends on usefulness and capacity—not enthusiasm alone.

A small project should still provide a complete piece of support.

Publishing a welcome tile is a content task. Helping someone understand an option, reach an appropriate person, and leave with an agreed next step is a pathway.

The distinction does not require sophisticated technology. It requires connecting the explanation to the help behind it.

Choose a beginning that can matter on an ordinary day.

Define the need before choosing the tool

For the worked example, the partners choose a specific situation:

Older adults returning home from one hospital service after cognitive concerns have been identified for further clinical assessment, with family or other chosen support people involved as appropriate.

The first project addresses the connection between the discharge conversation and an initial community-support conversation.

It does not diagnose dementia. It does not require a diagnosis before someone can ask about everyday support. It does not assume that a Day Center is the right destination.

Clinical follow-up continues through the responsible healthcare team. The community pathway helps people understand available support, discuss practical difficulties, and pursue an appropriate next step they choose.

Those two lines of work need to connect without becoming confused.

AHRQ's IDEAL discharge-planning guidance supports including people and families as partners, discussing life at home and follow-up, using clear explanations, checking understanding, and listening to goals and concerns. It provides a foundation for the hospital portion—not a substitute for individualized clinical planning.[15]

Define the project's starting and review points.

The beginning might be the hospital conversation in which community support is offered. The initial review might follow the completed support conversation and the next action agreed there.

An unresolved need does not disappear at the project's reporting deadline. It retains a

responsible person and an appropriate route onward.

Do not make having a nearby relative, smartphone, or comfortable use of English an unexamined condition of receiving support. Identify the assistance and alternatives required for the population the project intends to serve.

A focused scope is useful. Quietly selecting only the easiest people to help is something else.

Design with the people who will live and deliver it

Bring together the people who understand different parts of the proposed experience.

The person receiving care and their chosen supporters can explain what would make the offer useful. Clinical staff know which information and follow-up must remain under clinical authority. Community staff know their services, capacity, and access requirements. Frontline staff and volunteers can identify practical problems a planning document may miss.

Include people receiving care and chosen supporters alongside the relevant professionals and community teams. Connect the purpose with actual resources, communication, accessibility, training, and evaluation.

Not everyone needs to attend every meeting. Everyone whose responsibility changes needs an opportunity to examine the change.

Ask a few concrete questions.

What is difficult now? What already works? What does the family repeatedly explain? Where does a request wait without an owner? What can the receiving service actually provide?

Pat and Ellen's contribution helps the fictional team ask better questions. It does not establish what every household will want.

Seek other perspectives, including people using different languages, people without family support, and those who have not found the existing route useful. Make participation accessible and account for the time and assistance it requires.

Then return the decisions to the contributors. Show which suggestion changed the design, which could not be adopted, and why.

Co-design should leave a trace in the project.

Choose the limiting condition before choosing the intervention

The people shaping the project have described the need. Now distinguish the result they want from the solution someone first suggested. If families want a useful response, producing another guide is only one possible action. It becomes the right choice when the problem actually concerns what the guide can address.

Use the Theory of Constraints questions from R2.5 to identify a suspected limiting condition, the evidence behind it, and at least one alternative explanation. A queue may

reflect unavailable capacity, unclear ownership, incomplete inputs, unsuitable timing, or a decision still being considered. Do not turn a convenient dashboard signal into a verdict on a family or colleague.

Name who has authority to change the arrangement and which resources are required. Select a proportionate test, protect existing care and private information, and decide what observation would make the team reconsider its explanation. COM-B informs the barrier analysis; TOC helps focus the process-wide choice; PDSA supports learning from the test. Their combination remains our proposed design approach. See the constraint fields in Appendix D1. See Appendix F6.

Write the charter before promising the experience

The **First Pathway Project Charter** is a short agreement about the work the organizations intend to undertake.

It is not a promotional brief. It should be understandable to the people expected to deliver it and specific enough to expose an unfilled responsibility.

The example below is a proposed design, not a ready-to-launch clinical protocol.

Charter element	Worked example
Human purpose	Help people returning home understand their next clinical and community contacts and reach a useful support conversation without carrying every coordination step themselves.
Population and scope	One defined hospital service; cognitive concerns remain under clinical assessment. Family involvement follows the person's preferences and appropriate authorization. The project does not replace discharge planning or treatment.
Initial offer	A clear explanation, a verified contact, an accepted community introduction, an agreed conversation, and a reviewed account of the chosen next step. Digital, telephone, and paper routes are available as appropriate.
Responsibilities	A named hospital lead owns the outgoing process; a named community lead owns accepted support requests. Clinical decisions remain with clinicians. Each role has coverage, and one project lead coordinates the test without inheriting every care task.

Charter element	Worked example
Resources	Protected staff time, response capacity, interpretation and accessibility support, approved information-sharing arrangements, technical assistance where needed, and a funded route for reviewing unresolved needs.
Timing and records	Defined enrollment and follow-up periods, response expectations agreed with services and participants, actual event dates, pathway versions, and a process for requests that remain unanswered.
Learning	Baseline and measures of understanding, completed conversations, subsequent service receipt, family effort, staff workload, access, and safety. A named owner reviews findings with contributors.
Decision rules	Continue, revise, narrow, pause, or expand according to usefulness, safety, workload, access, and available capacity. People already receiving support retain a clear plan if the test changes or ends.

Before launch, replace role descriptions with names and confirm the arrangements behind each row.

For example, a proposed target of responding to a nonurgent community request within two working days must be checked against staffing and coverage before it appears in family information. That is an illustrative operational commitment—not a clinical standard or a reason to delay urgent care.

Agree who acts when the target cannot be met.

A promise is part of the workload.

Map the smallest useful sequence

A pathway can combine digital resources and human encounters. It does not have to begin in an application.

For this project, a compact sequence could look like this:

Point in the experience	What the person encounters	Responsibility and confirmation
The need is discussed	A direct conversation about what matters, what is becoming difficult, and whether community support would be useful.	The hospital professional separates clinical questions from support questions and confirms whom the person wants involved.
The offer becomes understandable	A brief explanation, available as a tile or printed page, with optional video, an article, and a way to ask a question.	The content owner verifies facts. The person can request a conversation without completing optional material.
The introduction is accepted	A telephone introduction or another agreed contact route. A verified contact can be saved in a phone book or provided on a card.	The receiving service accepts a defined next action. Sending the request alone does not complete the handoff.
A conversation happens	An agreed call, virtual meeting, or in-person encounter, with appropriate access assistance.	The receiving professional discusses the person's priorities and practical options. Required clinical questions return to the clinical team.
A chosen next step is supported	A reviewed summary stating what was agreed, what remains open, who acts, and when the person will hear again.	Each responsibility has an accepted owner. Any later service assessment, booking, or attendance is confirmed separately.
The experience is reviewed	A brief, optional opportunity to say what helped, what was difficult, and what should change.	The project lead organizes review; the responsible professionals address individual needs. Useful changes return to the people who contributed.

AHRQ's referral guidance supports making the process easier to navigate and following up on what happens after a referral. It does not turn a transmitted request into a completed service.[89]

A Day Center introduction may follow the support conversation when it is wanted and appropriate. Its eligibility, capacity, costs, and required assessment remain separate questions.

Check each proposed destination's eligibility and assessment requirements. A

requirement of one Day Center must not become a condition for asking about broader community support. Appendix J identifies the dated program-specific example.

The initial pathway should remain useful even when the eventual answer is a different service—or no service at present.

Make the content answer today's question

The first resource does not need to explain the entire care journey.

It needs to make the immediate offer understandable.

An illustrative introduction might read:

A conversation about support at home

Returning home can bring practical questions alongside the questions you are discussing with your healthcare team.

A community professional can help you explore available support and decide what would be useful to discuss next.

You do not need to know every question in advance. You might begin with: "I would like help with the arrangements, but I still want to make my own decisions."

Your clinical questions remain with your healthcare team. This introduction is not a diagnosis or an agreement to enroll in another service.

You can ask us to help arrange contact, take the information to use yourself, or decline for now. We will explain who will respond, what information would be shared, and what happens next.

The organization adds its verified contacts, response arrangements, privacy explanation, and appropriate urgent-care route.

A short video can show the conversation: someone asks a question, the professional answers, and the person chooses how to proceed. Show one exception, such as the preferred appointment time being unavailable.

The article can provide more detail. A survey or interactive question can help prepare the conversation, provided someone is responsible for reading and responding. A message can confirm the actual arrangement.

Use the familiar pattern: why it matters, the main idea, a demonstration, a chosen next step, questions or connection, and what follows. It remains flexible; urgent information leads, and validated instruments retain their wording and scoring.

Ask about language, culture, beliefs, preferred involvement, format, and assistance. Do not assume that a shared address or demographic category means people want the same explanation.

Keep controls, action labels, and help routes familiar. Adapt the content and support without making every new item feel like an unfamiliar remote.

Bring the methods together around a life

> **In context**
>
> A retrospective teaching walkthrough of the established fictional family. This organizes questions and possible responsibilities; it adds no diagnosis, treatment, accepted family duty, or measured outcome to their story.

Pat's wish to read, spend time with people, and remain part of decisions gives the project a human purpose. Ellen's request for help with arrangements gives it another. We should be able to point to what changes for each person without requiring one person's needs to be justified by the other's.

CarePhysics keeps that wider life in view: relationships, language, beliefs, practical resources, enjoyment, and choice. The 4Ms provide a more specific older-adult care lens within it. They do not replace the financial, legal, social, or caregiver concerns around the plan.

Relevant 4Ms question	What it changes in this proposed plan
What Matters	Begin with Pat's stated wish to read, see people, and remain involved. Confirm the particular activity he wants now, the company he chooses, and whether he would rather rest.
Medication	Bring relevant medication information and questions to the qualified clinician or pharmacist. Do not infer that a medicine caused a difficulty, add a treatment, or record a review as completed before it occurs.
Mentation	Use the appropriate clinician's assessment and distinguish it from Pat's account, family observations, and Day Center observations. Choose an activity that does not test recall or turn enjoyment into a diagnostic signal.
Mobility	Connect the chosen activity with current professional guidance on movement and the practical help required for access, travel, and arrival. A risk score is not the assistance itself.

Ellen has a separate support pathway. A C4C-informed approach recognizes her needs, offers an appropriately private conversation, agrees assistance with an accepted owner, and returns to ask what changed. Any clinical assessment or psychotherapy requires the relevant professional. Only the information suitable and agreed for the shared plan travels into the family discussion.

Now map the experience. The existing transport episode distinguishes an unavailable vehicle from a missing update. One prevents the visit; the other prolongs uncertain waiting. Pat's and Ellen's accounts explain what each failure meant. TOC helps the partners decide which operational change they can test, while an honest update can remain worthwhile even before replacement capacity exists.

COM-B asks about the conditions for the chosen next action. Self-Determination Theory and respectful conversation keep the choice self-endorsed. Communication and learning design shape the invitation, demonstration, questions, and help route. A pathway makes timing, responsibility, confirmation, and alternatives explicit.

Technology can help carry agreed information. An approved assistant can prepare a source-labeled draft from authorized material; it must not receive Ellen's confidential assessment just because it is preparing a family meeting. Sam, the clinical team, and Lena retain their distinct responsibilities. The grandchildren remain family members, not monitors.

Finally, examine the result at the level the evidence supports. Was the question answered? Was the journey made? Did the participant find the visit worthwhile? Did the caregiver receive usable support, and what work did the arrangement create? The extra-Tuesday request remains unresolved unless the responsible provider accepts a suitable arrangement. A local test informs the next decision; it does not validate the complete combination.

The methods do different jobs. The person's life gives those jobs a common purpose.

For a first project, use only the elements the situation requires. The overview above is not a new combined intervention, and it does not create another form for every model. R1 explains the evidence; R2 explains the methods; the existing appendices help turn a chosen design into accountable work.

A single reviewed summary might therefore carry several principles without displaying their names.

Love is visible when someone listens without rushing the answer. Purpose appears in what the person wants the support to protect. Trust grows when a promised call happens. Contribution appears when a participant's suggestion changes the design.

None requires another mandatory field.

Use AI to prepare a better first version

The team already has useful knowledge: relevant CarePhysics chapters, approved clinical and program guidance, verified local services, and experience contributed by the people doing and receiving care.

An approved assistant could help turn that material into a draft pathway and content set.

A practical assignment is:

Using these approved sources, prepare a first version of this pathway for the stated

population and need. Identify the purpose of each encounter, the information required, the responsible person, and the confirmation needed. Draft the introductory article and demonstration outline. Preserve source limits, identify unavailable resources, and mark every assumption requiring review.

Generic design work does not require private patient records.

Keep research, design guidance, local facts, fictional demonstrations, and permissioned personal context separate. Record sources, owners, review dates, approved uses, and corrections. The proposed knowledge-bank workflow moves from relevant material through local context, drafting, human review, testing, and revision.

In Context — The first draft asks too much

The assistant's proposed pathway included a detailed questionnaire before the introductory call.

Sam reviewed it.

"We would be asking people to tell us most of the story before meeting the person who could help them."

Casey pointed to information already available through the permitted discharge handoff.

"And some of these questions have already been answered."

Lena found another problem.

"This draft treats a Day Center visit as the expected next step. It should be an option we discuss when it fits."

The team shortened the preparation, removed duplicate questions, and restored the decision point.

The revised invitation asked what the person most wanted to discuss and whether assistance was needed for the conversation.

The first draft had helped reveal the work.

The reviewers made the offer appropriate.

With reliable knowledge, guidelines, rules, and accountable review, AI can be a gift: less repetitive assembly and more attention available for people. That value must include the effort of checking and correction.

WHO's guidance supports defined tasks and stakeholder involvement while warning about inaccurate outputs, bias, privacy risks, and inappropriate delegation. A confident draft is not authority to make a care decision.[1]

For the first project, AI may remain entirely behind the scenes. A tested family-facing assistant could later explain approved routine information or help prepare questions at any hour. Actual human availability and urgent routes must remain

> **In Context — The first draft asks too much**
>
> explicit.
>
> Optional live conversation assistance is another separate decision. Establish consent, accuracy, distraction, privacy, and reviewer requirements before introducing it. Do not bundle it into the project simply because drafting proved useful.
>
> Uploading the book is not training a model, and successful drafting is not proof that every additional AI role is ready.

Rehearse the ordinary route—and the interruption

Before inviting people into the new process, walk through it.

Use a clearly fictional case and the actual staff roles, contact methods, materials, and permissions proposed for the service.

Can the receiving person find the request? Do they know what they are accepting? Can the family obtain the same essential support without using an app? Does someone know how to correct an inaccurate summary?

Then introduce an interruption.

The usual coordinator is absent. The person wants another language. A contact cannot be reached. A service has no capacity. A private concern has been placed in the wrong draft.

Do not create these errors in live care records as a staff test.

> **In Context — “Who has it now?”**
>
> During the rehearsal, Casey sent the fictional request through the proposed route.
>
> Sam was assigned to be unavailable.
>
> The group waited.
>
> “Who has it now?” Jordan asked.
>
> The draft procedure named Sam’s role but did not identify the person covering it.
>
> “That would send the work back to the family,” Casey said.
>
> The community lead corrected the coverage arrangement and tested the route again.
>
> The problem had been found before a person was left waiting for help.
>
> Rehearsals and fictional branching scenarios can help staff prepare, but available materials are not evidence of readiness. Provide time, support, and appropriate competency checks for the actual role.

> **In Context — "Who has it now?"**
>
> Provide protected practice time, appropriate supervision, and clear volunteer boundaries. The purpose is to improve the process and prepare people, not rank how much they care.

Start small enough to learn responsibly

A first test can be modest without being casual about care.

The Institute for Healthcare Improvement's Plan–Do–Study–Act approach supports trying a change on a small scale, examining what happened, and refining it through repeated tests under different conditions. It is a learning method, not permission to bypass necessary approvals.[56]

After preparation and appropriate review, the team might begin with one willing person or household, then a small number the services can support. Include realistic variation as the test develops rather than restricting it indefinitely to the easiest circumstances.

Usual care continues. Optional project participation should not determine access to necessary services.

Before real-world testing, the responsible organizational review process should establish what approvals, consent, privacy protections, and evaluation oversight apply. Calling something a pilot does not settle those questions.

An illustrative enrollment period might last four weeks, with each participant followed through a defined first-month review. A decision about expansion would wait until the relevant follow-up was available. These are planning examples, not clinical deadlines or evidence-based guarantees about how quickly support should be resolved.

Clinical needs follow their own appropriate timing.

Unresolved support needs keep their owners after the evaluation window closes.

Decide what would count as useful

Establish the baseline before claiming improvement.

Where existing records can answer the question reliably, use them. Where they cannot, observe the current process with appropriate permissions rather than inventing a starting value.

Choose a few measures that can change a decision.

Understanding: Can the person identify the relevant clinical contact, community contact, and next step, with the materials and assistance they normally use?

Follow-through: Of requests due for an agreed community conversation during the review period, how many resulted in that conversation? Report all requests lacking an agreed date separately, so they do not disappear from the denominator.

Received support: What subsequent assistance was actually provided? Keep an introduction, assessment, booking, and service received separate.

Burden and safety: What did preparation, calls, travel, documentation, AI review, and corrections require? Were important concerns delayed, information shared inappropriately, or people excluded by the chosen route?

IHI distinguishes process, outcome, and balancing measures; balancing measures examine whether improvement in one part of the service creates difficulty elsewhere.[75]

Report how many people were eligible for the offer, received it, requested assistance, participated, and provided feedback. Identify withdrawals, later choices, unavailable services, and unknown outcomes without converting them all into “nonparticipation.”

A small test can reveal an unowned request or a confusing invitation. It cannot establish reduced hospital use, sustained caregiver relief, or cost savings merely because the first encounters went well.

The behavioral review distinguishes reach, understanding, first action, adoption, useful participation, outcomes, burden, equity, and safety. Willingness to recommend, an actual referral, and a referred person receiving support are also separate questions.

The records must support the measure. Verify return communication, evidence of learning, and the dates defining the pathway. Plan the human follow-through and appropriate records rather than assuming those facts will appear automatically.

Let people improve the project while it is small

After an encounter, offer a brief opportunity to say what helped, what remained unclear, and what should change.

Patients, participants, caregivers, clinicians, frontline staff, and volunteers may identify different improvements. Preserve those differences.

A person may prefer the call before the article. A staff member may discover that the response process duplicates existing work. A caregiver may notice that the summary leaves them responsible for contacting everyone else.

An approved assistant can help organize authorized feedback and prepare options. It should not infer agreement, decide which person is right, or turn feedback into a hidden performance score.

Record the suggestion, contributor’s preferred credit, decision, actual change, and later review. Share null, difficult, and burdensome findings alongside the encouraging ones.

Give findings authority to stop, narrow, or redesign the process. Record the decision and remeasurement in an accountable place, whether or not the product supplies that register.

Then return to the contributor.

“You raised this. Here is what we changed.”

That is where feedback becomes part of the care culture rather than another collection of

answers.

Expand the support—not just the invitation

Before increasing enrollment, ask whether the process works beyond its most favorable conditions.

Can someone other than the original champion deliver it? Are sources maintained? Is coverage dependable? Have people using different routes been included? Can receiving services accept the additional work?

Continue when the offer is useful and the remaining questions can be examined safely.

Adapt when the need is real but the format, timing, ownership, or service arrangement is wrong.

Pause or narrow when errors, privacy problems, missed responses, or workload make the proposed process unacceptable. Preserve continuity for people already receiving care.

Expand only when the evidence is sufficient for the decision being made and the resources are available.

Those choices should be recorded, not treated as a judgment about the team's enthusiasm.

A resource gap may require funding rather than more content. A missed response may require coverage rather than a more persuasive reminder. A lack of clinical follow-up cannot be repaired by labeling a community conversation complete.

Budget for the full work: preparation, interpretation, accessibility, staffing, supervision, review, technical support, measurement, and the handling of exceptions. Include what happens when initial funding ends.

Genus supplies technology. Partners retain responsibility for their care, staffing, programs, relationships, professional decisions, and voice.

Community and state groups can help fund capacity and share reviewed learning. They should not require every organization to adopt the same sequence or judge unlike populations by one completion rate.

Begin elsewhere when the need is elsewhere

The hospital-to-community example is one starting point, not the required CarePhysics project.

A rehabilitation team might begin with helping people use one professionally taught skill at home and obtain help when it is difficult.

A home-care organization might improve the first visit: who arrives, what assistance is agreed, what remains private, and how a change is communicated.

An independent-living community might begin with a request for support that currently

passes between several people without clear acceptance.

A Day Center might improve its first-visit introduction or the reviewed account families receive afterward.

In each case, use the same discipline: a meaningful need, a workable offer, an accepted responsibility, accessible participation, and a way to learn.

The framework is shared. The starting point belongs to the people and organization using it.

Models and Evidence Behind This Chapter

This chapter combines the earlier principles into a proposed project. The charter, sequence, scripts, and test periods are design examples—not validated interventions.

IDEAL discharge planning

Begin with the person's life after the encounter

AHRQ's IDEAL approach includes people and families as partners, addresses practical life at home and follow-up, supports clear explanations and checks of understanding, and listens to goals and concerns. It informs the clinical-transition side of the proposed pathway.[15]

Evidence boundary: This is practice guidance. Copying its headings into a tile does not establish that the resulting service improves outcomes.

Local question: Does the person understand what follows, with appropriate support behind the explanation?

The Care Transitions Intervention

Study the whole support package

Eric Coleman and colleagues' 2006 randomized trial included **750 community-dwelling adults aged 65 or older** in a Colorado delivery system. The intervention combined communication tools, support for expressing preferences, and continuity from a transition coach.

Thirty-day rehospitalization was **8.3 percent with the intervention versus 11.9 percent with usual care**; the adjusted comparison was statistically significant. Eligibility included English language, telephone access, and no documented dementia.[57]

Evidence boundary: The study tested a multicomponent intervention in a defined population, not this proposed pathway or an AI assistant. Its exclusions limit direct application to people with diagnosed dementia.

Local question: Which human services and practical arrangements make the pathway more than information delivery?

Structured caregiver support

An introduction is not the complete intervention

Gitlin and colleagues' ADS Plus trial included **203 caregivers across 34 adult day-service sites**, randomized by site to usual services or services with structured caregiver support. Trained staff provided education, validation, referrals, problem-solving, and self-care support over time.

Adjusted depression scores were lower in the added-support group at 12 months. The sample was predominantly female and college educated; **22.7 percent** were lost to follow-up. The reported attendance difference did not meet the conventional statistical-significance threshold.[44]

Evidence boundary: A completed introduction does not deliver the sustained program studied here. The result should not be assigned to a brochure, occasional call, or technology feature.

Local question: What support is actually available after the first conversation?

Behavioral models

Match the response to the obstacle

The research review informing this book uses COM-B to examine capability, opportunity, and motivation; Self-Determination Theory to preserve chosen participation; and Social Physics to consider how people discover and work with knowledge through relationships.

Its judgments differ: strong conceptual support for COM-B, moderate intervention evidence for Self-Determination Theory, and emerging-to-moderate support for the broader Social Physics perspective. They are not a combined effectiveness grade for the proposed project.

The review's first-use experiment—one immediately useful action rather than a feature tour—is explicitly a hypothesis to test.

Local question: Are we removing the barrier people described, or asking them to become more motivated?

Small-cycle improvement and responsible AI

Learn before making the arrangement standard

IHI's Model for Improvement combines clear aims and measures with repeated Plan–Do–Study–Act tests. The approach supports learning under different conditions before making a change routine.[55]

WHO's guidance adds defined AI tasks, stakeholder involvement, human responsibility, and assessment of errors and unintended consequences.[1]

Evidence boundary: These are methods and governance guidance, not guarantees of

success. A satisfactory demonstration does not establish sustained effectiveness, and a small pilot cannot answer every outcome question.

Local question: What must we learn before more people are asked to rely on this arrangement?

One thing to try

Bring together one person who understands the need from experience, one person who provides the relevant care, and one person authorized to change the process.

Complete this statement:

For these people, at this particular moment, we believe this defined support will improve this meaningful result without creating unacceptable burden or risk. We will examine it using these measures, during this period, with this person responsible for the decision.

Then walk through the proposed experience, including one interruption.

Do not begin by asking which feature to add.

Ask:

What is the smallest complete piece of support we can make dependable?

The project should leave something with the family

> ### In Context — A place to begin
>
> When Sam next spoke with Pat and Ellen, he brought back the revised description.
>
> “The first project begins with a clearer offer and an accepted community conversation,” he said. “The teams are checking the response arrangements before they invite people.”
>
> “And the medical questions?” Ellen asked.
>
> “Stay with the healthcare team. The summary will make the different contacts clear.”
>
> Pat read the page.
>
> “This sounds less like joining something.”
>
> “That was one of the changes your questions helped us make.”
>
> “Good.”
>
> Ellen looked at the final line about reviewing whether the support had been useful.
>
> “Make sure somebody asks that.”

In Context — A place to begin

“They will need to,” Sam said. “And be able to change the plan because of the answer.”

The proposed project had not produced a result yet. It had a purpose, a first experience to test, and people responsible for what would happen next.

That is enough to begin—but not enough to declare success.

CarePhysics started with questions about understanding, relationships, practical help, and the knowledge people could share. It ends by asking us to put those questions to work in one place where they matter.

A clearer explanation. A completed introduction. A responsibility someone has accepted. A useful idea carried forward with credit. A service a person can actually receive.

From there, we can learn what deserves to grow.

The measure of the work remains outside the project plan: in the choices people regain, the support they can reach, and the ordinary time they can spend with one another.

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

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44. Gitlin LN, Roth DL, Marx KA, et al. (2024). Embedding Caregiver Support Within Adult Day Services: Outcomes of a Multisite Trial. The Gerontologist. 64(4):gnad107. DOI: 10.1093/geront/gnad107. Source

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Epilogue — More Room to Be a Family

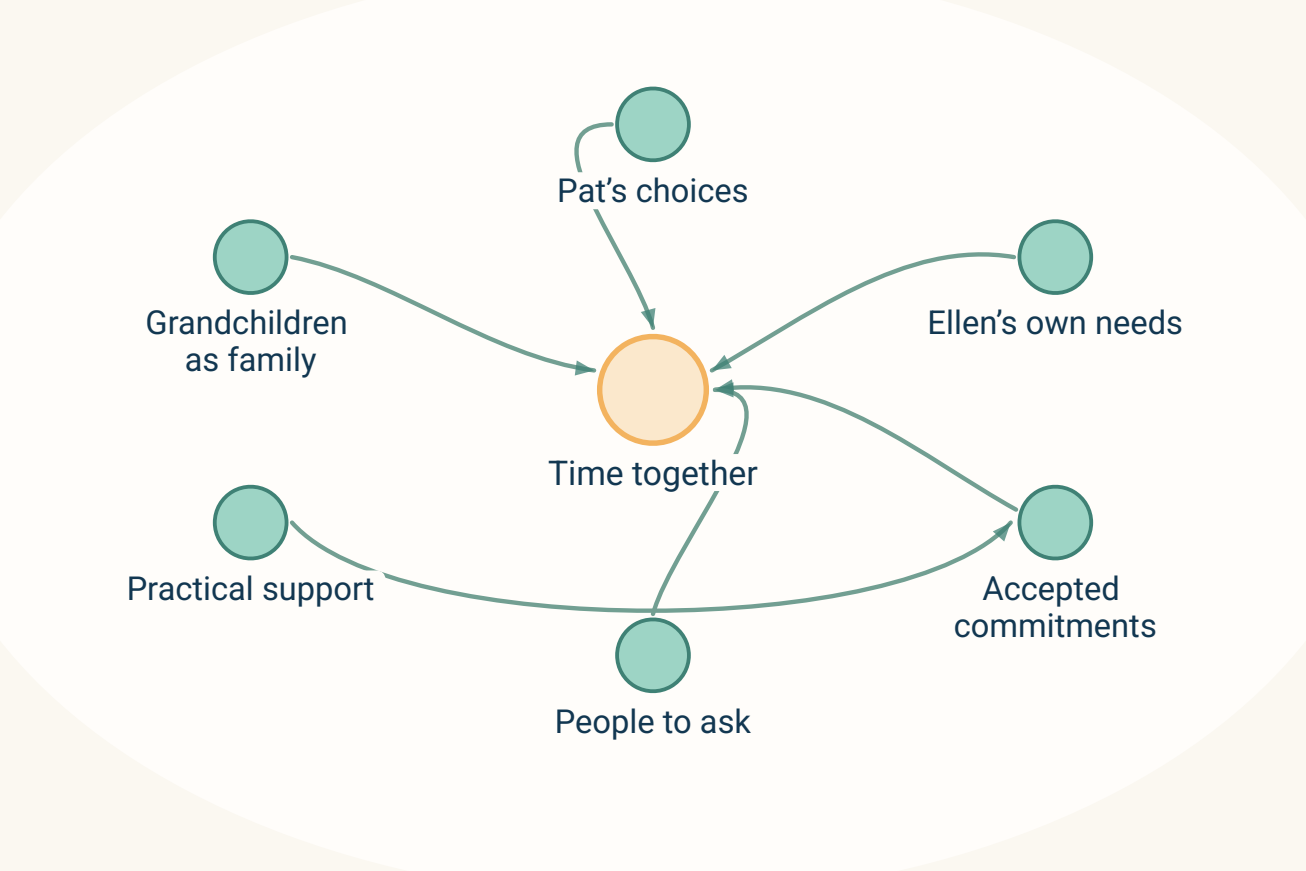


Figure 17 · More room to be a family. Fictional illustration; ordinary time together remains the focus.

In the fictional family story, Pat's choices shape their time together. Ellen's own needs belong alongside the shared family time. Accepted commitments are part of the arrangements that make room for ordinary time. Knowing people to ask means every question need not start by reconstructing whom to contact. Practical staffing, preparation and services make accepted commitments workable. The grandchildren share enjoyment as family rather than taking responsibility for a care plan. The fictional ending retains uncertainty and service limits; it is not evidence of an intervention's outcomes.

> **In Context — Shall we start?**
>
> Emma had two stories ready on the television.
>
> "The harbor or the railway?" she asked.
>
> "The harbor," Pat said.
>
> Noah settled beside him.
>
> "Does anything happen in it?"

In Context — Shall we start?

“We could read it and find out.”

Daniel had helped open the story and check that the words were comfortable to see. Now he was bringing tea from the kitchen. There was no care record on the screen, no set of questions the children needed to complete.

Ellen came into the room carrying the reading guide.

“Do we need this?” she asked.

“Only if we get stuck,” Emma said.

“Then put it somewhere we can find it,” Pat replied. “Not on top of the biscuits.”

Ellen placed it on the side table.

Pat read the first paragraph. Then he asked Emma to continue.

The illustration showed a small boat, a crowded quay, and a dog looking toward something beyond the edge of the picture.

“That dog knows something,” Pat said.

“What?” Noah asked.

“We haven’t reached that part.”

They stayed with the picture for a moment.

Ellen sat down beside her husband.

What has changed—and what has not

Pat was still living with dementia. The family still had questions. There were appointments to attend, choices to discuss, and days that did not go as planned.

Ellen still sometimes wondered whether she had missed something important. Maya and Daniel could not take on everything. The services around the family had limits, and not every request had become an arrangement they could rely on.

This was not an ending in which uncertainty disappeared.

But Ellen no longer had to begin every question by working out whom she might ask. There were people whose roles she understood, conversations in which she could raise her own concerns, and parts of the week supported by commitments others had accepted.

She had used some of that time for a friend. She had begun explaining what help needed to include, rather than apologizing for needing it.

Pat had found people at the Day Center he wanted to talk with. He could enjoy the reading group and ask for a different afternoon. His preferences could change an

arrangement, not merely be recorded beside it.

Maya had learned that helping from a distance could mean accepting a particular responsibility, with its limits made clear. Daniel had begun making offers that included arranging and finishing the work, not waiting for Ellen to direct every step.

Emma and Noah had stories to share with their grandfather. They did not have a care plan to manage.

These changes did not restore an earlier version of the family's life. They made more of the present life available to them.

The work behind an ordinary evening

The people whose work helped make this evening possible were not all in the room.

Casey had listened when the hospital conversation widened beyond the fall. Clinicians had assessed questions that belonged with them. Sam had helped the family hear different perspectives and turn some concerns into agreed next steps.

Lena and the Day Center team had asked what Pat enjoyed, offered appropriate choices, and listened when part of the day did not suit him. Partner organizations had been asked to account for a failed arrangement rather than leave Ellen to reconstruct it alone.

None of those contributions was sufficient by itself.

Nor could a thoughtful conversation replace a service that was unavailable. The work included staffing, practical arrangements, preparation, and people accepting responsibility for what came next.

That is part of what this book asks organizations to protect. A good explanation deserves a working service behind it. A staff member asked to listen needs time to hear the answer. An invitation to ask for help needs someone able to respond.

For a leader, the useful question is not only whether the new process has launched. It is what people can now do, understand, or set down because of it.

Could a family make one fewer unnecessary call? Could a professional arrive better prepared? Could a participant change an activity without being described as difficult? Could a caregiver use the time the service was intended to provide?

Those are things to examine with the people involved. An encouraging story gives us a reason to ask; it does not supply the result.

What our knowledge is for

Losing both of my parents to dementia is part of why I began this work. I cannot know how different information or support would have changed our experience. I do know that the questions it left with me became part of the purpose of Genus and CarePhysics.

As I met other families and the people working beside them, the question became larger than my own experience. How could more of what people knew become available while someone could still use it—to understand a choice, ask for help, share a responsibility, or

protect a relationship under strain?

I have been humbled by the people willing to bring their experience into that conversation. Their insight belongs beside the research, with its source and limits respected. A professional's practical judgment, a participant's preference, and a study finding contribute different things. We lose something important when we treat one as a substitute for all the others.

CarePhysics brings those kinds of knowledge into a common discussion. Its ten principles are an evidence-informed way to examine care, not literal laws or proof that a particular product works. The framework asks what matters, what gets in the way, what support is available, and how we will learn whether our response helped.

That is also why this book was written as something to work with, not simply something to finish.

A team can return to a chapter when preparing a conversation, revising an article, developing training, or reconsidering a handoff. Its own reviewed guidance, services, culture, and experience belong in that work. The purpose is to give the next person a better starting point, not prescribe an identical answer everywhere.

Use assistance to make room for people

AI gives us another way to work with that knowledge.

Properly applied, it can be a gift to an organization: assistance with finding relevant guidance, organizing questions, preparing a draft, or carrying a useful explanation into another format. We should give it defined tasks, appropriate sources, clear rules, and responsible reviewers—and test whether the work becomes better or easier rather than assuming it does.

A useful idea can come from anyone involved in care. The assistant may help capture it, but the contribution still belongs to the person who made it. The organization remains responsible for deciding what to try and returning to find out what happened.

A family could also use an approved assistant to revisit routine information or prepare a question when the thought occurs, rather than only during office hours. Human availability must remain clear, and getting to a person must remain a real option.

The opportunity is not to keep families talking to technology for longer. It is to help them understand what they need, reach appropriate support, and spend less of their lives assembling the same information again.

We should be willing to discover that the best use of the assistant was brief. It prepared a question. A person answered. The family went on with its day.

The next family will be different

Pat and Ellen's household is one way to make the principles visible. It is not a template for everyone else.

Another person may live alone. Their trusted support may be a friend or neighbor rather than an adult child. Someone may be caring for a younger relative, returning from rehabilitation, or arranging assistance in an independent-living community.

The language, beliefs, routines, resources, and care needs will differ. So may the meaning of privacy, the people someone wants included, and the kinds of contribution they enjoy.

The question is not how closely those lives resemble this story.

It is whether the organization is prepared to ask, listen, and adapt.

A health system can begin with an explanation people need after an encounter. A care organization can begin with a first visit. A Day Center can begin with a welcome or a useful account of the day. A community or state group can begin where families repeatedly encounter a gap that no one organization can close alone.

Keep the important questions recognizable: What matters here? What is known? What remains uncertain? Who has accepted the next action? What help is actually available? How will we find out whether it was useful?

The answers must come from the setting and the people, not from the expectation that every pathway should look the same.

Carry the learning forward

The next person should not have to rediscover every useful lesson.

Share the explanation that helped, with its context. Credit the participant who suggested a better choice. Preserve the staff member's practical insight. Report the change that created more work as honestly as the one worth keeping.

Protect the private story while making the lesson available.

And return to those who contributed. Let them know what was considered, what changed, and what still needs attention. That is a more meaningful response than thanking people for feedback that never influences anything.

We welcome what you discover—including where this book needs a clearer explanation, a different example, or stronger evidence. The work should remain open to correction by the people who use it.

There is no need to begin everywhere. Begin with one responsibility you can make clearer, one encounter worth improving, or one piece of support you can make dependable. Let the people involved help judge the result.

Then carry forward what is useful.

The page can wait

In Context — One more page

On the television, the little boat had reached the other side of the harbor.

Noah wanted to know where it would go next.

“Out to sea,” Emma said.

“Or back for something they forgot,” Pat replied.

“What did they forget?”

“I expect we’ll find out.”

Emma reached for the next page, but Pat pointed to the dog again.

“Wait a moment.”

She waited.

He made a comment about the picture. Noah offered a different explanation. They talked about which of them was more likely to be right, and Daniel joined in from his chair.

Ellen laughed.

There was still a calendar in the other room. Some questions would need another conversation. The people supporting the family would need to keep listening and adapting; an evening like this did not mean their work was finished.

But none of those questions needed to be answered in this moment.

Ellen was not preparing an update or finding someone to call. She was listening to her husband and their grandchildren argue about a dog in a picture.

Emma looked at Pat.

“Shall I go on?”

“Yes,” he said. “I want to see where they end up.”

She turned the page.

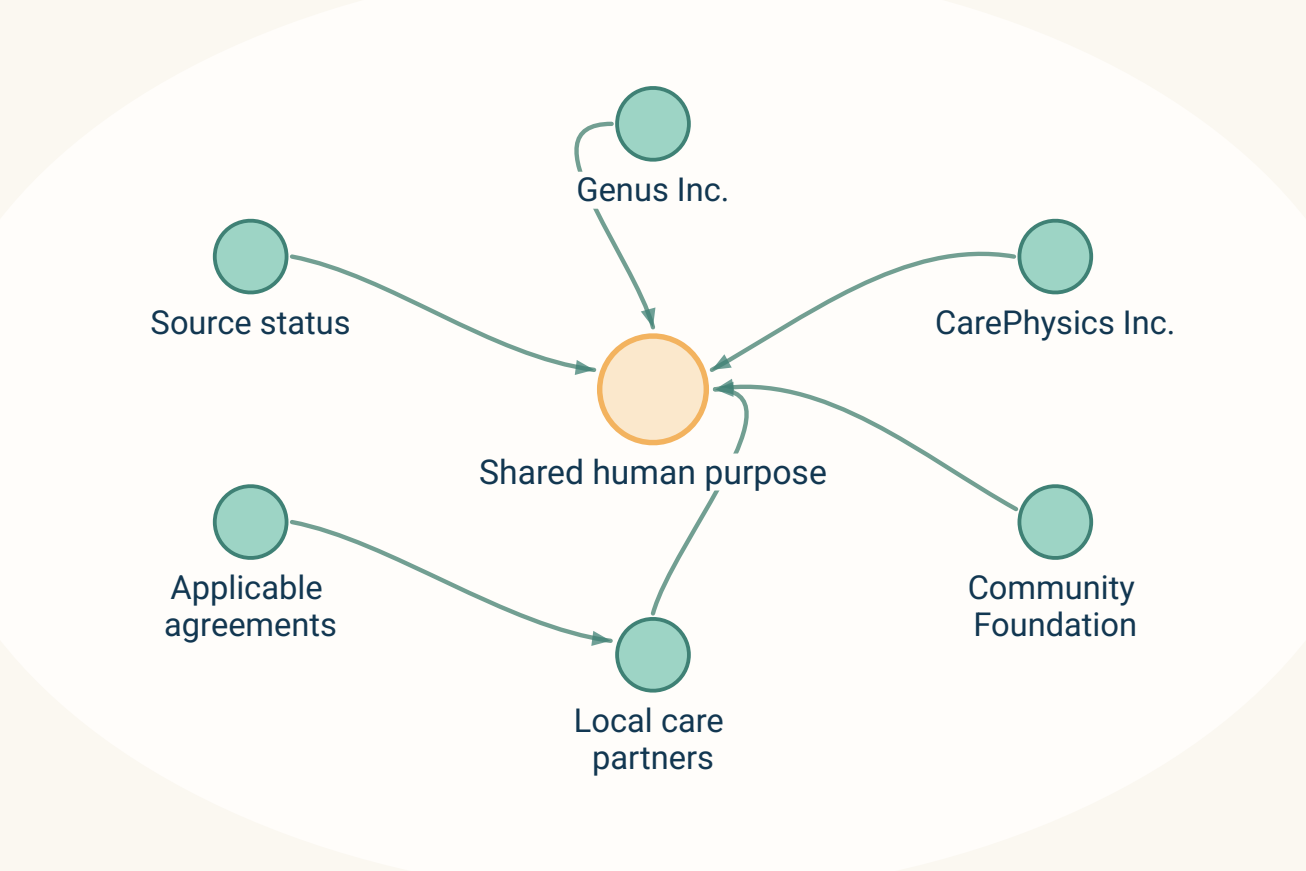
They had not removed every uncertainty. They had people to turn to, responsibilities they could discuss, and support that made room for something beyond the next arrangement.

Tonight, they were using that room to be together.

More Room to Be a Family.

About Genus and This Book

Protecting the purpose as the technology evolves



Connection map — Keep purpose and responsibility visible

In the company account reproduced by this edition, Genus Inc. builds, operates and licenses the platform in service of the shared purpose. That account assigns engagement methodology and training stewardship to CarePhysics Inc. That account describes the Genus Community Foundation as stewarding mission, trust and community participation. Local partners retain responsibility for care, staffing, clinical judgment and services. Applicable governance, licensing and service agreements define the actual commitments to a partner. Source status keeps origin stories, fictional examples, research, proposed applications and dated implementation records distinct. This depicts the book's dated company account, not a legal opinion, current capability verification or independent governance assurance.

CarePhysics grew from a family's experience and from the knowledge of many people receiving, providing, and improving care. Genus is one place where we put that learning to work. The ideas in this book can also inform an organization's own methods and tools.

Genus's public company account describes complementary roles: Genus Inc. builds, operates, and licenses the platform; CarePhysics Inc. stewards the engagement methodology and training; and the Genus Community Foundation, styled

genusCommunity Foundation in that account, stewards mission, trust, and community participation. These are the organization's descriptions of its roles, not a legal opinion or an independent assurance of governance.[102]

The stewardship model described for this book makes room for sustainable commercial development alongside a nonprofit mission. Genus and commercial partners may license and adapt versions of the technology under their applicable agreements. A mission-driven Foundation version is intended to remain a continuing point of reference for the purpose that brought the work together.

The intention is to let different applications develop without allowing the shared human purpose to depend only on one commercial offering. For a partner, that means understanding which version is being adopted, who is responsible for it, and what actual commitments support its use over time.

Rights to use or modify software, receive support, and continue using a version come from the applicable governance, licensing, and service agreements. This book does not create those rights. Nor does Foundation stewardship transfer a partner's responsibility for care, staffing, clinical judgment, or local services.

We want the technology to evolve without losing the reason it exists.

How the sources are used

The author's family account explains the origin of the work. Pat and Ellen's fictional story illustrates decisions. Published research and professional guidance inform the framework; proposed applications remain the author's synthesis. Dated Genus records describe an implementation at a particular time and are kept in Appendix J rather than treated as independent evidence of effectiveness.

This revised edition consolidates the manuscript and repairs its source references. Targeted primary-source and bibliographic checks were made for the identified research corrections, including the behavioral foundations, caregiver support, the 4Ms, Theory of Constraints, and selected communication and AI studies. This was not a new systematic review of every subject in the book. R1 explains the evidence categories and the scope of those checks.

Purpose belongs in the way the work is governed, described, and improved. The continuing invitation is to contribute useful knowledge while preserving the people, context, and responsibility behind it.

Notes

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About the Author and Acknowledgments

Joe Gleason

Joe Gleason is the author of CarePhysics. His work on Genus and the framework grew from caring for his parents, both of whom he lost to dementia, while raising three children. The questions his family encountered became a wider inquiry with families and the people receiving, providing, and improving care.

CarePhysics brings that lived experience into conversation with research and practical design. Its purpose is to help useful knowledge travel: from one encounter to the next, across a team, and into support that people can understand, choose, and use.

With gratitude

To the families, patients, participants, volunteers, nurses, social workers, doctors, researchers, and organizational leaders who have shared questions, experience, and practical wisdom: thank you. Your perspectives have helped shape both the questions and the work. They do not have to be identical to belong in this conversation.

To my family, and to the people who made room for us during difficult days: the attention, patience, and generosity we encountered remain part of this book's purpose. To everyone reading this draft, thank you for helping us see what is clear, what is missing, and what should change.

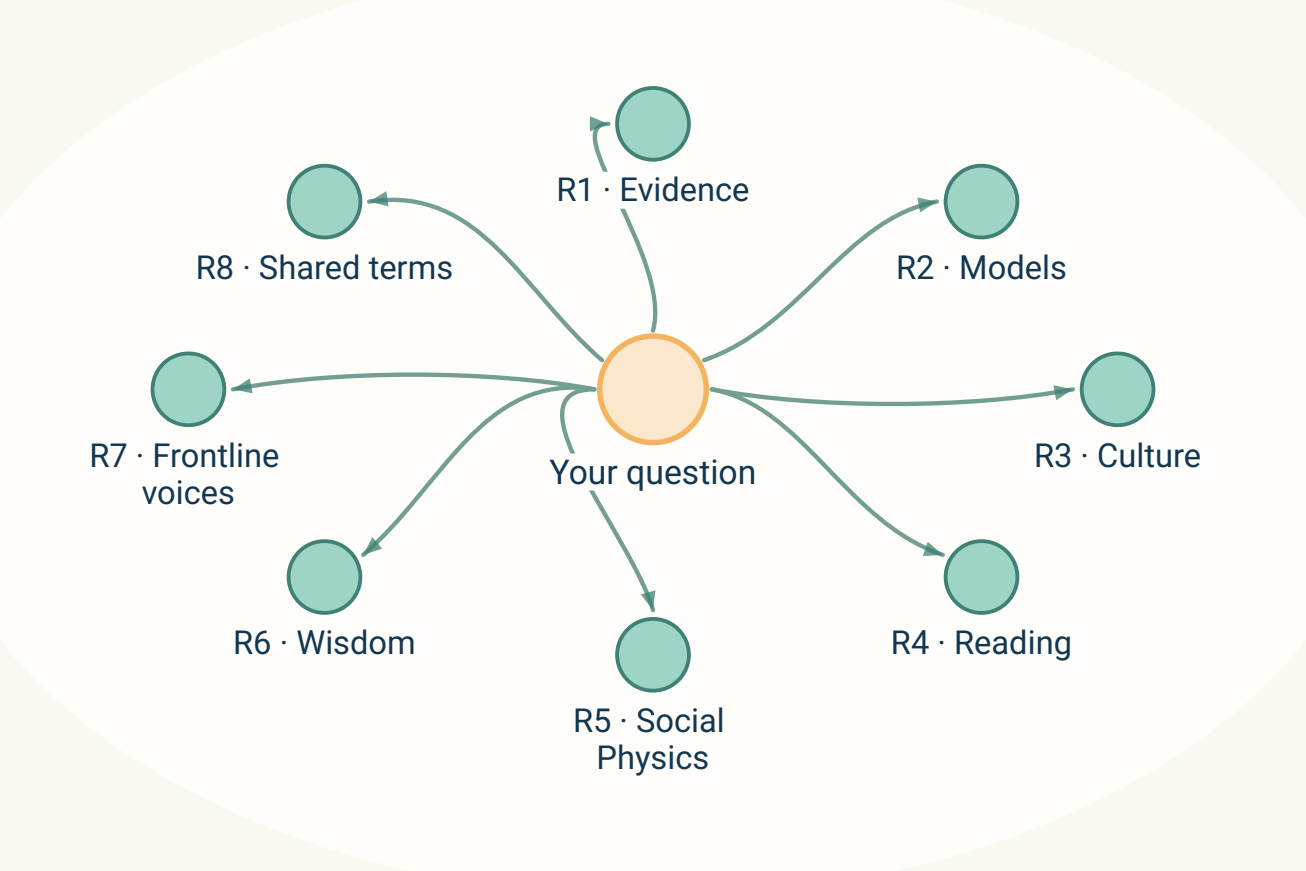
Sources and illustrations

Published research, quotations, and named methods are attributed in the notes and Reference Companion. The illustrations and concept diagrams are carried forward from the author's manuscript and should be read according to their captions. The fictional family is distinct from the author's own family account; the scenes are not records of a particular service or product deployment.

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CarePhysics Reference Companion

Evidence, Models, and Care Across Differences



Connection map — Choose a route into the companion

Take an evidence question to R1 to examine findings and how far they can travel. Take a model or method question to R2. Take a question about culture, beliefs and care to R3. Take a reading question to R4. Take a question about Social Physics and complementary care knowledge to R5. Find public voices and wisdom for reflection in R6. Find reflections on words from the front line in R7. Use R8 to clarify shared terminology. These are optional reading routes; local guidance, human review and source distinctions remain necessary.

How to Use This Companion

The main chapters put the CarePhysics principles into situations people can recognize. This companion lets you examine what stands behind those choices.

R1 examines the research: what was studied, what was found, and how far the findings can reasonably travel. R2 explains the models and methods. R3 explores culture, beliefs, and care. R4 offers reading routes, R5 considers the Social Physics foundation, R6 brings together public voices, R7 reflects on words from the front line, and R8 provides a shared

terminology and an A–Z finder.

You do not need to read these chapters in order. Begin with the question your team is facing, follow the relevant sources, and bring your own professional guidance, services, and experience into the discussion.

Selected entries can also support an approved AI assistant preparing content, training, or pathway options. Keep the research separate from local facts, fictional examples, and private information. A source collection gives the work a starting point; it does not establish that the assistant will use it correctly. The organization remains responsible for review and application.

The closing reflection follows this companion. The practical appendices then provide working tools rather than another set of principles.

R1 — Research Summary — What the Evidence Helps Us Understand

At a Glance

The central idea: Research gives us a better reason to choose what to try. The people using the support help us discover whether it fits.

What you'll explore: How to distinguish a theory, a study finding, professional guidance, and a proposed application. Read selected studies on purpose, communication, choice, community access, caregiver support, staff well-being, activities, and technology—including results that qualify an encouraging story.

Design and AI: Connect findings with specific decisions about articles, videos, questions, conversations, and pathways. Examine evidence for AI-assisted drafting and conversation support without treating fluent answers as proof of better care.

Put it to work: Use the study summaries to build a source-linked evidence entry and select a meaningful local test. Keep the original population, intervention, comparison, outcomes, and limits attached to the finding.

Evidence and evaluation: Preserve source-specific evidence grades. Examine benefit, burden, safety, access, and follow-through. Neither the fictional family nor a documented product capability establishes an outcome.

> *"Absence of evidence is not evidence of absence."*
>
> — **Douglas G. Altman and J. Martin Bland**, medical statisticians, title of their 1995 *BMJ* statistics note.[103]

The purpose of this chapter is not to prove CarePhysics by surrounding it with references.

It is to help readers judge a claim, understand a design choice, and identify what should be learned before people are asked to rely on a new approach.

CarePhysics brings human priorities, professional knowledge, community resources, and planned encounters into the same discussion. It is an evidence-informed design approach, not one intervention validated by the separate studies of its components.

This is a selected guide to research informing the book, not a comprehensive systematic review. The revised edition includes targeted primary-source and bibliographic checks made on October 1, 2026 for the identified corrections. The later PDC30 randomized trial is distinguished from the earlier acceptability study in R1.4. Other sources retain their original study populations, dates, and scope.

R1.1 — How to Read the Evidence

This companion distinguishes published findings and professional guidance from our design proposals and author-held working materials. Numbered notes identify sources with bibliographic details and direct links. Repeated numbers refer to the first note for that source. Thematic registers retain the detailed C4C, 4Ms, TOC, and design references.

Descriptions of the author's framework and fiction do not serve as independent outcome evidence.

The author-held rapid review From Understanding to Participation: Evidence-Graded Behavioral Influence (September 26, 2026) supplies the labels Strong, Moderate, Emerging, Plausible but untested, and Unsupported/contradicted. These are source-specific judgments, not formal GRADE ratings or a peer-reviewed classification. A published review's certainty ratings retain its own terminology; public citations identify the research behind the claims.

Author accounts explain origins; fictional scenes illustrate choices; dated organizational records document described capabilities. None establishes effectiveness. Author-held outlines, communication-design materials, and the September 2026 rapid review informed this manuscript, but are not presented as peer-reviewed public research. Appendix J identifies the dated Genus export; public evidence is cited separately.

Ask what kind of answer the source can provide

A theoretical model organizes thinking. COM-B, for example, helps investigate barriers before an intervention is selected. It does not supply a percentage improvement for everything designed with it. The research review informing this book makes that distinction explicit.

A qualitative study examines experiences and explanations. It can reveal why a service feels inaccessible without establishing how many people everywhere face that barrier.

An observational study follows what happens without randomly assigning the support. It can identify associations and useful questions; differences in health, resources, or circumstances may also explain the result.

A randomized trial uses chance to assign an intervention or comparison. A cluster-randomized trial assigns groups, such as sites; its analysis must account for people sharing a site. These designs strengthen causal comparisons, but incomplete follow-up, biased measurement, or implementation problems still matter. Reviews bring studies together; a meta-analysis combines selected results statistically. A pooled estimate does not remove weaknesses in the contributing studies.[104]

Professional guidance and accessibility standards serve another purpose: they help define responsible practice and design. A product record establishes what a supplier describes or documents, within its date and scope. It is not independent evidence of a health benefit.

Read the finding and the uncertainty together

How large was the difference? A statistically detectable change may be too small to matter in practice. Conversely, a study may be too imprecise to distinguish a useful benefit from no meaningful difference. Look at the estimate and its confidence interval, not only whether a *p* value crossed a threshold.[103]

An illustrative change from 20 percent to 25 percent is a **five-percentage-point increase**, or a **25 percent relative increase**. Both calculations describe the same change,

but sound different. Neither tells us whether the improvement was worth its cost.

Who supplied the answer? A participant's own report, a caregiver's report, and a staff observation may concern different aspects of the experience. Identify the respondent rather than blending the accounts.

Who was missing? Report the people who did not complete follow-up, could not access the offer, or withdrew. Do not convert silence into satisfaction. The CarePhysics measurement approach treats access, burden, and useful participation as distinct from recorded activity.

Keep the grading system attached to the grade

The research review informing this book uses these judgments:

Source-review judgment	Meaning in that review
Strong	Convergent, high-quality experimental or systematic evidence supports the specified conclusion.
Moderate	Supporting studies exist, but variation, indirectness, implementation, or methods limit confidence.
Emerging	Evidence is limited, new, contextual, or insufficiently replicated.
Plausible but untested	Relevant mechanisms and adjacent evidence exist, but the proposed application lacks direct testing.
Unsupported/contradicted	Strong claims lack adequate support, or better evidence weakens them. The reason must be stated.

These are the review's judgments, not a new clinical rating system applied by this chapter. Evidence for a mechanism does not establish evidence for a product feature.

Some underlying reviews use **GRADE**, which assesses certainty by outcome as high, moderate, low, or very low, considering bias, inconsistency, indirectness, imprecision, and publication bias. Do not silently translate a source's "Emerging" into a GRADE category or apply a broad domain label to every outcome.[104]

For teach-back, the underlying 2026 review reports low or very-low certainty by outcome. The summary below preserves those published ratings rather than replacing them with a broader editorial label.[23]

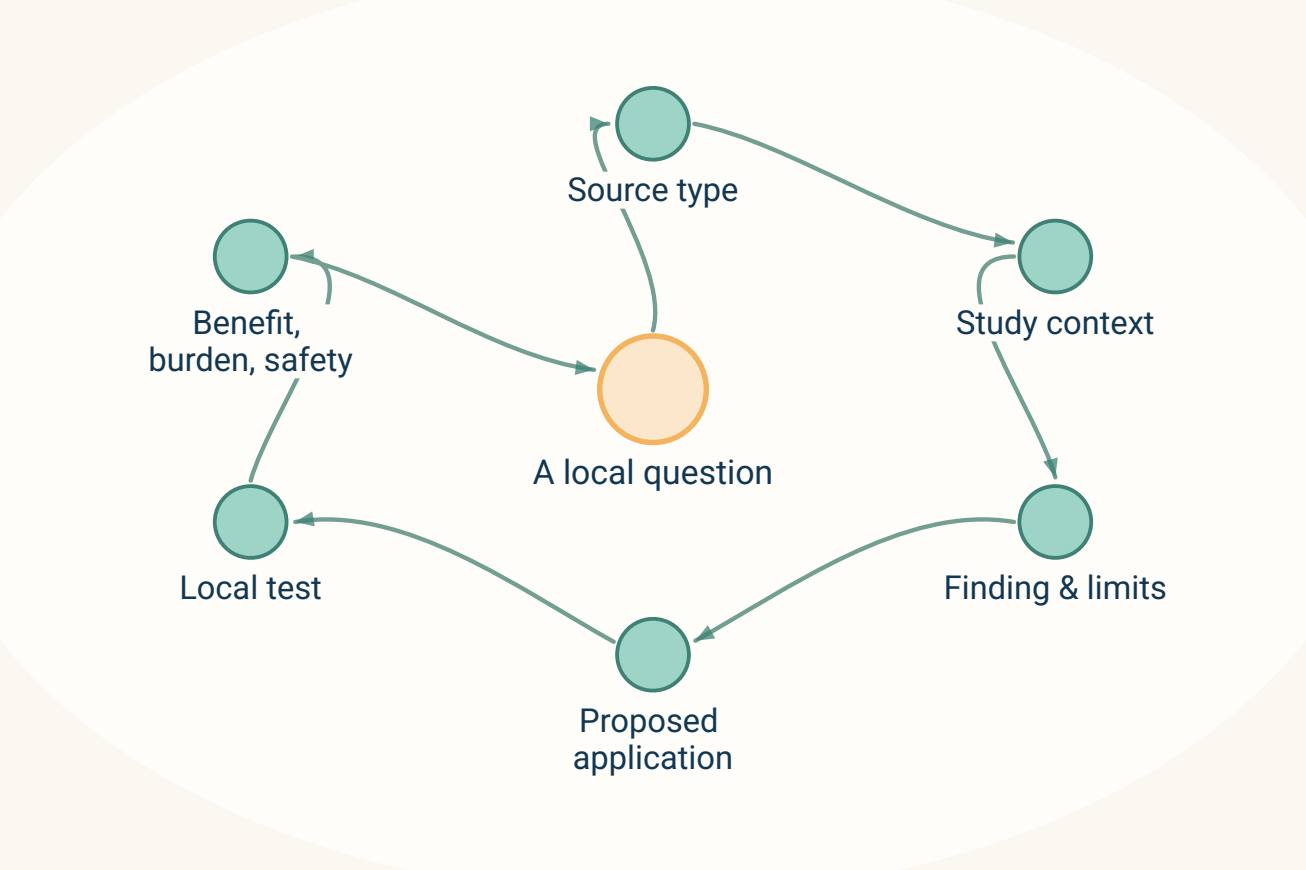


Figure 18 · Read the evidence in context

Choose sources relevant to a local question and identify the kind of answer each can provide. Read the source with its population, setting, intervention, comparison and methods. That study context qualifies the finding and its limits. Findings can inform a proposed application without proving that it works locally. A proposed application needs an appropriate local test and responsible owner. The test examines benefit, burden, safety and access. Use those observations to refine the local question and next decision. Keep source-specific evidence grades attached; theory, guidance, study findings and proposed applications are different kinds of material.

Ask of the source	Keep with the application
Who, where, and compared with what?	Population, setting, intervention, comparator, and study design.
What was found—and how uncertain?	Actual outcomes, estimates where useful, missing data, and limitations.
What are we proposing?	The new care application, local dependencies, reviewer, and evaluation; no borrowed effect.

R1.2 — The Research Map Across the Ten Principles

This map directs readers to a question and the relevant material. It is not a grade for each principle. Chapters 11–15 apply these same foundations at family, organizational, and community levels. The research discussed here remains distinct from the practical tools and applications proposed in the chapters.

Principle	Research question to explore	Where to look here; related applications
1. Holistic Care	What do purpose, circumstances, and family capacity add to understanding the person?	R1.3: purpose and caregiver studies; Chapters 11 and 15
2. Awareness	Did the explanation improve understanding, and what remained unchanged?	R1.3: plain language and teach-back; Chapter 13
3. Behavioral Influence	Which barrier is being addressed, and does the person retain meaningful choice?	R1.3: autonomy and motivational interviewing; R2 for fuller model explanations
4. Communications	Can practice improve the experience of being heard?	R1.3: empathy training; R1.4: conversational assistance; Chapter 11
5. Community	Do relationships and services become usable support?	R1.3: networks, Day Centers, and navigation; Chapters 12 and 14
6. Engagements	Is the activity or content worthwhile to the person?	R1.3: tailored activities and comprehension; Chapter 13
7. Pathways	What combination of people and follow-through was actually tested?	R1.3: care transitions; R1.5: coordinated dementia-care comparisons; Chapters 12 and 15
8. Technology	What does the complete access-and-support offer achieve?	R1.3: PRISM; distinguish technology from its training and support

Principle	Research question to explore	Where to look here; related applications
9. Care AI	Does assistance improve this task or outcome under these conditions?	R1.4; Chapters 13–15
10. Scoring	Are we observing activity, experience, outcomes, or attributable impact?	R1.1 and R1.6; Chapter 14

R1.3 — Key Studies, Explained

The proposed applications below are design choices to consider. They are not additional results of the studies.

Purpose: what makes the next step worthwhile?

Kim and colleagues, 2022 — prospective observational study. Researchers used data from **12,998 U.S. adults over 50** in the Health and Retirement Study, examining purpose and subsequent outcomes across four years. Higher purpose was associated with several favorable physical and psychosocial outcomes, including lower depression and loneliness, but not with every outcome examined. The study did not randomly assign a purpose-building intervention.[16]

Application and limit. Ask what someone wants to preserve, enjoy, or contribute. Do not turn an association into a promise that leading a group or completing a "purpose activity" improves health. A person does not have to demonstrate usefulness to deserve support.

Use in Chapters 1, 3, 5, and 6. Examine whether the offer reflects the person's stated priorities—not whether staff assigned an inspiring goal.

Plain language: can clearer content improve understanding?

McCormack and colleagues, 2016 — randomized online study. Among **1,244 U.S. consumers**, a revised drug-safety message produced better average performance on a five-item comprehension index: **63 percent correct versus 52 percent** for the standard version. The groups did not differ significantly in behavioral intentions, risk perception, or trust.[22]

Application and limit. Test wording, headings, and organization with intended readers. The study supports a comprehension claim about the message tested—not a claim that plain language alone changes behavior or care outcomes.

Use in Chapters 2, 6, 8, and 13. Ask people to explain the main point and locate help, while separately examining whether a practical next step became possible.

Teach-back: did the explanation work?

Vick and colleagues, 2026 — systematic review and meta-analysis. The review included **18 randomized trials with 1,985 adult patients or care partners**, examining teach-back in a single encounter. It found no clear pattern of benefit for knowledge acquisition, with **very-low certainty**. Pooled findings favored self-efficacy, also with **very-low certainty**, and self-reported short-term adherence, with **low certainty**. Results varied substantially and estimates were imprecise.[23]

Application and limit. Teach-back offers a way to discover misunderstandings. It is not a guaranteed memory intervention. AHRQ describes checking the explanation rather than testing the person and permits reference to written materials.[24]

Use in Chapters 2, 4, and 15. Check whether the relevant misunderstanding was resolved and whether the person felt respected.

Empathy training: can people notice the difference?

Riess and colleagues, 2012 — randomized trial. Ninety-nine resident and fellow physicians at two Boston institutions received standard education or additional training consisting of three one-hour sessions. The training group improved more on patient-rated empathy, with a **2.2-point difference in change** on the CARE measure. Follow-up ratings were collected one to two months later.[36]

Application and limit. Offer practice and feedback on actual communication skills. This small study of medical trainees does not establish lasting clinical effects, validate AI emotion-reading, or justify covert empathy scores for staff.

Use in Chapters 4, 10, and 11. Ask whether people experience better listening and responses, while providing time and organizational support for the practice.

Choice and motivation: what kind of participation are we supporting?

Ntoumanis and colleagues, 2021 — meta-analysis of 73 health-intervention studies. Self-Determination Theory–informed interventions produced generally small-to-medium changes in motivational measures and health behavior, with modest, variable improvements in health outcomes. The research review informing this book grades the intervention evidence **Moderate**.[17]

Uzun and Gürhan, 2024 — motivational-interviewing meta-analysis. Across **38 chronic-illness studies involving 25,425 participants**, quality of life improved by a small average amount; the pooled self-efficacy difference was not statistically significant. Variation was very high, and some studies used weaker before-and-after designs. The literature search ended in May 2021.[31]

Application and limit. Support the person's own reasons and investigate mixed feelings. These findings do not turn selected phrases into a complete intervention, or AI rehearsal into trained motivational interviewing. Neither model creates an unavailable service.

Use in Chapters 3, 6, and 11. Examine informed choice, perceived pressure, and the practical barriers still present.

Social networks: does the route through people matter?

Centola, 2010 — randomized online-network experiment. More than **1,500 participants** entered deliberately structured networks. Adoption of an online health resource was higher in clustered networks than in networks emphasizing longer-range connections; reinforcement from multiple contacts mattered in that setting.[27,27]

Application and limit. Consider whether someone needs a conversation with an appropriate trusted person, not simply another exposure to information. This was not a trial of Day Center attendance or family care. It is related network evidence, not a test of Pentland's entire *Social Physics* framework.

Our commissioned review grades the broader Social Physics perspective **Emerging-to-moderate** and warns that social learning can spread mistakes too.

Use in Chapters 5, 12, and 14. Measure useful, permissioned connections rather than message volume.

Day Center participation: what happens to a caregiver's day?

Zarit and colleagues, 2014 — Daily Stress and Health study. 173 caregivers of people with dementia completed daily interviews over eight consecutive days. On adult-day-service days, they reported fewer care-related stressors, more positive experiences, and lower anger, while noncare stressors increased. This was an observational comparison within caregivers' lives, not random assignment to service use.[43]

Application and limit. Treat the caregiver's experience as something to ask about directly. Attendance is not a complete account of respite: preparation, travel, uncertainty, and other work may remain. The finding does not establish a benefit from a digital summary or app.

Use in Chapters 5, 10, and 11. Examine whether the arrangement provides usable time and what it costs the caregiver in effort.

Added caregiver support: what must exist beyond the service day?

Gitlin and colleagues, 2024 — ADS Plus cluster-randomized trial. 34 sites and 203 caregivers participated. Trained staff added education, validation, referrals, problem-solving, and self-care support over 12 months. Adjusted caregiver depression scores were lower in the intervention group at 12 months. The sample was predominantly female and college educated; **22.7 percent** were lost to follow-up.[44]

The attendance comparison was available from only 18 sites and had **p = .079**. Although the abstract's conclusion describes increased utilization, that estimate should not be presented as a statistically established attendance gain.[44]

Application and limit. A service can offer structured support addressed to caregivers themselves. Reproducing the intervention requires the people, preparation, and sustained work—not merely an article or chatbot.

Use in Chapters 5, 11, and 15. Identify who provides caregiver support and evaluate the outcomes separately from participant attendance.

Personally tailored activities: is relevance enough?

Möhler and colleagues, 2020 — Cochrane review. Five randomized studies involved **262 people with dementia who completed the studies**, generally living at home with mild-to-moderate dementia. Follow-up ranged from two weeks to four months. **Low-certainty evidence** suggested improvement in some behavioral difficulties and slight improvement in caregiver-rated quality of life. Clear benefits were not established for several other outcomes, including caregiver burden. None of the studies assessed adverse effects.[51]

Application and limit. Begin with interests and preferences, then assess fit, assistance, and enjoyment. The review did not test the shared-TV story or show that tailored activities slow dementia. A lack of assessed harms is not proof of safety.

Use in Chapters 5 and 6. Rest, listening, changing activities, and stopping remain valid choices—not unsuccessful engagement.

Care transitions: test the support package, not just the message

Coleman and colleagues, 2006 — randomized trial. 750 community-dwelling adults aged 65 or older received usual care or an intervention combining communication tools, support for expressing preferences, and transition-coach assistance. Thirty-day rehospitalization was **8.3 percent versus 11.9 percent**, with a statistically significant adjusted comparison.[57]

Application and limit. Connect information to someone who supports the transition. Participants were English speaking, had telephone access, and had no documented dementia. The population and multicomponent design limit transfer to Pat's later situation or to software alone.[57]

Use in Chapters 7, 12, and 15. Evaluate the completed human connection and subsequent support, not only whether a discharge resource was sent.

Navigation and transport: an offer can be insufficient

Gottlieb and colleagues, 2016 — navigation trial. 1,809 caregiver–child families at two safety-net hospitals were allocated by day to written information or in-person navigation with follow-up. At four months, the navigation group reported greater reductions in social needs and improvement in parent-reported child health. Follow-up was available for **1,054 participants, or 58.3 percent**. This pediatric result does not directly establish effects in older-adult care.[90]

Chaiyachati and colleagues, 2018 — pragmatic transportation trial. Among **786 Medicaid-insured adults**, a free rideshare offer did not produce a statistically significant difference in missed appointments: **36.5 versus 36.7 percent**. Allocation used a fixed weekday scheme rather than individual randomization. Uptake was limited; this was not assisted transport for people living with dementia.[91]

Application and limit. Investigate the actual barrier and whether the offered assistance matches it. Neither a directory nor a free service automatically becomes accessible care.

Use in Chapters 5, 12, and 14. Track accepted help, received services, unresolved needs, and family coordination work separately.

Workforce support: change the conditions as well as the individual response

Panagioti and colleagues, 2017 — systematic review and meta-analysis. 19 studies involving 1,550 physicians contributed 20 comparisons. Interventions produced small average reductions in burnout measures focused on emotional exhaustion. Organization-directed interventions showed larger average effects than physician-directed approaches. The review included randomized and controlled before-and-after studies.[86]

Application and limit. Examine workload, coverage, role clarity, and task design alongside personal support. A subgroup finding in physician studies does not establish which staffing change works in a Day Center or for volunteers.

Use in Chapters 10 and 11. Count after-hours work, review effort, and whether people can actually obtain assistance. Do not infer well-being from training completion.

Technology access: what did the full offer include?

Czaja and colleagues, 2018 — PRISM randomized trial. 300 older adults at risk of social isolation received a specially designed computer system or a binder with similar information. The technology offer included equipment, access, training, and support. The PRISM group reported less loneliness and more perceived social support and well-being at six months; the reported between-group advantages were not maintained at 12 months. Computer confidence and proficiency improved.[67]

Application and limit. Evaluate the complete access arrangement. Participants did not have cognitive impairment; this is not evidence that the same results apply to Pat or that a device without support would work equally well.[67]

Use in Chapter 8. Examine successful useful tasks, assistance, privacy, and continuing value. WCAG provides accessibility requirements, not proof that every intended person can use the finished service.[62]

Public practice models: caregiver support and the Age-Friendly 4Ms

The following sources serve a different purpose from the trials above. They describe care-delivery and implementation approaches, supported by named instruments and a wider evidence base. The proposed CarePhysics applications are not additional findings of these sources.

RUSH C4C. Carbonell, Mariani, and Golden (2025) describe a customizable caregiver-support model. Their report notes lower caregiver symptoms of depression and anxiety and lower burden at one- and three-month follow-up after intervention. These uncontrolled observations are encouraging, not causal estimates. The named Planning for What Matters component is brief psychotherapy delivered by a designated clinician; it is not equivalent to an ordinary Day Center planning meeting. C4C is used here primarily as a workflow and measurement model. No caregiver effect size or denominator is inferred from the separate care-recipient utilization data.[76]

A separate caregiver record. Opthof's 2022 implementation profile, informed by RUSH program leaders, documents caregivers receiving their own electronic record. This supports the design rationale for a distinct caregiver pathway. It does not establish a particular platform's access controls or a universal legal rule that individual-session information can never be shared.[83]

Age-Friendly 4Ms. IHI's 2026 hospital guide sets out What Matters, Medication, Mentation, and Mobility as an assess-and-act framework delivered together. The framework is attributed to The John A. Hartford Foundation and IHI. Our Day Center crosswalk is 4Ms-informed, with clinical responsibility and setting-specific requirements kept visible.[7]

What the evidence can support. Mate and colleagues' 2021 synthesis examines evidence for the individual elements and their interactions; it is not a trial of this book's approach. Howe and colleagues' 2026 outpatient systematic review included 12 U.S. comparative studies found through a search ending November 22, 2024. Its public abstract reports improved process measures, while outcome and structural measures were infrequently reported and heterogeneity and reporting limits constrained interpretation. Neither source supplies a transferable effect size for a Genus implementation.[105]

Use these foundations to plan and examine real support. A recorded domain is not an action delivered; a documented action is not automatically a better health outcome. The person's experience, professional review, and appropriate evaluation are still needed.

The measurement tools have different jobs

C4C's public case study identifies the tools below. Their original research is credited separately: RUSH uses these resources; it did not create all of them. This is an orientation, not a ready-to-administer battery or a reproduction of scoring instructions.[76]

Measure or assessment	Purpose in the support process	Public source
BSFC-s	The 10-item short Burden Scale for Family Caregivers: subjective caregiver burden.	Graessel et al., 2014; CG8
GAD-2 / GAD-7	Brief and fuller anxiety symptom screening. Interpretation and further assessment belong to qualified professionals.	Spitzer et al., 2006; Kroenke et al., 2007; CG9–CG10
PHQ-2 / PHQ-9	Brief depression screening and fuller depressive-symptom assessment. Follow the adopted clinical protocol and response pathway.	Kroenke et al., 2003 (CG12) and 2001 (CG11)

Measure or assessment	Purpose in the support process	Public source
BRIEF	Health-literacy screening to inform how information and assistance are offered—not a judgment of intelligence.	Haun et al., 2009; C4C use in CG1; CG13
Social-needs screening	Practical conditions affecting support. C4C describes a RUSH tool; other organizations must specify the tool they use.	Carbonell et al., 2025; CG1
Biopsychosocial assessment	A professional assessment of relevant personal, health, relational, and practical circumstances—not one interchangeable numeric score.	Carbonell et al., 2025; CG1

The locally described four-item caregiver intake is not established as equivalent to this battery. Before use, verify each instrument's exact version, language, permissions, population, recall period, scoring, missing-response rules, and interpretation. An AI rewrite does not preserve validation automatically. New or urgent concerns need a response when raised, not only at scheduled reassessment.

The public case study's one- and three-month follow-ups are counted after completion; the public implementation page permits a locally appropriate schedule. A six-month review may be a local decision, but should not be attributed here as a universal RUSH requirement. Our recommendation to allow a declined response is a CarePhysics design choice, not a verified statement that every item in every public C4C form has that option. Appendix F makes those choices explicit.

Operational support: where should improvement begin?

Groop, Ketokivi, Gupta, and Holmström, 2017 — design research in municipal home care. Working with practitioners in Espoo and Porvoo, Finland, the researchers combined TOC with demand-responsive resource allocation. They reported more balanced resource use and improved productivity in later implementations. An initial Espoo implementation had been terminated; the later work involved redesign and fuller implementation.[106]

The comparisons were uncontrolled. The authors caution against assigning all observed changes to the intervention and emphasize stakeholder goals, labor arrangements, and institutional limits. The lead author disclosed work at a for-profit health-and-social-care consultancy. These findings do not establish caregiver-health effects, a universal staffing model, or benefits from Genus.

Our application: involve people receiving and providing care when defining the

objective; investigate the suspected constraint; then test a feasible change with benefit, burden, safety, and access measures. R2.5 explains the focusing method. No new overall evidence grade is assigned to TOC from this study.

R1.4 — What AI Research Does—and Does Not—Establish

AI is not one intervention. Finding a passage, drafting a reply, assisting a live conversation, and supporting a caregiver over time are different tasks. Each needs an appropriate test.

Retrieval can improve a starting point

Lewis and colleagues, 2020 — computational research. Retrieval-augmented generation combined a language model with access to an external collection. It improved performance on selected knowledge-intensive language tasks and produced more factual and specific generated language than the comparison model in the tasks studied.[70]

Boundary: These were language benchmarks, not clinical encounters. Retrieval does not guarantee correct source selection, faithful interpretation, privacy, or care outcomes. Providing a book is not the same as training the underlying model or testing a service.

A draft can reduce perceived effort without saving measured time

Garcia and colleagues, 2024 — single-group quality-improvement study. Over five weeks at Stanford Health Care, **162 clinicians** used a system offering drafted patient-message replies; **73 completed both surveys**. Mean draft use across clinicians was about **20 percent**. Survey measures suggested less perceived task burden and work exhaustion, but measured reading, writing, and reply times did not improve.[73]

Boundary: The short, uncontrolled study cannot establish a general causal benefit. It demonstrates why usefulness, perceived burden, and actual time require separate measures.

Timely conversational suggestions can be worth testing

Sharma and colleagues, 2023 — nonclinical randomized experiment. 300 TalkLife peer supporters received a writing environment with or without HAILEY's just-in-time suggestions. The authors reported a **19.6 percent increase on their measure of conversational empathy** in assisted replies.[78]

Boundary: This was text-based peer support—not a trial of spoken clinical meetings, reliable emotion detection, or impartial conflict mediation. The outcome was not a 19.6 percent improvement in care or in the support seeker's health.

CarePhysics application: With agreement, investigate whether suggestions help a person clarify a question or improve a response. Also measure distractions, errors, perceived pressure, and whether the intended human follow-up occurred.

Caregiver AI: distinguish acceptability from an outcome trial

Cheng and Ng, 2025 — PDC30 acceptability study. 21 caregivers used a purpose-built dementia-caregiving chatbot for two weeks and generally rated it as usable, understandable, and helpful. The study did not establish reduced caregiver burden or clinical benefit.[72]

External evidence update: Cheng and Ng, 2026 — randomized waitlist-controlled trial. Identified during verification for R1, this later study randomized **274 caregivers from 43 countries** to immediate or delayed access to a broader PDC30 program: a guidebook, AI chatbot, and interactive exercises. At one month, the intervention group showed improvements in depression (**d = −0.37**), burden (**d = −0.34**), and positive aspects of caregiving (**d = 0.42**), but not anxiety. These are standardized effect sizes, not percentages.[107]

Once the waitlist group received the intervention, between-group differences mostly disappeared. The comparison therefore does not establish a longer-term advantage over a group remaining without the program. Recruitment was online, eligibility required substantial caregiving and at least mild depressive symptoms, and the study tested the whole package—not the chatbot's isolated contribution or equivalence to professional care.[107]

This is encouraging outcome evidence for that defined program. It should update the discussion without becoming a claim that any caregiver assistant—or Genus—produces the same result.

Evaluate the whole assistant-supported service

The Day Center research materials separate **draft quality, human-review quality, workflow efficiency, family impact, and safety and fairness**. A high approval rate alone can reflect good drafts, rushed review, or overreliance.

For the proposed real-time and post-encounter learning approach, ask whether the assistant preserved the person's words, identified an actually unanswered question, brought forward a relevant available option, and credited the contributor. Then ask whether anything useful changed.

Patients, participants, caregivers, volunteers, and frontline teams should be able to contribute or decline. Private feedback needs an appropriate route; the assistant is not inherently neutral. WHO's guidance supports defined tasks, stakeholder participation, privacy, and accountable human judgment.[1]

With suitable knowledge, guidelines, rules, and review, assistance can be a gift: less repetitive preparation and more support around a human conversation. Whether it returns time or improves that conversation remains a task-specific question.

Around-the-clock access to approved routine information is not continuous professional coverage. Make human availability and urgent routes clear. No assistant can supply unavailable staffing, transport, or respite through reassuring language.

R1.5 — Where Findings Are Mixed or Questions Remain

Coordinated dementia care does not produce one uniform result

The **2019 Care Ecosystem randomized trial** enrolled **780 person–caregiver pairs** in three U.S. states. A navigator-led program with specialist support improved caregiver-rated participant quality of life and selected caregiver and service-use outcomes compared with usual care. **571 pairs completed the 12-month survey**.[59]

The **2025 D-CARE trial** enrolled **2,176 pairs** and compared health-system care, community-based care, and usual care over 18 months. It found no significant group differences in its primary outcomes of participant behavioral symptoms and caregiver strain; caregiver self-efficacy improved in the intervention groups. These were different programs and comparisons, not direct replications of one another.[60]

The practical conclusion is to describe and evaluate the service actually delivered. “Coordinated care” is not a single treatment with a transferable effect size.

A saving estimated is not a saving established

Pizzi and colleagues’ 2025 ADS Plus economic analysis, drawn from the 34-site, 203-caregiver trial, estimated a delivery cost of **$433 per person–caregiver pair over 12 months** in that study. Estimated payer and societal savings were not statistically significant; the uncertainty included possible additional cost. The amount is not a current service price or the cost of the underlying adult day program. Two authors disclosed interests in a company receiving fees for ADS Plus training.[108]

Costs, affordability, and benefits belong to different parties. Report whose perspective is being used. Service evidence does not establish reimbursement eligibility, and documentation does not guarantee payment.

Delaying residential care is not a supported general promise

Udeh and Menne’s 2025 scoping review found only two studies directly addressing its question about adult day services and long-term-care placement. Both reported increased placement risk associated with use. The review judged the evidence too sparse for firm conclusions.[109]

That does not show that Day Centers cause earlier placement: people with greater or changing needs may be more likely to use services. It also does not justify promising that attendance delays a move. The review cannot resolve either causal claim.

Valuable design is not automatically a validated intervention

No product-specific causal evidence in the material reviewed here establishes that a CarePhysics tile, the shared-TV reading configuration, a reviewed evening note, symbolic community points, or the complete proposed pathway produces all the intended care outcomes. The behavioral review explicitly labels many of these applications plausible or emerging.

The Jack Scale remains a historical and proposed review tool; the evidence reviewed here does not establish it as a validated clinical measure.

These limits are reasons to test suitable applications, not to treat “not established” as either “certain to work” or “worthless.” A precise null result can rule out a meaningful benefit; an imprecise result may leave the question open. The evidence, not the preferred conclusion, determines the distinction.[103]

R1.6 — From Research to Local Learning

Make the evidence usable without making the claim larger

> **In Context — A study becomes a design question**
>
> *This hypothetical planning exchange illustrates evidence use; it does not add an event or outcome to Pat and Ellen’s chronology.*
>
> A Day Center team is preparing a family-support resource.
>
> “The caregiver trial gives us a reason to include support for the caregiver,” one person says. “Could we describe our new article as reducing caregiver depression?”
>
> “What did the trial actually provide?” the reviewer asks.
>
> They look again: trained staff, repeated support, education, referrals, and problem-solving—not an article alone.
>
> The team changes the assignment. The article will explain a support conversation the center can actually offer. A short video will demonstrate how someone can ask a question. The pathway will identify the responder and what happens after the request.
>
> They will first test understanding and the response process. Any claim about depression will require a suitable intervention and evaluation of its own.
>
> The study has still changed the design.
>
> It has also kept the promise honest.

Build one evidence entry your team can reuse

Start with the question, not a pile of articles. Record the source and year, the population and setting, the intervention or exposure, the comparison, the findings, the limits, and whether the result concerns a service, a mechanism, or a product.

Add the relevant chapters, approved uses, source-access status, reviewer, and review date. Keep a proposed application visibly separate from the research finding. This follows the book’s evidence-entry specification.

An entry can inform an article, video, survey, message, conversation, or feature-planning

brief. Use a recognizable structure—why it matters, main idea, demonstration, chosen next step, question route, and follow-through—without altering clinical facts or validated instruments.

The organization supplies current service facts. A clinical reviewer checks clinical material. The program owner checks capacity and commitments. Intended users help assess language, culture, format, access, and practical fit.

Choose a local question with a responsible owner

IHI recommends outcome, process, and balancing measures: what changed, whether the process happened, and whether improvement created another problem.[75]

For an introductory resource, an initial question might be whether people can explain the offer and reach the person who responds. Establish a baseline, a defined test period, and the versions being compared.

Report the number offered the resource, the number who used each route, and who provided feedback. Count uncompleted requests and unanswered questions. Keep missing dates visible and distinguish intake timing from referral timing; the dated example appears in Appendix J.

Include staff preparation, review, corrections, interpretation, transport, and family coordination. A service can reduce one burden while creating another. Give someone authority to change the work, staffing, or offer—not only its wording.

For stronger health or economic claims, obtain appropriate research expertise and oversight, a suitable comparison, and measures with relevant evidence. Do not label a convenient before-and-after count a causal trial.

Keep reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact distinct. Willingness to recommend, actual referrals, and services received by referred people are also different questions.

No leaderboard should rank how much families care. Staff suggestions should support better work, not concealed surveillance. Credit contributions and report negative findings as readily as positive ones.

Give an assistant the evidence, the task, and the boundaries

An approved assistant could retrieve a selected entry and help prepare options:

Use this study and its limitations alongside our verified local information. Prepare an explanation and a demonstration for the stated audience. Identify what the research supports, what we are proposing, what resources must exist, and who must review the output. Suggest a way to check usefulness, burden, safety, and access. Do not invent a result, service, quotation, or personal preference.

The working sequence is **retrieval → local context → draft or options → human review → testing → revision**. Keep sources, owners, review dates, approved uses, and corrections. Generic design work does not require private family records. Uploading a book is not model training or proof that a configured assistant is reliable.

Genus supplies technology; partners retain care, staffing, programs, voice, and professional accountability. Research can help choose a promising direction. It cannot supply the people or capacity behind the next step.

Public sources for caregiver support and age-friendly practice

These references give readers direct access to the public material behind the additions in Chapters 1, 10, and 11, R2, R8, and the practical tools. CG labels identify sources, not evidence grades. Sources were checked October 1, 2026. Public availability does not by itself grant permission to reproduce complete instruments, training manuals, or graphics.

CG1. Carbonell E, Mariani D, Golden R (2025). Caring for Caregivers Within Age-Friendly Health Systems: An Organizational Case Study of National Scale and Spread. INQUIRY. 62:00469580251325660. DOI: 10.1177/00469580251325660. https://journals.sagepub.com/doi/full/10.1177/00469580251325660

Public organizational case study; full text reviewed. Describes a customizable clinical model and uncontrolled observations, not a randomized outcome trial. Follow-up is described as one and three months after completion or other predetermined times. The June 2026 erratum corrects the online volume number to 62; it does not alter the reported findings.

CG2. RUSH Center for Excellence in Aging (n.d.). Caring for Caregivers Across U.S.. Public implementation resource. https://aging.rush.edu/professional-older-adult-family-care/c4c/

Official program guidance; page reviewed. Describes identification, assessment, assistance, skill-building, Planning for What Matters, care-team planning, and locally arranged follow-up. Program description is not independent evidence of effectiveness.

CG3. Opthof E (2022). Rush Caregiver Intervention: Advancing Age-Friendly Health Systems by Prioritizing Family Caregivers. Center for Health Care Strategies. January 13, 2022. https://www.chcs.org/rush-caregiver-intervention-advancing-age-friendly-health-systems-by-prioritizing-family-caregivers/

Public implementation profile informed by RUSH program leaders. Documents registration of caregivers as patients with their own electronic record. This does not verify any Genus privacy control or establish that all individual-session material is legally unshareable in every circumstance.

CG4. Institute for Healthcare Improvement (2026). Age-Friendly Health Systems: Guide to Using the 4Ms in the Care of Older Adults in Hospitals. Boston: IHI. Especially pp. 4–6 and 9. Public IHI 2026 hospital guide (PDF) Also available through IHI's public resource directory.

Official implementation guide; relevant text and 4Ms figure reviewed. Defines the four elements and an assess-and-act approach, delivered together. Hospital guidance is not a universal Day Center protocol. Our tables are original paraphrases, not reproductions of IHI graphics or instruments.

CG5. Institute for Healthcare Improvement (n.d.). Age-Friendly Health Systems: Recognition. Official recognition guidance. https://www.ihi.org/partner/initiatives/age-friendly-health-systems/recognition

Official recognition process; page reviewed. Recognition is a separate process for care locations. A software label or a 4Ms-informed worksheet does not establish recognition, affiliation, or endorsement.

CG6. Mate K, Fulmer T, Pelton L, Berman A, Bonner A, Huang W, Zhang J (2021). Evidence for the 4Ms: Interactions and Outcomes Across the Care Continuum. Journal of Aging and Health. 33(7–8):469–481. DOI: 10.1177/0898264321991658. https://doi.org/10.1177/0898264321991658

Expert synthesis and literature review; public abstract and text checked. Examines component evidence and interactions; not a trial of the CarePhysics framework or Genus. Calls for more evidence on delivery of the full set.

CG7. Howe RJ, Rieke K, Mai HJ, et al. (2026). Age-Friendly Health System Implementation in Outpatient Settings: A Systematic Review. Journal of the American Geriatrics Society. 74(6):1756–1770. DOI: 10.1111/jgs.70346. https://doi.org/10.1111/jgs.70346

Systematic review; public abstract and bibliographic record reviewed. Twelve U.S. comparative studies of all four Ms; search through November 22, 2024. Process improvements were reported, but outcome and structural measures were uncommon and reporting/heterogeneity limited interpretation. No overall certainty grade is assigned here beyond what was available in the public abstract.

CG8. Graessel E, Berth H, Lichte T, Grau H (2014). Subjective caregiver burden: validity of the 10-item short version of the Burden Scale for Family Caregivers BSFC-s. BMC Geriatrics. 14:23. DOI: 10.1186/1471-2318-14-23. https://doi.org/10.1186/1471-2318-14-23

Instrument-validation research; public publication checked. Validation evidence belongs to the specified tool and its studied use, not a locally written four-item intake or an AI rewrite.

CG9. Spitzer RL, Kroenke K, Williams JBW, Löwe B (2006). A brief measure for assessing generalized anxiety disorder: the GAD-7. Archives of Internal Medicine. 166(10):1092–1097. DOI: 10.1001/archinte.166.10.1092. https://doi.org/10.1001/archinte.166.10.1092

Instrument research; public abstract checked. A symptom screen supports appropriate assessment; it is not an autonomous diagnosis or a treatment decision.

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Primary-care screening research; public abstract checked. Supports discussion of brief anxiety screening. Clinical interpretation and the actual follow-up protocol require qualified review.

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Instrument-validation research; public publication checked. Does not establish that a local score is a diagnosis or that administration without a response service improves care.

CG12. Kroenke K, Spitzer RL, Williams JBW (2003). The Patient Health Questionnaire-2: validity of a two-item depression screener. Medical Care. 41(11):1284–1292. DOI: 10.1097/01.MLR.0000093487.78664.3C. https://pubmed.ncbi.nlm.nih.gov/14583691/

Instrument-validation research; public abstract checked. A brief screen and the fuller PHQ-9 have different roles. Do not substitute one tool for the other without the approved protocol.

CG13. Haun J, Noland-Dodd V, Varnes J, Graham-Pole J, Rienzo B, Donaldson P (2009). Testing the BRIEF Health Literacy Screening Tool. Federal Practitioner. 26(12):24 [public record]. https://www.mdedge.com/content/testing-brief-health-literacy-screening-tool

Public original-publication record; author list and bibliographic entry checked. Cited to credit the instrument, not to reproduce its items or claim validation in every language or setting. Its use in C4C is documented separately in CG1.

CG14. The John A. Hartford Foundation (2024). Age-Friendly Health Systems Updated Guides: Guide to Using the 4Ms in the Care of Older Adults in Hospitals and Ambulatory Practices and Guide to the Care of Older Adults in Nursing Homes. May 28, 2024. Public Hartford Foundation guide announcement

Official foundation publication; attribution and guide context checked. Acknowledges The John A. Hartford Foundation and IHI, with the initiative's AHA and Catholic Health Association partnership. This attribution does not imply an endorsement of this book.

Public sources for constraint-focused improvement

These references support the method, research, and reading notes on Theory of Constraints. The care examples, planning fields, and measurement definitions are our proposed applications. Public sources checked October 1, 2026.

TOC1. Goldratt Research Labs (n.d.). Introduction to Theory of Constraints (TOC). Public description of the Five Focusing Steps. Public source

Method terminology and sequence; a practitioner organization's explanation, not independent evidence of care outcomes.

TOC2. Theory of Constraints International Certification Organization (TOCICO) (n.d.). Masterclass Series: Introduction to Theory of Constraints. Public presentation description and learning summary; Alan Barnard. Public source

The public summary places definition of the system, goal, and measures before the focusing steps. The

complete course was not reviewed.

TOC3. Groop J, Ketokivi M, Gupta M, Holmström J (2017). Improving home care: Knowledge creation through engagement and design. Journal of Operations Management. 53–56:9–22. DOI: 10.1016/j.jom.2017.11.001. Public source · University record and open-access route

Public article text and Aalto University's publication record reviewed. Context-specific design research and uncontrolled operational comparisons; no CarePhysics or Genus evaluation.

TOC4. Institute for Healthcare Improvement (n.d.). How to Improve: Model for Improvement: Establishing Measures. Public source

Improvement guidance on outcome, process, and balancing measures, participant perspectives, and repeated learning; not an effectiveness estimate.

TOC5. Goldratt EM, Cox J (2004). The Goal: A Process of Ongoing Improvement. Third edition. Routledge. ISBN 9780566086656. Public source

Authors, edition, and scope checked against the publisher's public description. This addition is not a cover-to-cover review or permission to reproduce the book.

One thing to try

Choose one claim in a handout, proposal, training resource, or demonstration.

Find its source. Then write three sentences:

The source found…

Our application proposes…

Before claiming that it helped here, we would need to establish…

Have someone else check whether the boundary between those sentences is clear.

Research becomes useful when it changes a decision without being asked to prove more than it can.

The next reference chapter explains the ideas used to make those decisions: how COM-B, Self-Determination Theory, Social Physics, motivational interviewing, and design methods ask different questions—and how to choose among them.

Public sources for the consolidated design examples

CON1. Agency for Healthcare Research and Quality (2024). Attend to Social Needs: Tool 18. Health Literacy Universal Precautions Toolkit, 3rd edition. Public source

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CON3. Royal College of Physicians (2016). Experience-based co-design: designing the future of hospital services. Public interview with Catherine Dale; March 30. Public source

CON4. National Institute on Aging (n.d.). Advance Care Planning: Advance Directives for Health Care. Public planning guidance; consult qualified local professionals about legal arrangements. Public source

These sources support navigation, planning, and co-design practice. The tables, sample wording, and combined walkthrough are original CarePhysics applications, not validated questionnaires, reproduced therapy manuals, or clinical/legal advice.

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R2 — The Models Behind CarePhysics — Ideas We Can Put to Work

At a Glance

The central idea: Use models to understand a situation—not to place a label on a person.

What you'll explore: How different ideas help explain barriers, motivation, learning, relationships, and organizational change. Understand COM-B, Self-Determination Theory, the Fogg Behavior Model, Social Cognitive Theory, social support, diffusion, and Social Physics. Distinguish these from communication methods and tools for designing learning.

Design and AI: Turn an idea into a practical choice about a video, article, survey, message, conversation, or pathway. Explore how an approved assistant could help apply reviewed guidance and local wisdom without deciding what a person believes or which outcome they should want.

Put it to work: Use the model-selection guide and a **Model-to-Design Brief** to identify the question, proposed response, responsible person, and appropriate test.

Evidence and evaluation: Keep each model's purpose and evidence limits visible. R1 supplies fuller study summaries. A theory can justify investigating an approach; it cannot establish the effectiveness of the care or technology built around it.

"In this conception, people are contributors to their life circumstances, not just products of them."

— **Albert Bandura**, psychologist, "Toward a Psychology of Human Agency," 2006.[110]

In Context — Three invitations, three different needs

This is a hypothetical planning exercise using the book's fictional professionals. It does not add events or outcomes to the family's chronology.

Lena and Sam are reviewing a proposed introduction to a Day Center.

"Suppose someone receives the guide but doesn't arrange a conversation," Lena says. "What should happen next?"

"A reminder?" a colleague suggests.

Sam puts three fictional responses on the table.

"I don't understand what happens there."

"I'm interested, but I can't manage the journey."

"I would like some help. I'm not sure this is the right help."

"Which of those does the reminder answer?" he asks.

The group looks again at the proposed sequence.

The first person may need an explanation. The second needs practical assistance. The third may need a conversation, a different option, or more time.

> **In Context — Three invitations, three different needs**
>
> They have not discovered three kinds of difficult people.
>
> They have identified three different design questions.

R2.1 — Why We Use More Than One Model

Different ideas do different jobs

Methods and theories do different jobs. Demonstration and goal setting are techniques; motivational interviewing structures a conversation; learning design organizes an experience. Do not treat them as interchangeable evidence for a single theory of engagement.

A **theory or behavioral model** offers an explanation to investigate. Self-Determination Theory asks about the quality of motivation. Social Cognitive Theory examines the interplay of people, behavior, and environment.

A **communication method** guides something a person does. Motivational interviewing structures a collaborative conversation. Teach-back checks how an explanation was understood.

A **design or improvement framework** organizes work. Backward design connects a learning purpose with evidence and instruction. ADDIE structures development. Plan–Do–Study–Act helps a team examine a change.

These categories describe their roles in this chapter; they are not rigid boundaries. The entries below explain the particular concepts and sources.

No single model should be asked to do every job.

A clearer message cannot supply an unavailable vehicle. A small first step cannot establish that the destination is appropriate. A trusted messenger cannot make an incorrect claim true.

The research review informing this book therefore begins with barriers, then considers motivation, manageable action, relationships, and learning. It calls that combination a synthesis—not a separately validated theory.

Begin with a question people can recognize

Describe the action specifically: who is trying to do what, in which circumstances, and why it matters to them.

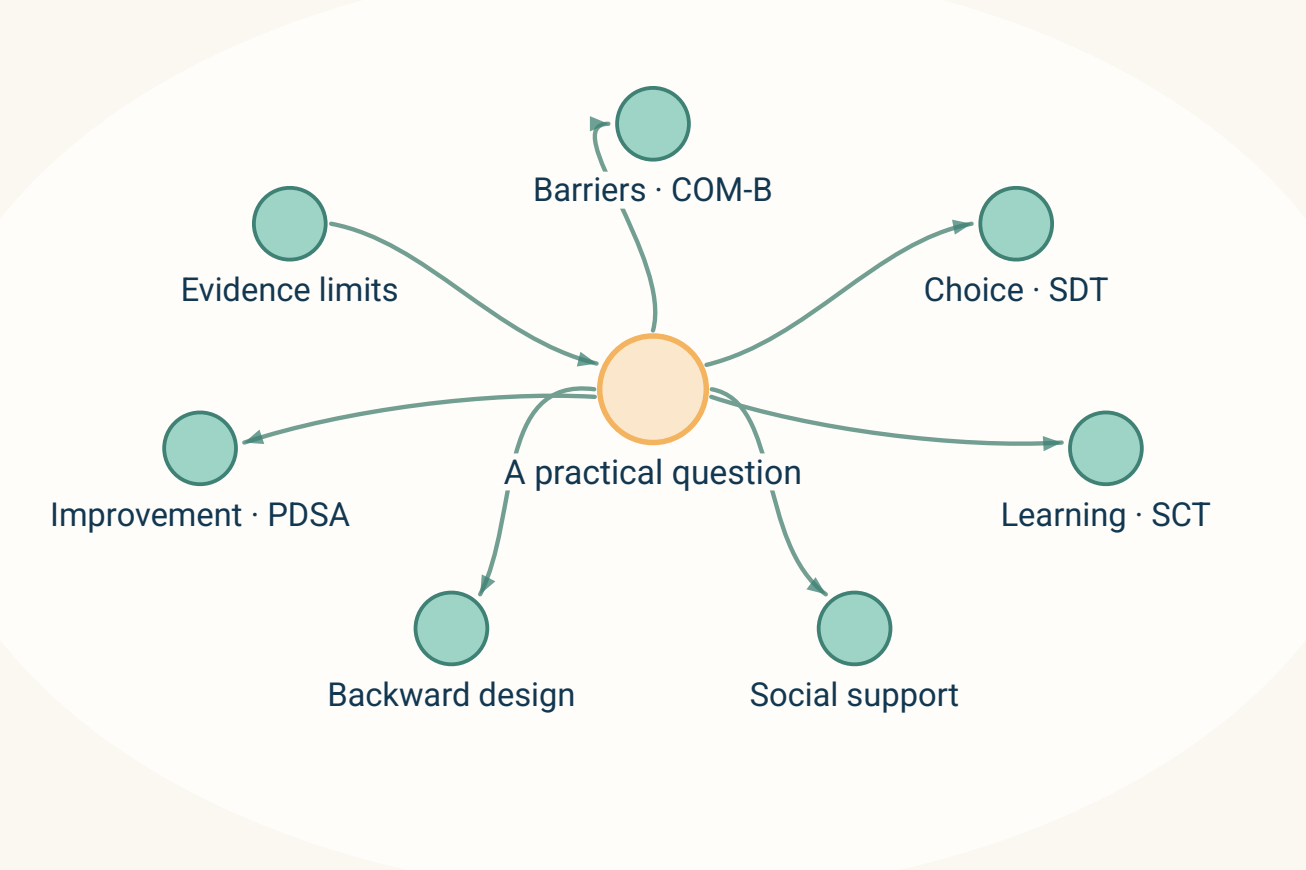


Figure 19 · Different models, different questions

Use COM-B to examine capability, opportunity and motivation around the practical question. Use Self-Determination Theory to examine autonomy, competence and relatedness. Social Cognitive Theory helps examine learning through interactions among the person, behavior and environment. Social-support ideas direct attention to what someone can actually rely on. Backward design starts with what the experience should make possible. Plan–Do–Study–Act supports a small, reviewed test of change. Evidence limits bound what any selected model can establish about the practical question. These are selected examples from the chapter, not its complete model list. SDT means Self-Determination Theory; SCT means Social Cognitive Theory. Models direct questions rather than label the whole person.

Method or perspective	The question it helps ask
COM-B and self-endorsed choice	What makes the action feasible and worthwhile to this person?
Journey mapping and social learning	What do people experience, and how does useful knowledge travel?
TOC and PDSA	What is limiting the agreed result, and what did an appropriate test teach us?

4Ms and C4C-informed support	What should older-adult care attend to, and what support does the caregiver need in their own right?

“Improve engagement” leaves too much open.

“Help someone who wants an introductory conversation reach the appropriate person without repeating their story” gives the team a design task.

Ask whether the behavior needing change belongs to the individual, the family, the professional, or the organization. Several may be involved.

The entries that follow preserve the models’ concepts while labeling care examples as proposed applications. Evidence judgments attributed to the research review informing this book are its judgments, not a new GRADE assessment. R1 explains those distinctions and the relevant study findings.

R2.2 — Understanding Barriers and Supporting Choice

COM-B and the Behaviour Change Wheel

What must become possible before this action can happen?

Foundational idea. Susan Michie, Maartje van Stralen, and Robert West’s COM-B model examines **capability, opportunity, and motivation** in relation to a specified behavior. The components interact; behavior can also change them. It is not a personality test or a clinical diagnosis.[2]

Component	Meaning in the model	A proposed care-design question
Capability	Relevant physical abilities and psychological capabilities, including knowledge and skills	Does the person understand the task, and can they perform it with appropriate assistance?
Opportunity	Physical and social conditions outside the person	Are time, transport, access, resources, and a supportive setting actually available?
Motivation	Reflective processes, such as intentions and plans, and automatic processes, such as habits and emotional responses	Is this wanted? What concerns, routines, or competing demands should we explore?

These subdivisions belong to the model. They should generate questions, not invite staff or AI to infer someone's inner state from silence or an unopened message.

What the wheel adds. The Behaviour Change Wheel links the analysis to intervention functions and enabling policy choices. Education addresses understanding; training develops skills; environmental restructuring changes the setting; enablement addresses obstacles beyond information alone. Its complete taxonomy also includes persuasion, incentives, modeling, restriction, and coercion. Describing those categories does not authorize their use in care. Our proposed applications prioritize informed choice and appropriate professional boundaries.

In the opening exercise, the transport problem is not repaired by another article. Someone must investigate a workable arrangement. If staff cannot return requested calls, the organizational response may involve coverage, time, or a different assignment —not another lesson about compassion.

Evidence and limits. The 2011 development paper reviewed **19 frameworks** and tested classification in tobacco-control and obesity-policy contexts. It called for research on whether the approach leads to more effective interventions. This supports an organizing framework, not a promised engagement increase.[2]

Use with Chapters 3, 7, 8, 12, and 15. Ask: Which barrier have we actually established, and who can change it?

Self-Determination Theory

Does participation feel chosen, manageable, and connected?

Foundational idea. Richard Ryan and Edward Deci's Self-Determination Theory distinguishes the amount of motivation from its quality. It identifies three psychological needs: **autonomy**, or acting with a sense of volition; **competence**, or experiencing effectiveness; and **relatedness**, or meaningful connection with others.[3]

Applied here, autonomy includes choosing whom to involve and when to accept help. It does not require a person to carry everything independently. Competence is not a certificate or proof that a consequential task can be performed safely. Relatedness is not the number of people copied into a message.

The theory also distinguishes **intrinsic motivation**, doing something because it is enjoyable or interesting, from actions undertaken for another valued result. Externally useful actions can still be personally endorsed; they are not all equivalent to pressure or reward-seeking.[3]

Pat's interest in reading can be worthwhile in itself. A family member may undertake an appointment task because it supports someone they love, even when scheduling is not enjoyable.

Design for both without turning either into obligation. Offer genuine choices, appropriate assistance, and relationships that permit disagreement. A request to contribute should not imply that belonging must be earned.

Common misuse. “Do this for your family” can sound purposeful while making refusal feel like a failure of love. A choice between two unsuitable options is not meaningful simply because the interface displays two buttons.

Evidence and limits. Our commissioned review grades SDT-informed health-intervention evidence **Moderate**, noting modest, variable effects and less favorable results in some disease-specific reviews. R1.3 summarizes the broader intervention evidence. It does not establish that a particular activity, reward, or care-circle feature improves health.

Use with Chapters 1, 3, 5, 6, and 11. Ask: Does the person recognize their own reason for taking part—and remain free to choose differently?

R2.3 — Making a Chosen Beginning Manageable

The Fogg Behavior Model

Is the requested action workable at the moment we invite it?

Foundational idea. BJ Fogg’s model focuses on **motivation, ability, and a prompt** coming together at the moment of an action. Here, ability concerns how easy or difficult the behavior is in context, not a judgment about intelligence or character. Stanford’s model description also notes the interaction between motivation and ease.[4]

An invitation to “organize your care network” asks for substantial work. An offer to request one conversation may be more manageable—provided it serves something the person actually wants.

For the proposed introduction, put the verified contact and response option beside the explanation. Avoid sending someone to another page to search for a number. Offer a telephone or paper route when appropriate.

A request for a callback remains a request. The receiving service must still accept and complete it.

Fogg and COM-B are complementary, not interchangeable. Fogg directs attention to the immediate action and prompt. COM-B makes the broader capability, resource, and social conditions explicit. Neither replaces asking whether the action is wanted.

Evidence and limits. Our commissioned review grades the named Fogg approach **Emerging**, while distinguishing more developed evidence for some component practices. A small action is not automatically a meaningful habit or health outcome.

Use with Chapters 3, 7, and 8. Ask: Can we remove unnecessary effort without removing informed choice?

Tiny habits, routines, and prompts

What is worth repeating—and does it need to be repeated?

The *Tiny Habits* approach uses small behaviors, existing routines as anchors, and positive

reinforcement. It is related to, but not identical with, Fogg's explanatory model. The research review informing this book also cautions that habit formation varies substantially; it does not support one deadline for everyone.

A proposed staff routine might place a brief preparation check within an existing paid huddle. The team still needs time, an owner, and a useful result.

Not every care action needs to become a habit. Requesting an introduction may happen once. A family reading evening can remain spontaneous. Do not turn it into a streak the grandchildren must maintain.

When routines change, ask what now fits. A prompt should support the person's plan, not keep an obsolete activity alive.

Choice architecture and nudges

Can the arrangement make a useful choice easier?

Choice architecture concerns how options are organized: their wording, order, defaults, visibility, and the effort involved in acting. The research review informing this book discusses Thaler and Sunstein's *Nudge* in these terms and distinguishes specific tested interventions from claims about a universal nudge effect.

A relevant care example is placing "Ask the team to contact me" beside an explanation, with the recipient and expected response made clear. That changes the route to help, not the person's beliefs.

Some friction protects people. Understanding a consequential choice, confirming a recipient, or authorizing access should not disappear in pursuit of fewer clicks.

Do not preselect family sharing, imply a service is reserved when it is not, conceal costs, or make declining unnecessarily difficult.

Evidence and limits. The review reports disagreement about broad pooled nudge effects and more useful evidence for particular interventions in particular settings. Test the actual design; do not use a clever label as evidence.

Social influence, recognition, and contribution

Are we offering useful reassurance—or creating pressure?

Cialdini's expanded framework groups influence around reciprocity, commitment and consistency, social proof, liking, authority, scarcity, and unity. The research review informing this book treats these as context-dependent mechanisms, not reliable buttons for changing people.

For our purposes, a documented peer experience may be offered as one perspective. A professional's expertise can explain a recommendation. A contribution can be acknowledged with permission.

None justifies invented testimonials, manufactured urgency, or "families like yours always choose this." Actual service scarcity should be explained honestly, not used to

pressure enrollment.

Purpose is also not a debt. Someone may want their feedback to help the next family; they should not be told the center's future depends on their participation.

The review classifies symbolic community points as **Plausible**, not demonstrated care impact. Positive and negative feedback deserve equal recognition; points must not rank families or imply funding without an actual, applicable arrangement.

R2.4 — Learning Through Other People

Social Cognitive Theory

Can people see a workable example and practice with support?

Foundational idea. Albert Bandura's Social Cognitive Theory examines reciprocal influences among personal factors, behavior, and the environment. In his health-promotion account, **self-efficacy**—belief in one's ability to perform an action—works with goals, expected consequences, and environmental barriers or supports. [111]

Observing another person is one route into learning. The care-design task is to show what matters and provide appropriate opportunity to try—not assume that watching creates competence.

For a fictional rehabilitation lesson, a qualified professional demonstrates the agreed skill, supports practice, checks performance, and adapts the instruction. For a digital task, a staff member could show where a question goes, then let the person try with chosen assistance.

Do not use confidence as a substitute for observed skill. Do not interpret difficulty as insufficient belief when the equipment, instructions, or support are wrong.

Evidence and limits. Bandura's 2004 article is a theoretical account of health promotion, including the need to change social systems. It is not a trial of this proposed lesson. R1 distinguishes demonstrations, training packages, and the outcomes tested.

Use with Chapters 2, 4, 6, and 11. Ask: What can the person practice safely, and what must the environment provide?

Social support and the buffering hypothesis

What can someone actually rely on?

Foundational idea. Cohen and Wills' social-support review distinguishes the structure of relationships from their functions. Their buffering hypothesis concerns support responsive to the needs created by stress; their analysis also considers broader associations with social integration.[41]

For planning, ask separately about someone who listens, someone who explains, someone who offers practical assistance, and someone who helps think through a concern. These roles may overlap. They should not be assumed from the number of

relatives available.

The family's bounded responsibilities in the main chapters illustrate the distinction. An accepted task can be checked against what happened; "the family is supportive" leaves its practical meaning unclear.

Being surrounded by people is not proof that the needed support exists. Nor should access to an appropriate service depend on having a large personal network.

Evidence and limits. This is a family of concepts and research findings, not one standardized care package. R1.3 examines direct caregiver-support studies; their service components cannot be replaced by adding names to an app.

Use with Chapters 1, 5, 11, and 12. Ask: What help is available, acceptable, and dependable for this particular need?

Diffusion of Innovations

What makes a new approach worth considering?

Foundational idea. Everett Rogers' diffusion framework examines an innovation, the communication channels through which it becomes known, the social setting, and adoption over time. Five useful attributes are **relative advantage, compatibility, complexity, trialability, and observability**.

Translated into design questions: Is it better for something that matters? Does it fit the person's life or team's work? How difficult is it? Can it be explored before a larger commitment? Can people see what it actually involves?

A hypothetical independent-living service might let a resident discuss and observe an appropriate support option before deciding. A clinical team might try a referral process with protected time and a colleague who can demonstrate it.

Trialability is not permission to bypass eligibility or safety requirements. Observability does not justify exposing private information. Do not turn adopter categories into labels such as "difficult families" or "resistant staff."

Evidence and limits. The research review informing this book identifies durable conceptual value and **Moderate** healthcare intervention evidence, including local opinion-leader research. Professional adoption and patient outcomes remain different endpoints.

Use with Chapters 5, 8, 13, and 15. Ask: What would make the offer understandable and realistically worth trying here?

Centola's network research and complex contagion

Does receiving information settle the decision?

Damon Centola distinguishes spreading information from adopting behaviors that may require reinforcing signals from more than one social contact. His randomized online-network experiment found that clustered networks supported greater adoption of the

studied health behavior than networks organized around more long-range connections.[27]

The proposed care application is not to surround a person with agreement. It is to make relevant, independent perspectives available when the person wants them: a professional explanation, a candid peer account, and an appropriate opportunity to explore.

Give room for unfavorable experiences and disagreement. Repeating the same message through three relatives does not make it three independent pieces of evidence.

Evidence and limits. The research review informing this book judges the network mechanisms **Moderate**, with strong causal evidence for some experimental findings but indirect transfer to many caregiver situations. It explicitly rejects the assumption that every group is an effective support network.

Use with Chapters 3, 5, 12, and 14. Ask: Would another perspective help this person decide—or only add pressure?

Pentland's Social Physics

How does useful knowledge travel and become usable?

Alex Pentland's *Social Physics* emphasizes idea flow and social learning. Two concepts matter particularly here: **exploration**, discovering ideas and people beyond the familiar circle; and **engagement**, interacting enough to interpret and work with what is discovered.[5]

This use of *engagement* is not identical to CarePhysics's name for a designed encounter, nor does it mean clicking on content. Keep the meaning clear.

In the family's story, finding a community resource represents discovery. Speaking with someone who can explain its actual conditions moves the information toward practical use. At the organizational level, a volunteer's suggestion or a participant's question may lead a team to try a better approach.

That suggests a learning practice: invite ideas, review them with the people affected, credit contributors, try appropriate changes, and report what happened.

Evidence and limits. Our commissioned review grades the broader perspective **Emerging-to-moderate**. Workplace and network research does not establish that more communication always improves care. Social learning can spread mistakes. This application does not require badges, continuous recording, or hidden staff analysis.

Use with Chapters 5, 10, 13, and 14. Ask: Who discovered something useful, who can help interpret it, and who can act on it?

R2.5 — Conversation, Learning, and Improvement Methods

Motivational interviewing

Can the person find and discuss their own reasons?

Motivational interviewing, developed by William Miller and Stephen Rollnick, is a collaborative communication method—not a personality theory or a script for obtaining agreement. The fourth-edition presentation names four tasks: **engaging, focusing, evoking, and planning**. These concern establishing a working relationship, agreeing what to discuss, exploring the person's reasons, and preparing action when appropriate.[112]

Core skills include open questions, affirmations, reflective listening, and summaries. Information can be exchanged by first exploring what the person knows, offering relevant information with permission, and asking how they understand it. MINT emphasizes practice, self-awareness, and respect for informed choice.[30]

> **In Context — A question that leaves room for the answer**
>
> This fictional conversation is a reference example, not a new event or a complete motivational-interviewing intervention.
>
> Suppose Ellen says, "I would like more help, but I don't want every family conversation to become a request."
>
> Sam could ask, "What would useful help look like without turning you into the person who manages all the offers?"
>
> The answer might concern a specific task, a service, or time to talk privately. The question does not decide which solution Ellen should choose.
>
> **Evidence and limits.** The supplied review supports MI for appropriate conversations while recognizing variable effects and the limits of resolving structural barriers through dialogue. R1.3 summarizes intervention evidence. AI rehearsal is not equivalent to trained MI practice.
>
> **Use with Chapters 3, 4, and 11. Ask:** Are we helping someone explore a decision—or guiding them toward an answer already chosen for them?

Teach-back

Did I explain this in a way the person can use?

Teach-back asks someone to explain relevant information in their own words. AHRQ distinguishes it from asking "Do you understand?" and from testing memory. People can use their written materials; if a misunderstanding appears, explain differently and check again. A related demonstration can examine a practical skill.[24]

For a service arrangement, a proposed question might be: “Using this page, how would you find out whether the visit is confirmed?”

The aim is not perfect recitation. It is a workable understanding with the support the person will actually have. Repeated difficulty calls for a different explanation or assistance, not shame.

Do not use a family storybook as a disguised comprehension test. Enjoyment and conversation are legitimate purposes without a teach-back requirement.

Evidence and limits. This is practice guidance, not a universal effect claim. R1.3 preserves the low and very-low certainty reported for different outcomes in the reviewed single-encounter literature; R2 assigns no new overall grade. CarePhysics_R1_Research_Summary

Use with Chapters 2, 4, 6, and 15. Ask: What misunderstanding did the check reveal, and what did we change in response?

Backward design

What should the learning make possible?

Associated with Grant Wiggins and Jay McTighe, backward design begins with **desired learning results**, then **acceptable evidence**, then **learning experiences and instruction**. McTighe’s account explains that sequence rather than beginning with an attractive activity and finding a purpose afterward.[47]

For a fictional volunteer orientation, the purpose could be knowing when to ask the activity lead for help. Evidence might be a supported response to a realistic practice situation. The lesson then provides the explanation, demonstration, and rehearsal needed.

A video completed is not that evidence.

For recreation, borrow the discipline of naming a purpose without turning the activity into a curriculum. Shared enjoyment calls for a different review from clinical skill development.

Use with Chapters 6, 11, and 13. Ask: What would show that the learning was usable beyond the lesson?

ADDIE

What work is needed to develop and maintain the experience?

ADDIE names **Analyze, Design, Develop, Implement, and Evaluate**. Robert Maribe Branch’s 2009 text presents it as an organizing approach to instructional design. It is a development framework, not a predicted outcome.[48]

For the proposed introduction, analyze audience questions and service conditions. Design the learning purpose and response route. Develop reviewed content. Prepare staff and provide the experience. Evaluate what people understood and what the process

required.

Return to earlier decisions when the test reveals a problem. Finding that no one has time to answer the questions is a reason to change the implementation—not simply shorten the article.

The following primary-source descriptions explain ADDIE, ARCS, and backward design as distinct planning approaches.

Use with Chapters 6, 13, and 15. Ask: Who owns development, delivery, review, and the next update?

ARCS

Why would this learning be worth beginning and continuing?

John Keller's ARCS model organizes motivational design around **Attention, Relevance, Confidence, and Satisfaction**. These categories also appear in the Day Center educational-design materials.

For care education, attention might begin with a recognizable question rather than a dramatic warning. Relevance connects the lesson with something the person wants to understand. Confidence is supported by clear expectations, manageable practice, and assistance. Satisfaction concerns the value of what was accomplished, not a requirement to award points.

Keller's 1987 paper describes field tests in two teacher-education programs and calls for further controlled research. It does not establish that an ARCS-shaped tile improves caregiver outcomes.[50]

Use with Chapters 2, 6, and 11. Ask: Does the encounter return useful value for the attention it requests?

Put the methods together without making every format identical

For one proposed first-visit engagement, the tools can inform different parts of the same experience:

Format or encounter	Its practical job
Video	Demonstrate the welcome and one genuine choice or exception. Identify staged examples and secure appropriate permissions.
Article	Explain the actual service, limits, costs, and available next steps at a comfortable reading pace.

Format or encounter	Its practical job
Survey or interactive question	Ask what would help prepare the conversation, explain who receives the answer, and allow skipping or another route.
Message	Offer the relevant item or confirm an actual arrangement, using consistent labels and accurate status.
Call, virtual meeting, or visit	Address the person's questions, confirm accepted responsibilities, and establish what happens next.

A **tile** may collect the related media, article, questions, and interactive elements. A **pathway** places it alongside contacts, calls, meetings, and planned encounters in an adaptable sequence. Neither is itself a theory of behavior.

The proposed CarePhysics pattern is **why it matters → main idea → demonstration → chosen next step → questions or connection → what follows**. It connects the design work without requiring six visible headings everywhere. Urgency overrides the sequence; validated instruments retain required wording and scoring; recreation can end with rest or enjoyment.

The communication guide contributes another useful discipline: begin with the human situation, make one idea clear, demonstrate honestly, and preserve the necessary detail. That is an adapted communication approach—not evidence that Apple's commercial success validates a care intervention.

Adaptive pathways

What information should change the next offer?

Just-in-time adaptive-intervention research describes decision points, tailoring information, intervention options, decision rules, and near- and longer-term outcomes. It also considers the fatigue that an intervention can create. This is a design framework, not proof that more frequent automated contact improves care.[58]

In our proposed human-reviewed application, a stated transport difficulty changes the next offer from another preparation tile to practical assistance. A request to pause optional material means pausing, not intensifying reminders.

Define who checks the information and authorizes a consequential change. A missing response is not a diagnosis, and a service not confirmed remains unconfirmed.

Use with Chapters 7, 9, and 15. Ask: What changed, and does it justify different support —or no additional message?

Caring for Caregivers: give assessment somewhere to lead

RUSH's C4C model provides a practical sequence: identify the caregiver, understand their circumstances, and assist through an agreed plan. Its public implementation resource includes professional skill-building, Planning for What Matters, and care-team planning. It is a care-delivery model, not another theory of motivation.[8]

The published Planning for What Matters Sessions are clinician-delivered brief psychotherapy. The ordinary support conversations proposed in this book should not be presented as that clinical component. See Chapter 11 and R1, public source CG1.

Our application asks who will hold the private conversation, what needs professional assessment, which support has actually been accepted, and when the caregiver will hear again. Read the measurement and source limits in R1 and the practical application in Chapter 11. Do not turn the invitation into a mandatory battery for every family.

The Age-Friendly 4Ms: assess and act together

The Hartford Foundation/IHI initiative organizes attention to What Matters, Medication, Mentation, and Mobility. Its contribution is not four new intake headings, but care that assesses and acts on the four elements together.[18]

In our 4Ms-informed application, connect each relevant need to an agreed action, an appropriately qualified owner, and a review point. Use Chapters 1 and 11 together so the caregiver's own needs do not disappear inside the participant's plan. R1 supplies public evidence and Appendix B a brief planning aid; neither the mapping nor use of software confers Age-Friendly recognition.

Journey mapping and experience-based co-design

What does the route through care look like from the people living and delivering it?

A process map identifies steps and responsibilities. A human-experience map adds the accounts of people receiving and providing support: what they understand, want, encounter, and need at each stage. In our proposed method, record who supplied an observation and which interpretations still need checking. Keep private accounts separate from the shared map.

Experience-based co-design brings patient or service-user experience and staff experience into joint service improvement. The Royal College of Physicians' published interview with a patient-centred care programme manager describes gathering patient and staff accounts and working together on service redesign. CarePhysics borrows the discipline of listening before redesigning; the compact worksheet in Appendix D is not a complete EBCD project or evidence of effectiveness.[54]

Use with Chapters 4, 7, 12, and 15. Let the experience inform content, timing, human contact, and practical support—not only a smoother interface. A pathway is the response we design; the map gives us something to question and test.

Theory of Constraints: focus improvement where it can help the whole process

What is currently preventing the agreed support from working?

Eliyahu M. Goldratt's Theory of Constraints is a management approach that focuses attention on what limits a defined system goal. Its Five Focusing Steps are identify, exploit, subordinate, elevate, and repeat while resisting inertia. Start by defining the system, goal, and measures.[9,29]

In our care application, define the result with the people affected. A timely introductory conversation, a dependable journey, and usable caregiver time are different objectives. A barrier makes an action harder; a system constraint limits the agreed result across the chosen process. A bottleneck is a capacity-limited stage. A queue is evidence to investigate, not proof of which cause governs it.

COM-B already asks about capability, opportunity, and motivation. TOC contributes a way to prioritize changes across the supporting process. PDSA helps test and refine the change. These are complementary questions, not rival explanations or a separately validated combined intervention.

The Five Focusing Steps, translated for care

The step names below are Goldratt's; the care questions are our adaptation. They are not a clinical protocol or instructions to maximize what an exhausted person can produce.

Formal step	CarePhysics interpretation	Question for the team
1. Identify	Find the condition currently limiting the agreed result.	What observations support that explanation? What else could explain the delay or unmet need?
2. Exploit	Protect existing capacity from avoidable loss.	Which missing inputs, interruptions, duplication, or rework can we remove without cutting needed rest or care?
3. Subordinate	Coordinate surrounding work to support the change.	Can schedules, preparation, and response promises align with the available service while unmet demand stays visible?
4. Elevate	Provide more capacity or redesign the arrangement.	What staffing, funding, training, equipment, partner, or policy decision is genuinely needed—and who can authorize it?

Formal step	CarePhysics interpretation	Question for the team
5. Repeat	Reassess the system after a change.	Did the intended support improve? Has the limit moved? Which former rules or assumptions now need revisiting?

Start with safety and appropriate care. These steps do not justify postponing urgently needed resources, removing clinical review, or eliminating breaks. A care plan can involve several interacting limits, and different objectives may expose different constraints. Narrow the project enough to investigate without pretending the household has one problem.

Optimize the arrangement—not the person

Making a nonlimiting step faster may leave the overall result unchanged. Yet work elsewhere can still help: clearer, accurate source material may reduce the demand on a constrained reviewer. Privacy, accessibility, comfort, and the quality of an encounter can also improve without increasing service volume. These are reasons to define more than a rate target.

Do not label a caregiver, nurse, or participant “the bottleneck.” Describe the arrangement: for example, an essential decision is assigned to one role without coverage, or requests exceed the capacity of the agreed response route. Ask about working conditions and realistic support, not how to press that person harder. More favorable numbers must not come from hiding demand or choosing only easier cases.

Chapter 7’s hypothetical callback example shows one way to apply this method. R1.3 provides a public home-care research example, with its limits. Neither establishes that a particular Genus workflow, reminder, or assistant will relieve the constraint.

Use with Chapters 3, 7, 8, 10–12, and 15, and Appendices C, D, and F. Ask: What can the organization change so the next person does not have to carry the same unnecessary work? See public sources TOC1–TOC5 in R1.

Plan–Do–Study–Act and the Model for Improvement

How will we learn whether the change helped?

The Model for Improvement, developed by Associates in Process Improvement and used by IHI, connects an aim, measures, and possible changes with **Plan–Do–Study–Act** tests. A team plans a test and prediction, tries it appropriately, examines the findings, and decides what to change next.[55]

For the introductory guide, test one revision with intended users and available staff. Examine clarity, unanswered questions, and preparation effort. Keep the result that did not improve. Scale the evidence to the claim: a useful local test is not proof of a regional

health effect.

Use with Chapters 10, 14, and 15. Ask: What did we learn that changed the next version?

Donabedian's quality framework

Are we measuring the conditions, the work, or the result?

Donabedian distinguishes **structure**, the resources and setting; **process**, what people do; and **outcomes**, what happens to health and experience. His methodological discussion cautions against assuming the relationships among them.[77]

A staffed response route is a structural condition. A completed conversation is a process result. Whether the person receives useful support and experiences meaningful improvement requires further examination.

An attractive portal does not establish any of the later results by itself.

Use with Chapters 10 and 14 and R1.6. Ask: Which kind of evidence do we have, and what conclusion does it support?

R2.6 — Other Foundations and Choosing a Useful Starting Point

Health Belief Model

Question: How does the person understand the concern and the possible response?

The model examines perceived susceptibility, severity, benefits, barriers, and cues to action. Rosenstock, Strecher, and Becker's 1988 paper explicitly proposes self-efficacy as an additional independent element. [113]

Use it to explore someone's understanding, not to manufacture fear. Believing that a service could help does not make it affordable. A value-focused opening may borrow one question from the model; it is not necessarily a complete Health Belief Model intervention.

Theory of Planned Behavior

Question: What shapes intention, and what could prevent intention becoming action?

Icek Ajzen's framework links attitudes toward a behavior, perceived social expectations, and perceived behavioral control with intentions and behavior. His account distinguishes perceived control from actual control; the former helps predict behavior to the extent it reflects real conditions.[114]

A caregiver might favor a support conversation and intend to attend but have no one available to provide the needed care during it. Ask about the conditions, not only the intention. Do not record an intention as service use.

Transtheoretical Model and stages of change

Question: Is the person considering, preparing, trying, or maintaining this particular change?

The original CarePhysics summary lists precontemplation, contemplation, preparation, action, and maintenance. The primary 1997 account by Prochaska and Velicer also includes termination and describes change processes, decisional balance, self-efficacy, and temptations—not stages alone. [115]

Do not turn the vocabulary into fixed labels for people. Someone may want one service and decline another. Inability to travel is not evidence of being psychologically unready, and an informed refusal is not an earlier stage that staff must move someone beyond.

The model's categories do not establish that a new stage-matched care program works. Its application needs its own evaluation.

Social marketing

Question: Is the whole offer useful, reachable, and worth what it asks of people?

Social marketing is treated here as an approach to planning for social benefit, consistent with Kotler and Zaltman's foundational account—not merely advertising or posting on social media. [116]

For our care application, examine the offer, its financial and practical costs, access, communication, and alternatives with intended users. A campaign cannot repair incompatible hours or an unavailable service.

Evaluate the benefit people receive, not only campaign response or enrollment.

Choose the question before choosing the model

This is a proposed decision aid, not a diagnostic algorithm. The model names point back to their explanations above.

Situation	Useful starting point	What to examine in practice
Someone wants help but cannot reach it	COM-B and social support	The resource, access barrier, responsible person, and received service
Someone has mixed feelings	Motivational interviewing and SDT	Their reasons, preferred options, informed choice, and perceived pressure
A chosen next step is unnecessarily difficult	Fogg and choice architecture	Necessary versus unnecessary effort; whether the step led to useful support

Situation	Useful starting point	What to examine in practice
A skill needs to be learned	Social Cognitive Theory, backward design, ADDIE	Demonstration, supported practice, appropriate performance check, and later use
A new approach is unfamiliar	Rogers and appropriate social learning	Fit, truthful demonstration, optional exploration, and actual implementation needs
Information travels but nobody helps use it	Social support and Social Physics	Who interprets the information, accepts the next action, and follows through
A promising approach needs adaptation	Adaptive-pathway design, PDSA, and Donabedian	The reason for the change, local conditions, results, burden, and safety

Start with the smallest combination that helps make the decision. Adding model names does not make an intervention stronger.

Create a Model-to-Design Brief

For one proposed change, write a short account of the **human purpose, established barrier, selected concept, design response, practical support, and test**.

For example:

Purpose: Help someone who requests an introduction reach an appropriate conversation.

Established difficulty: The current process asks the person to locate a separate contact and initiate another call.

Concepts: COM-B directs attention to the practical route; choice architecture suggests reducing unnecessary steps; SDT preserves the person's choice.

Proposed change: Offer to request a callback, explain who receives it, and retain self-contact and nondigital alternatives.

What must exist: A staffed receiving service, accepted responsibility, suitable permissions, realistic response expectations, and a fallback.

Test: Establish the baseline, count requests and completed conversations over a defined period, include unresolved needs, and examine family effort, staff workload, access, and safety.

This brief is a proposed planning tool. It is not a validated instrument or an automatic recommendation.

Before development, ask staff, participants, caregivers, and volunteers what the description misses. Name an owner and budget for preparation, interpretation, training, review, and coverage. A model cannot supply unavailable resources.

At community or state level, the same discipline can expose a repeated gap without ranking unlike organizations. A resource shortage may require a funding or service decision, not a more persuasive message.

Give AI a defined part of the work

An approved assistant could retrieve these model explanations, combine them with verified local guidance, and prepare options for the team. It could help a staff member turn an effective explanation into a reviewed article, demonstration, or training exercise.

A practical assignment is:

Use the evidence reviewed here, model entries, and verified local facts to examine this stated need. Distinguish what people have told us from what remains unknown. Recommend a small number of relevant concepts and explain the design decision each informs. Draft options that preserve choice and identify resources, reviewers, and measures. Do not infer beliefs, diagnose reluctance, or claim that theory proves the application will work.

Keep **research, design guidance, local facts, fictional examples, and permissioned personal context** distinguishable. Retain sources, owners, review dates, permitted uses, and corrections. Follow the proposed sequence: **retrieve → add local context → draft options → human review → test → revise**. A book upload is not model training, and a source collection is not proof of reliable retrieval or care.

With appropriate knowledge, rules, and review, AI can be a gift: less repeated preparation, more useful material within reach, and more attention for the person. Measure the complete task after checking and correction.

Where configured and tested, an assistant could make approved routine information available around the clock and help someone prepare questions. State actual human response hours and keep the route to a person visible. Clinical or urgent concerns go to the appropriate professional service; the assistant does not inherit care decisions.

Optional live assistance and post-encounter feedback can help capture a question or proposed improvement. Consent, privacy, accuracy, and distraction need examination. A patient, participant, caregiver, volunteer, or frontline worker may supply the useful idea; preserve their contribution and permission rather than crediting the model.

WHO’s guidance emphasizes defined tasks, stakeholder participation, human responsibility, and risks from inaccurate outputs and overreliance. A plausible prompt is not a neutral judgment of a person or family.[1]

Genus supplies technology. Partners remain responsible for their care, staffing, programs, relationships, and voice. The AI examples here describe proposed tasks, not verified deployment or product-specific outcomes.

Keep the evidence attached to the result

R1 examines the studies; R2 explains how their concepts can inform a decision. Keep those roles separate.

For a local test, specify the baseline, unit, denominator, time window, data source, version, and owner. Measure the intended benefit alongside burden, safety, privacy, and access. Preserve validated instruments' wording and scoring; label local feedback questions as local questions.

Distinguish reach, understanding, a first chosen action, adoption, useful participation, outcomes, and attributable impact. Also distinguish willingness to recommend, an actual referral, and another person receiving a service.

The distinctions matter in any system: delivery is not completed learning, a booking is not attendance, and sending information to a referring practice is not the same as the practice reviewing it. Appendix J records the dated implementation examples.

Keep disagreements and unfavorable results. Do not rank families by participation or staff by inferred kindness. A useful finding should have authority to change the content, workflow, staffing, or offer—including stopping an approach that creates more difficulty than support.

One thing to try

Choose one recurring request such as "read this," "join this," or "contact this service."

Ask an intended recipient what they believe the request means and what would make it useful or difficult. Select one relevant model, identify one practical change, and name the support it requires.

Complete this sentence:

This model helps us notice _____. We will change _____, with _____ responsible, and examine whether _____ improves without increasing _____.

Then try the change appropriately and ask what happened.

Your team's question is:

Are we using the model to understand the person—or using the person to demonstrate the model?

The person supplies what the model cannot

A model can direct attention toward a question. The person explains which belief, relationship, routine, or concern matters today.

Ask about language, format, timing, chosen companions, and help. Learn from the person rather than assigning a cultural script. The next reference chapter brings that curiosity into practice.

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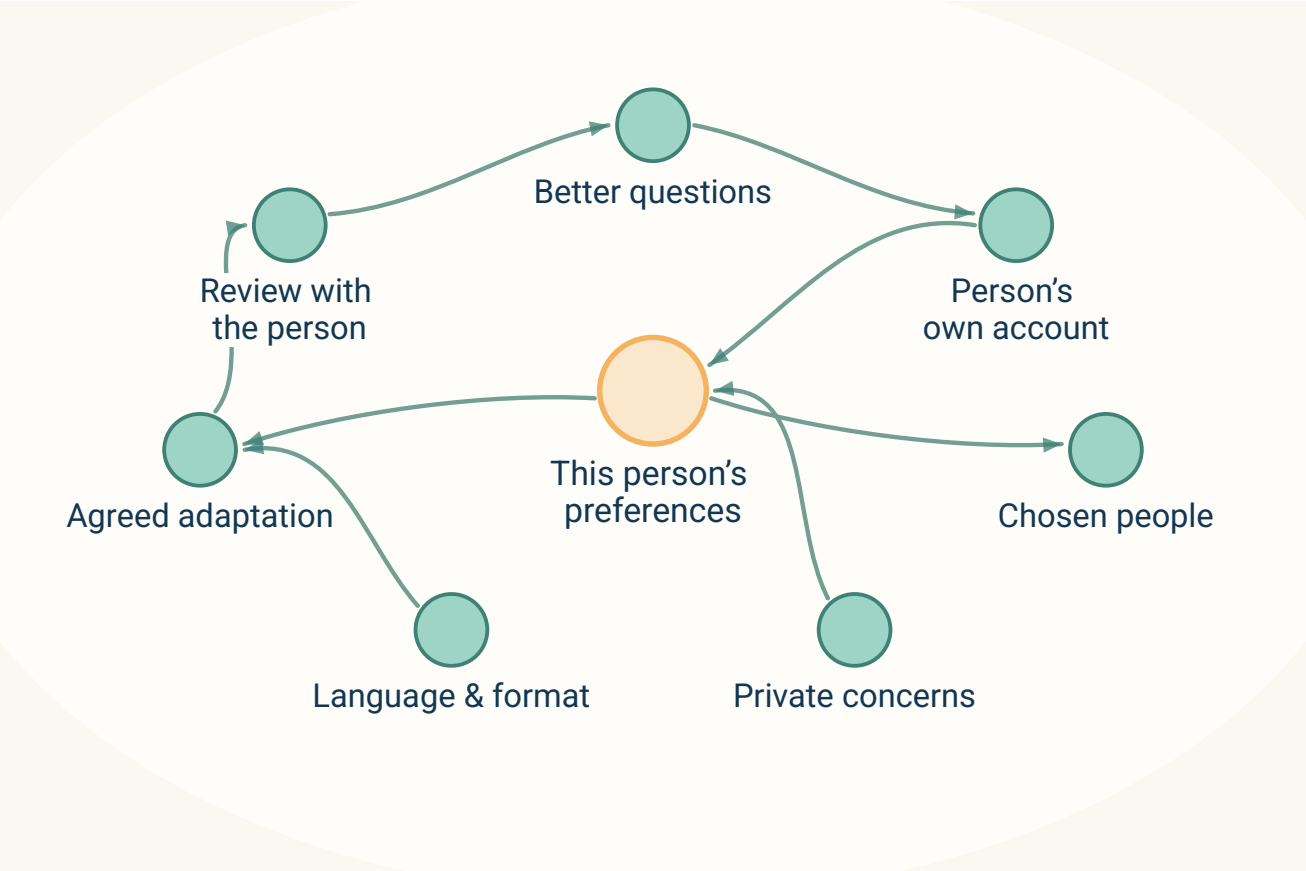
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R3 — Culture, Beliefs, and Care — Understand the Person, Not Just the Background



Connection map — Ask, then let the answer change support

Better questions invite the person's own account rather than substitute a cultural assumption. The person's account establishes which preferences matter here. Ask whom the person wants involved in the conversation. Respect private concerns and the boundaries around sharing them. Language and format preferences inform a usable adaptation. The person's expressed preferences change the agreed offer. Review the fit of the adaptation with the person. What is learned helps the next question become more useful. Cultural knowledge helps form a question; it does not establish someone's beliefs or replace their answer.

At a Glance

The central idea: Cultural knowledge can help us ask a better question. The person supplies the answer—and the answer should change the support.

What you'll explore: How beliefs, relationships, life experience, language, and practical circumstances shape what care means to someone. Examine family involvement, privacy, faith and secular values, everyday routines, trust, and meaningful participation without treating a cultural background as a set

of instructions.

Design and AI: Adapt explanations, videos, questions, messages, and pathways to preferences people actually express. Use approved AI assistance to prepare options and preserve useful knowledge—not infer beliefs, interpret silence as agreement, or replace professional judgment.

Put it to work: Create a **Conversation and Adaptation Guide** that connects what someone wants understood with an agreed action, a responsible person, appropriate sharing, and review.

Evidence and evaluation: Distinguish cultural-humility principles, professional guidance, and intervention research. Evaluate whether people receive respectful, workable support—not how many cultural details an organization collects.

"Cultural humility incorporates a lifelong commitment to self-evaluation and self-critique..."

— **Melanie Tervalon and Jann Murray-García**, "Cultural Humility Versus Cultural Competence," 1998.[117]

In Context — "Which part would you change?"

The reference scenes in this chapter are fictional teaching examples. They do not continue Pat and Ellen's chronology or assign new beliefs to the established family.

Lena and Sam are reviewing an invitation with people helping them examine a proposed community-support pathway.

The draft says: "Bring your family so we can plan together."

"That would suit me," Ruth says. "I would like my daughter there. Perhaps someone from my faith community too."

Ben reads the sentence again.

"I'd like to speak with you first. Then decide what I want to tell everyone."

"Would you prefer a different explanation?" Sam asks.

"Not necessarily. A different arrangement."

Elena has another question.

"Can the conversation happen after work? The invitation makes sense. The time doesn't."

Lena draws a line beneath the proposed instruction.

They do not need three assumptions about three backgrounds.

They need an invitation that allows three people to explain what would work—and a service able to respond.

R3.1 — Culture Is Part of the Person's Story, Not the Whole Story

Learn enough to ask, not enough to assume

Communication, language, health beliefs, food, religious practices, and preferred involvement can all matter. Begin with the individual's account rather than a country-based or cultural profile.

Cultural knowledge can help us ask a better question. It cannot answer on someone else's behalf.

Culture includes customs, meanings, values, and ways of relating. It is not confined to ethnicity or religion. AHRQ's guidance recognizes multiple influences, including age, occupation, language, family composition, and identity, and recommends learning from the individual rather than assuming preferences from group membership.[13]

For care design, ask what matters here, now, and for this decision. A family tradition may be central to one person and unimportant to another. Someone may welcome help with a practical task while wanting a different degree of privacy around health information.

A group's history or a well-reviewed cultural resource can prepare a respectful inquiry. It should not produce a standing instruction that everyone from that group wants indirect explanations, family-led decisions, a particular activity, or a particular kind of clinician.

The revised writing guidance is explicit: do not infer religion, family structure, literacy, technology comfort, or decision preferences from race, age, language, disability, or neighborhood. Ask how this person wants care organized.

The organization brings a culture too

A clinic may prize a concise explanation. A family may need space to tell the story before the explanation feels relevant. A program may treat its timetable as fixed while asking participants to describe what matters to them.

Examine those institutional habits alongside individual preferences. Kleinman and Benson's clinical essay argues that culture belongs to professionals and institutions as well as patients, and that a focus on presumed cultural traits can obscure practical difficulties.[118]

This is not a reason to abandon professional standards. It is a reason to ask which routines protect care and which merely reflect how the organization has always worked.

A useful staff question is: **"Whose assumptions made this the default?"**

Cultural humility adds a continuing willingness to examine one's own assumptions, address unequal power, and develop partnerships rather than claim mastery of another person's culture. Tervalon and Murray-García proposed it as an educational orientation, not a checklist that confers permanent competence.[117]

R3.2 — Beliefs About Illness, Help, and Hope

Begin with the meaning of the concern

Before offering an explanation, find out what the person is trying to understand.

You might ask: “How have you been making sense of these changes?” or “What concerns you most about the help being suggested?”

These are proposed conversation starters, not a diagnostic interview. They can reveal a question about the condition, the service, the future, or what accepting assistance would mean.

Kleinman and Benson’s explanatory-model approach similarly seeks the person’s account of illness and what is at stake. Their purpose is to open communication, not turn the answer into another fixed classification.[118]

Keep belief and clinical assessment distinguishable. Someone’s understanding deserves a hearing; it does not establish the medical cause of symptoms. When a clinical explanation is needed, the appropriate professional supplies it and checks understanding.

A respectful account can say, “The person is concerned that…” without converting the concern into a diagnosis or dismissing it as irrational.

Make room for faith, spirituality, and secular purpose

Invite the topic without prescribing its importance: “Are there beliefs, practices, or sources of strength you would like us to take into account?”

The answer may concern prayer, a trusted community, being present for family, independence, art, nature, friendship, or something not on the form. A person can also choose not to discuss it.

When spiritual support is requested, clarify what kind and from whom. Ask before arranging contact or sharing information. Do not assume a generic religious message represents the person’s own tradition or that a faith community is the appropriate place for a private concern.

A secular option should be equally usable. Someone should not have to participate in religious content to obtain ordinary service information.

The practical goal is to learn what support should protect. It may be time for a valued practice, a familiar meal, an important relationship, or a conversation about fear. Record the relevant adjustment rather than collecting an unnecessary biography. The book’s person-and-family profile already includes meaningful roles, routines, concerns, and communication preferences.

Do not confuse love with unlimited capacity

A caregiver may describe receiving help as a difficult personal decision. Explore that meaning without telling them that their culture explains it.

They may also be facing cost, unavailable transport, exhaustion, or an earlier poor experience. The research review informing this book treats these as different possible barriers requiring different responses.

An invitation such as “What would support need to include for it to be useful?” leaves more room than “Your family needs to become comfortable asking for help.”

Love can be expressed through providing care, accepting assistance, setting a limit, or protecting time together. The proposed design should make those possibilities discussable—not make sacrifice the test of devotion.

R3.3 — Family, Independence, Privacy, and Decisions

Ask who belongs in this conversation

Start with the person receiving care. Who would they like involved, in what role, and with access to which information?

A daughter, partner, friend, neighbor, or another chosen supporter may help prepare questions or consider options. An emergency contact is not automatically the person authorized for every decision or disclosure.

AHRQ recommends confirming the person’s wishes about companion involvement, speaking directly to the patient, preventing a companion from taking over the discussion, and preserving private time. These are practice recommendations, not a requirement that everyone attend with someone.[119]

Interdependence can be chosen. So can an individual conversation. Do not describe one as “over-involvement” and the other as a lack of support.

Make the scope explicit: joining one meeting does not authorize access to every future note. Being invited to help does not establish availability. As Chapter 11 showed, family responsibilities need acceptance and realistic limits.

When someone says, “Please don’t tell them”

A relative may want to protect someone from distress. Take that concern seriously without quietly making the relative the sole authority over what the person receives.

Ask what they fear, involve the responsible clinician, and establish the person’s own information preferences through the appropriate process. The AMA’s ethics guidance distinguishes sensitive, paced disclosure from withholding information without the patient’s knowledge or consent. It also recognizes a patient’s genuine wish not to receive certain information or to designate another recipient.[120]

This is not a task for an AI assistant to settle. Questions about decision-making ability, representation, and legal authority require the relevant professional assessment and applicable local procedures.

The book’s practical boundary is straightforward: do not let a diagnosis, a group label, or the most confident relative substitute for that work.

Protect the caregiver's separate voice

Ellen's needs in the main story matter alongside Pat's. That does not mean every private concern belongs in a joint summary. Preserve who said what and what may be shared.

Offer a confidential route appropriate to the service and explain its limits. Do not promise secrecy the organization cannot provide, or place a sensitive response in a shared field and rely on discretion later.

Keep children in their family role. They can enjoy stories, celebrations, and ordinary time together; they are not responsible for interpreting consequential conversations, monitoring symptoms, or managing adult disagreements.

R3.4 — Communication and Trust

Separate language, format, and understanding

Ask separately about the language someone prefers for speaking and reading. Confirm the particular language or variety needed rather than assuming a broad label is sufficient. Ask about accessible formats and assistance as well.

Interpretation works with spoken or signed communication; translation works with written material. AHRQ recommends qualified language assistance and cautions against substituting untrained staff, family members, or children. Assessing language proficiency and interpreting competence are not the same task.[14]

Plan the service before the encounter. Explain the interpreter's role, address the person directly, allow time for the exchange, and check whether the arrangement supports private questions. The family can remain family rather than carry responsibility for accurately relaying medical information.

Include language access in scheduling, written instructions, technical support, billing questions, and follow-up—not just the clinical room. Provide a fallback when the planned interpreter or connection is unavailable. These are service-design responsibilities, not a request that the person bring their own solution.[121]

A translated article is not proof of comprehension. A captioned video may still need a clearer explanation. Ask the person to use the information with their normal assistance, not perform a memory test.

Ask about style without assigning a personality

Offer a choice of depth and pace: a brief explanation first, fuller detail, a demonstration, or time for questions.

Do not infer agreement from a nod, a quiet answer, or the absence of an objection. In the proposed interaction, check directly: "What would you like us to clarify or approach differently?"

AHRQ recommends open-ended questions, attentive listening, and responsive explanations. Its cultural guidance also cautions that expectations around eye contact

and touch can differ. Neither guidance makes one visible behavior a dependable indicator of what someone believes.[6]

The unfamiliar-remote analogy applies here. Someone can understand the purpose while needing help with unfamiliar controls. Keep action names and help routes recognizable; adapt the explanation without treating technical difficulty as a personal deficiency.

Earn trust through the response

Offer room to discuss a previous difficult experience without requiring a detailed account of trauma or discrimination before improving the service.

In a hypothetical home-care introduction, “I don’t like people coming into my home” may lead to useful questions about identification, advance notice, privacy, and exactly what the visit involves. It need not trigger a cultural explanation.

Show the agreed response: introduce the worker, explain the task, ask before entering a private area, and identify who handles a concern. Trust is something to examine through experience, not a label an organization gives itself.

When the organization gets something wrong, correct the arrangement as well as the wording. “That note does not reflect what you agreed to; we will correct it and tell the relevant people” is a practical commitment.

R3.5 — Everyday Dignity and Meaningful Participation

Let preferences shape an ordinary day

Care does not become responsive only during a major decision. Ask how the person wants to be addressed, what assistance they welcome, and which routines help the day feel like theirs.

The following are proposed topics—not a checklist to complete at every encounter or assumptions about any group.

Topic to explore	What the answer might change
Meals and food practices	Ingredients, preparation, meal timing, or a discussion with the food-service and clinical team. Keep allergies and clinically required precautions distinct from preferences.
Faith, reflection, or secular routines	A requested quiet space, timing consideration, or chosen support contact; participation remains optional.
Privacy, clothing, touch, and assistance	How staff explain a task, seek agreement, protect privacy, or explore a requested staffing arrangement.

Topic to explore	What the answer might change
Music, stories, language, and celebrations	The available content and invitations, including unfamiliar material someone wants to explore and activities they prefer to avoid.
Rest and sensory comfort	Pacing, quieter alternatives, lighting or sound adjustments, and appropriate assistance.
Contribution and enjoyment	An optional role, a chance to teach or share an idea, or permission simply to listen and enjoy the day.

For every requested adjustment, check what the service can actually provide. An invitation to choose is incomplete if nobody can explain the available choices.

The dated Day Center materials offer relevant design examples: asking about present as well as past interests, supporting different ways to participate, and allowing a person to change their mind. They do not establish that every center provides identical options.

> **In Context — A quiet place, not a new label**
>
> This is a fictional Day Center example separate from the continuing family.
>
> Nora asks whether there is somewhere quiet she can use for prayer after lunch.
>
> Lena asks what she needs from the arrangement and checks which space is available, including whether assistance is required to reach it.
>
> “Would you like anyone to join you?” she asks.
>
> “No. Just some quiet.”
>
> The working note records the agreed time and place for the people arranging it. It does not announce Nora’s beliefs in the family newsletter or assign her to lead a religious activity.
>
> Later, the team asks whether the arrangement worked.
>
> Respect is visible in what was provided and what was left private.

Belonging does not require a performance

Do not ask one participant to represent a religion, nationality, or generation for the room. Invite a contribution because the person wants to make it, with appropriate permission for any further use.

Someone may enjoy discussing a tradition without wanting to teach it. Someone else may welcome an opportunity to introduce a song or story. Both can help shape the program.

Offer adult material, real choices, and room for novelty. Familiarity is an option, not a requirement to live inside a past identity. Rest and enjoyment do not need a productivity score.

R3.6 — When Preferences Meet Constraints or Disagreement

Find out which problem needs a response

A requested adjustment may conflict with another preference, clinical advice, the rights of others, or the service's resources. Begin by clarifying the request and the reason, without demanding a personal disclosure unnecessary to resolve it.

Then separate what can change now, what needs professional review, and what is not currently available. Name who will investigate the next option and when the person will hear.

For example, a requested caregiver arrangement may require scheduling review. A meal practice that affects a prescribed treatment belongs in a conversation with the relevant clinician. A timing difficulty may require a different service, not a revised explanation.

The behavioral review's barrier-first approach applies: information, opportunity, family circumstances, and motivation can require different responses.

A limit should be specific. "We cannot provide that assistance on this visit; the coordinator will discuss the available alternatives with you" is more useful than "That is against our culture."

Do not promise that every request can be met. Do not conceal an unmet need by recording that the person declined an unsuitable offer.

Respect does not mean agreeing that every claim is true

Listen when someone describes a remedy, practice, or explanation important to them. The appropriate clinician or pharmacist can review relevant safety questions; an AI assistant should not endorse an unverified treatment to appear culturally sensitive.

In disagreement, preserve the person's question and explain the professional concern plainly. Provide appropriate language assistance and a route for further discussion or review.

Nor should "respecting culture" require staff to accept harassment or erase the rights of other participants. Distinguish a care-related need from discriminatory treatment, involve the responsible manager or professional, and follow the applicable policy. Do not leave a frontline worker to settle the issue alone.

Address the resource gap

If a person cannot reach a service because of transport, cost, working hours, language access, or staffing, record that obstacle accurately.

Relationships may help locate alternatives. They cannot replace unavailable support. A

sent referral is not a completed handoff, and a list of resources is not proof that any of them can meet the need.

Community and state groups can help examine recurring gaps. Share appropriately governed evidence about unmet needs—not assumptions that one community is less willing to engage.

R3.7 — Adapting the Same Engagement for Different People

One purpose, different ways to begin

Return to the three people reviewing the opening invitation. Their shared task is deciding whether to explore a community-support service. They have expressed different preferences and circumstances; their names are not evidence of any cultural identity.

> **In Context — Ruth wants chosen people involved**
>
> Ruth would like her daughter at the first conversation and wants to ask a trusted faith-community contact to join.
>
> The coordinator confirms who Ruth wants involved, what each person may receive, and whether the participants are available. Ruth receives the same service facts as anyone else, with an invitation that acknowledges her chosen support network.
>
> The faith contact does not replace the program professional or speak for Ruth automatically. No invitation is sent before the necessary agreement.

> **In Context — Ben wants a private beginning**
>
> Ben is active in the same local community network, but wants the first conversation alone and asks for information without religious framing.
>
> The coordinator arranges the private route and asks whether Ben would prefer to read first or discuss the main points. Ben can involve other people later without having to justify why he did not start that way.
>
> The content has not become less caring because it uses a different expression of support.

> **In Context — Elena needs the offer to fit the week**
>
> Elena's concern is practical: she cannot answer service calls while working and wants a time she can use with her chosen supporter. They also need to understand the transport arrangements before planning a visit.
>
> The coordinator checks available call times and the actual transport process. If no workable arrangement exists, the need stays open while an appropriate alternative is explored.
>
> A warmer reminder would not solve it.

Change the right part of the experience

These proposed adaptations use different formats for different jobs:

The video can demonstrate how to ask a question, include a supporter, or request a private conversation. Use appropriately consented or clearly labeled demonstration footage. Do not imply that the people shown represent a whole culture.

The article preserves the service facts, conditions, costs, and response route. It can offer a brief introduction with further detail available, in reviewed formats and languages.

The survey or interactive question asks what would make the next encounter workable. Include options to skip, respond privately, or speak with someone. Explain who receives the answer and what it can change.

The message reflects the arrangement actually made: the participants, timing, contact method, and any unresolved question. It should not imply confirmation merely because a request was submitted.

The pathway connects these materials with a saved contact, telephone call, virtual meeting, visit, or another planned encounter. A tile may contain the related video, article, survey, and interactive elements; a human response makes the connection useful.

The familiar CarePhysics pattern remains: **why it matters → main idea → demonstration → chosen next step → questions or connection → what follows**. Adapt the content without moving help or changing action labels unnecessarily. Urgency comes first; validated instruments retain their required wording and scoring.

AHRQ recommends evaluating materials for understandability and actionability with the intended audience. An attractive translation or representative photograph does not establish that a service is usable.[26]

R3.8 — A Conversation and Adaptation Guide

Ask only what can help the care

The practical output is a **Conversation and Adaptation Guide**, not a cultural assessment or score.

Use a few relevant questions, spread across encounters when appropriate. Explain why you are asking and allow the person to decline details they do not want to share.

What would help us approach this in a way that feels right to you?

Who would you like involved, and is anything better discussed privately?

Are there practices, routines, or sources of strength you want us to consider?

What language, format, timing, or assistance would help?

What would make this arrangement difficult to use?

These are original practice prompts to test, not a validated instrument. They should lead somewhere.

Working record	What to capture
The person's account	Their expressed preference or concern, with its source and date; separate family and professional accounts.
Requested adjustment	The specific change in communication, environment, involvement, timing, or support.
Permission	What may be recorded or shared, with whom, and for this purpose. Avoid unnecessary identity details.
Feasibility and review	What is confirmed, what needs professional assessment, and what cannot yet be supplied.
Responsibility	Who has accepted the next action, the response expectation, and the backup route.
Review	Whether the arrangement helped, what changed, and when to ask again.

Let the person correct the account. Retain "not discussed" and "prefer not to answer" rather than replacing either with a guess.

A preference may change. Review it when the situation changes or the person asks—not only when the form expires. Relevant staff need the current practical instruction; they do not necessarily need the private story behind it.

Give AI a useful, bounded task

An approved assistant could help organize expressed preferences, prepare alternative wording, retrieve local resources, or turn a reviewed staff explanation into a draft article or training example.

A suitable assignment might be:

Use these approved sources and the preferences the person has explicitly shared for this task. Prepare options for the introduction and next contact. Keep service facts, clinical guidance, and uncertainty unchanged. Identify the reviewer and any missing resource. Do not infer religion, family roles, literacy, or decision preferences from identity, appearance, voice, or location.

Suppose a draft says, “Ben does not value family involvement.” A reviewer should reject it. What is known is that Ben requested the first conversation privately. Preserve that narrower meaning.

Work from **research → relevant design guidance → verified local facts → permissioned personal context**, keeping those sources distinguishable. Then **retrieve, prepare options, review with responsible people, test, and revise**. Retain source owners, review dates, approved uses, and corrections. Uploading this book is not model training or evidence that an assistant will follow it reliably.

AI may help draft language adaptations, but generated translation should not automatically replace qualified interpretation or reviewed material in consequential care. Clinical meaning and instrument validity need appropriate review.

With suitable knowledge and rules, the assistance can be a gift: less repetitive preparation and more individualized support. Measure the work after review and correction, not only the speed of generation.

A configured assistant might offer approved routine explanations or question preparation at any hour. Make human response times explicit and provide a direct route to a person, with separate urgent guidance. It is not continuous professional care.

Optional live assistance or immediate feedback can help surface a question while it can still be addressed. Obtain appropriate agreement, allow pausing or declining, and keep private feedback separate. Do not turn tone, eye contact, accent, or silence into cultural or emotional scores.

WHO identifies risks from inaccurate or biased outputs and overreliance, and calls for defined tasks and stakeholder involvement. AI should support fair facilitation, not be presented as an inherently neutral judge of a family disagreement.[1]

Support the people expected to adapt

Responsiveness requires organizational resources: language services, accessible materials, preparation time, appropriate staffing, supervision, and someone authorized to resolve unmet needs.

The National CLAS Standards place leadership, resource allocation, workforce

preparation, communication assistance, community partnership, and evaluation within the same organizational framework. They are practice standards, not proof that a particular implementation improves outcomes.[121]

Give staff and volunteers realistic practice using fictional situations. Do not ask a colleague to represent an entire community or interpret consequential information merely because they speak another language.

Invite patients, participants, caregivers, volunteers, and frontline teams to contribute ideas. Credit them with permission and return the result: what was tried, what changed, and what did not help. The dated Day Center materials describe paired practice and contributions from staff and families, while making clear that documented features are not measured care outcomes.

Genus supplies technology. Partners retain their care, staffing, programs, voice, and professional accountability. The guide and AI assignments here are proposed workflows, not claims of deployed cultural personalization.

How would we know the adaptation helped?

Begin with one encounter, a baseline, a defined review period, and a named person able to change the process. A four-week local test could examine practical usefulness; it would not establish lasting clinical benefit.

For requested adjustments due during the period, report how many were provided as agreed out of all adjustments due. Keep unresolved, declined, and unknown results separate. Recording a preference is not providing the support.

Ask whether people understood the option, felt accurately represented, could disagree, and received the help they chose. Include private, telephone, paper, interpreted, and assisted routes. Count preparation, translation review, staff work, family coordination, and unwanted disclosure or pressure.

Separate reach, understanding, a first action, adoption, useful participation, outcomes, and attributable impact. Willingness to recommend, actual referrals, and received services are different events. Do not rank families or staff by how much they disclose or participate.

Investigate who is missing without guessing identities from names. The dated Day Center intake lacks demographic fields needed for some group comparisons; those analyses require separately governed information, not invented categories.

Report negative findings and unresolved access gaps. The useful outcome is not a more detailed cultural profile. It is an experience the person can understand, influence, and use.

Foundations and Evidence Behind This Chapter

Cultural-humility guidance informs the structure of this chapter. The following primary publications and official guidance add external support and qualifications. The examples and tools remain CarePhysics proposals—not a tested cultural-care intervention.

Cultural humility: an ongoing professional commitment

Tervalon and Murray-García, 1998. Their conceptual article proposes continuing self-examination, attention to power differences, and partnership in multicultural medical education. It supplies the opening quotation and orientation. It is not an outcome trial and does not establish an effect size for humility training.[117]

Understanding what matters in the person's setting

Kleinman and Benson, 2006. Their clinical essay criticizes reducing culture to ethnic traits and proposes inquiry into the person's own experience and practical circumstances. The article's case scenarios are identified as fictional. It supports a way of asking, not a validated prediction of an individual's beliefs or behavior.[118]

Cultural-competence education: important questions, limited outcome evidence

Horvat and colleagues, 2014 — Cochrane review. Five randomized trials involved **337 health professionals and 8,400 patients** in the United States, Canada, and the Netherlands. The interventions and outcomes differed too much for meta-analysis. Some findings favored patient involvement or perceptions, but effects on treatment outcomes were not demonstrated and care evaluations were mixed. Evidence was generally low quality; no included study assessed adverse outcomes. Searches were updated in early 2014.[122]

This dated review does not establish that training is ineffective. It limits claims that completing a course guarantees better care. The chapter assigns no new overall evidence grade.

Professional interpretation: a distinct service to evaluate

Karliner and colleagues, 2007 — systematic review. Of **28 included studies**, 21 examined professional interpreters separately from ad hoc interpretation. The review reported benefits associated with professional interpretation across communication, utilization, clinical outcomes, and satisfaction. Its search was restricted to English-language publications and extended through September 2005. It is historical evidence, not a pooled prediction for every setting and not validation of AI translation.[123]

Guidance for putting the commitments into practice

AHRQ's tools address culture, language access, family involvement, and understandable materials as related but separate responsibilities. The National CLAS Standards add organizational governance and continuing evaluation. These are implementation resources; local services still need to demonstrate what they provide and what people experience.[124]

One Thing to Try

Take one invitation, guide, or intake step your organization uses often.

Ask several intended users, through appropriate routes, what the item assumes about

their family, beliefs, language, time, or resources. Do not ask any one person to speak for an entire group.

Choose one change together. Name the responsible person, verify the support behind it, and return to ask whether it helped.

Your team's question is:

What did we learn about this person that actually changed what we offered?

The answer should be visible in the care

> **In Context — The invitation leaves room**
>
> The revised invitation no longer instructs everyone to bring family.
>
> It asks whom the person would like involved, whether a private beginning would be preferable, and what would make the conversation workable.
>
> Ruth checks that she can invite the people she chose. Ben checks the private contact route. Elena asks which call times are actually available.
>
> Lena looks at the responses.
>
> "The words are better," she says. "Now we need the arrangements."
>
> That is where this companion leaves the question.
>
> R1 examines the research; R2 explains the methods; R3 brings both back to the person whose life the care is entering.
>
> The appendices help turn that understanding into listening, action, and follow-through. Their value is in the support they make possible, not the number of fields completed.
>
> The person need not fit a cultural profile. Our understanding must leave room for the person.

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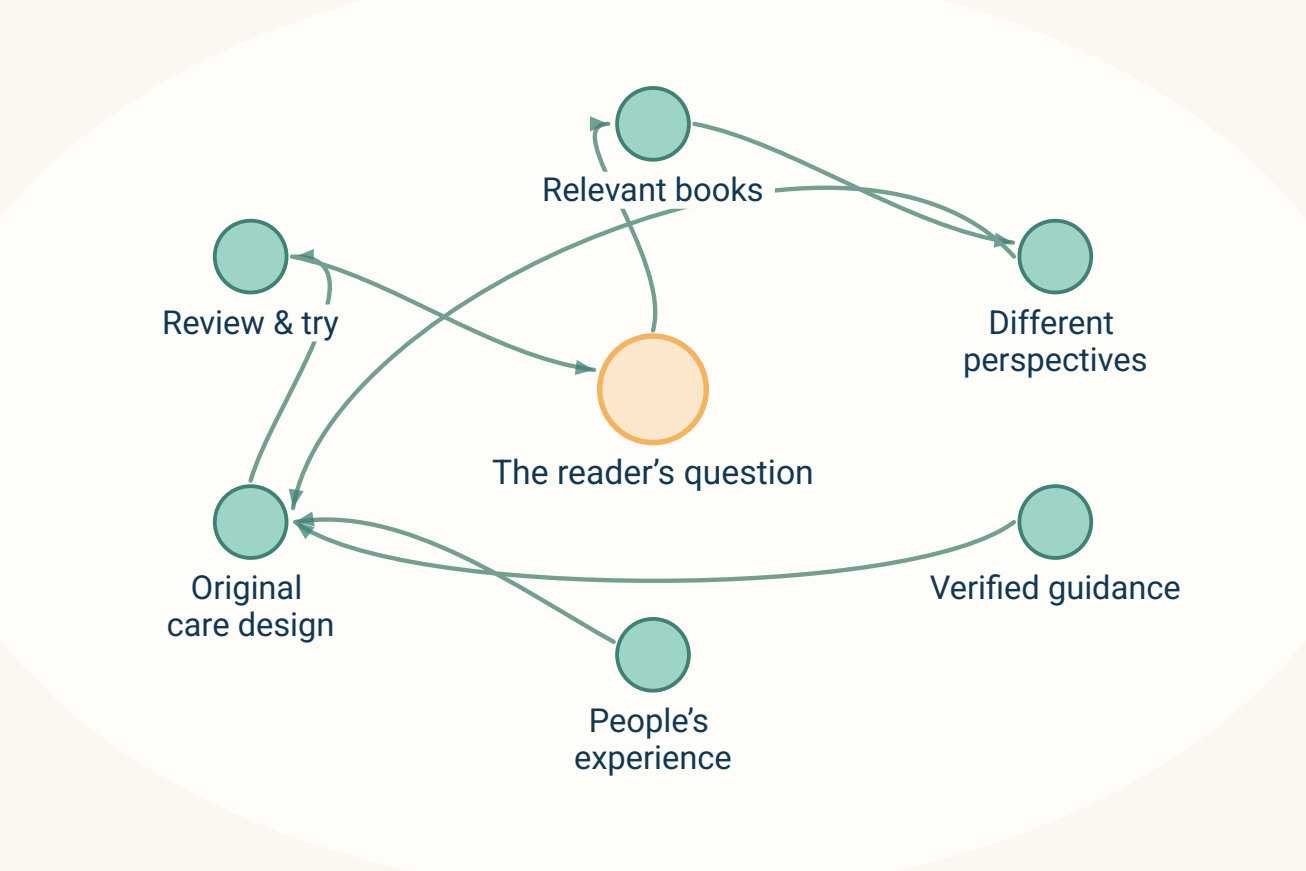
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R4 — Books Worth Bringing into Care

What They Offer, What They Share, and How to Use Them



Connection map — Bring a useful reading back to care

Choose relevant books for the reader's actual question. Compare the perspectives the selected books offer rather than claiming they all agree. Those perspectives inform specific choices in an original care design. Verified organizational and professional guidance grounds that design locally. The experience of the people involved helps shape the design. Give the proposed design responsible review, resources and a way to be tried and judged. Return what is learned to the reader's original question. A book's argument, a research finding and a proposed application remain distinct; this diagram does not reproduce the books' content or create clinical authority.

At a Glance

The central idea: The most useful book is not always the one with the most answers. It may be the one that helps us notice the question we have been missing.

What you'll explore: Thirteen books offering practical guidance, lived experience, creative approaches, and organizational insight. Find a starting point for family caregiving, home care, Day Centers, clinical teams, community leadership, or content and technology design.

Read them together: Examine shared concerns and important differences: the person's priorities,

relationships, practical responsibility, understandable design, staff voice, and the purpose of technology.

Put it to work: Develop one original care experience using a small set of relevant ideas, your organization's verified guidance, and the knowledge of the people involved.

Evidence and AI: Keep an author's argument, a research finding, and a proposed application separate. Use approved AI assistance to prepare and compare—not to manufacture book quotations, clinical authority, or proof that an approach works.

"But everyone is a designer at times..."

— **Don Norman**, design researcher, "Design as Communication."[125]

In Context — Which book would help?

This is a fictional reference exercise, separate from Pat and Ellen's continuing story. The dialogue and later care example are original illustrations, not passages from the books.

A care organization is selecting books for its team and family resource collection.

"Which one should we all read?" the manager asks.

A family caregiver looks at the proposed shelf.

"I need help with what happens when we get home."

A volunteer has another question.

"I want to know how to spend time with someone without making every conversation about their condition."

A staff member points to the work around a first visit.

"We need to stop asking the family to explain the same arrangements to three people."

The manager puts down the list.

"Perhaps we should begin with what each book is for."

That is the purpose of this chapter.

Not to assign everyone the same reading.

To help useful knowledge reach the situation where it can make a difference.

R4.1 — Choose a Book for the Question in Front of You

"Best" depends on the reader's need

A practical handbook, a memoir, and a leadership book should not compete on one score. They offer different kinds of help.

A handbook can help someone locate a topic. A memoir lets a particular person describe

an experience. A research-informed argument connects ideas and evidence. A design book helps a team reconsider the experience it creates.

These reading shelves bring family and first-person accounts alongside professional, organizational, and design resources. Select a book for the question it helps you examine, not as a substitute for the care or evidence your situation requires.

Choose for the question—not for the prestige of the title.

The selection is strongest in adult caregiving, aging, dementia, home-based support, and service design. It is not a complete library for every disability, condition, culture, or jurisdiction. Use relevant specialist and local guidance alongside it.

Nor should reading become a test of commitment. An exhausted caregiver does not owe the organization a completed book. A team asked to learn needs appropriate time, access, and support.

What these profiles can tell you

These are source-linked reading profiles, not thirteen cover-to-cover reviews. They draw on verified publisher and author descriptions, available contents and selected public excerpts, and the project's behavioral research. Source access is described in R4.8 and the accompanying ledger.

The **book descriptions** explain the contribution supported by those materials. **Reading pairings and CarePhysics applications are our editorial proposals**, not interventions the authors jointly designed or evidence that their books validate this framework.

R1 remains the place to examine selected research findings. R2 explains models and methods in more detail. R3 addresses learning about the person before adapting the approach.

R4.2 — The Reading Shelves

The shelves below are entry points, not restrictions on who may benefit. A hospital leader can learn from a family memoir; a caregiver may find a design question unexpectedly useful.

Start with this need	Books profiled below
Practical family care and difficult decisions	*The 36-Hour Day; The Soul of Care; Being Mortal*
Care in the home	*A Guide for Caregiving: What's Next?; Handbook of Home Health Standards*
Participation, creativity, and the person's perspective	*Creative Care; Somebody I Used to Know*

Start with this need	Books profiled below
Reliable and humane organizations	*The Checklist Manifesto; Compassionomics; The Fearless Organization*
Understandable experiences and purposeful technology	*The Design of Everyday Things; The Power of Moments; Deep Medicine*

Family caregiving, personal home support, skilled home health, and hospice-related work should remain distinct when choosing a reference. Sharing a location does not make the responsibilities interchangeable.

R4.3 — What Each Book Offers

The profile numbers are navigation aids, not a ranking.

1. The 36-Hour Day

Nancy L. Mace and Peter V. Rabins

Practical family reference; eighth edition, 2025.

The question: Where can we begin when dementia care brings more questions than we can hold at once?

What it offers. The book organizes a broad range of dementia-care concerns: obtaining medical help, everyday care, changes in behavior, outside assistance, family relationships, caregiver needs, and longer-term arrangements. Its contents give readers several entry points rather than requiring a continuous narrative reading. The eighth edition also updates discussion of diagnosis, treatment, and research.[126]

Its distinctive contribution. Practical breadth. Start here when the immediate need is to locate and understand a care topic. Read it alongside *The Soul of Care* for a different kind of attention to the lived work of caregiving.

A CarePhysics application. A social worker could help a family select one relevant topic and prepare questions for the appropriate professional. The organization can attach its own verified contact and assistance route rather than handing over a large reference and assuming support has been delivered.

The book should not become an independent treatment plan. Do not use a chapter title as proof that an intervention prevents decline or that a particular arrangement suits every family.

Question to carry into practice: After we offer information, who helps the family use it?

Related chapters: 1, 2, 5, and 11.

2. The Soul of Care: The Moral Education of a Husband and a Doctor

Arthur Kleinman

Memoir and reflection; 2019.

The question: What does caregiving require that professional expertise alone does not capture?

What it offers. Kleinman writes about caring for his wife, Joan, after her Alzheimer's diagnosis, bringing his medical experience into contact with the practical, emotional, and moral work of being her husband and caregiver. The book considers presence, ordinary tasks, relationships, and the place of caring within medicine and society.[127]

Its distinctive contribution. A professional becomes a family caregiver. That perspective makes it a useful companion to a procedural handbook: not another set of instructions, but an account of what instructions cannot fully describe.

A CarePhysics application. Before revising a family-support process, invite caregivers to describe one recent part of the day. Listen for the work of arranging, noticing, explaining, and adapting—not only the task recorded by the service. Select something the organization can change and return with an answer.

This is one person's account, not a measure of what every family experiences. Do not use its moral seriousness to make unlimited self-sacrifice the standard of love.

Read alongside: *The 36-Hour Day* for practical reference, or *Somebody I Used to Know* to place a person's own account beside a caregiver's.

Question to carry into practice: What work are we depending on without recognizing or supporting it?

Related chapters: 1, 4, and 11.

3. Being Mortal: Medicine and What Matters in the End

Atul Gawande

Narrative inquiry into medicine, aging, and serious illness; 2014.

The question: What should care help someone preserve when medical treatment cannot settle everything?

What it offers. Gawande examines the limits of a medical approach focused on fixing problems or extending life without sufficient attention to how a person wants to live. His account considers institutional routines, autonomy, dependence, difficult conversations, and approaches to care near the end of life. The published opening explicitly asks how medicine responds to what it cannot repair.[128]

Its distinctive contribution. It brings goals and trade-offs into the center of the discussion. Start here when a family or organization needs to reconsider what a successful plan is intended to accomplish.

A CarePhysics application. Add a conversation about priorities before assuming the

objective of a pathway. Ask what the person wants protected and what concerns them about the available options. The appropriate clinicians explain medical implications; the person's values help shape the decision.

Do not turn the book into a general instruction to avoid treatment or accept risk. An individual decision still requires current information and appropriate professional support.

Read alongside: *The Checklist Manifesto*. One helps question the purpose of the plan; the other prompts attention to dependable execution.

Question to carry into practice: Are we delivering the plan well—and is it a plan the person wants?

Related chapters: 1, 7, and 11.

4. A Guide for Caregiving: What's Next?

Tina Marrelli

Practical guidance for family and friend caregivers at home.

The question: How do professional instructions become something a household can understand and organize?

What it offers. Marrelli's guide covers advocacy, records, a care notebook, home-care safety, healthcare terminology, and information concerning several long-term conditions and end-of-life care. Its intended reader is the family or friend caregiver rather than only the licensed professional. The author's description explicitly includes both the person receiving care and the caregiver.[129]

Its distinctive contribution. It connects everyday organization with the unfamiliar administrative and clinical language families encounter. Its scope is broader than dementia alone.

A CarePhysics application. Help a household create a short, current contact-and-question page using the guidance relevant to its situation. Let adults accept bounded responsibilities for maintaining different parts. Provide a person who can clarify instructions; do not transfer the organization's entire recordkeeping burden to the caregiver.

Reading about a consequential task does not establish that someone can perform it safely. Required instruction, supported practice, and professional assessment remain separate. Check clinical and service information against current guidance.

Read alongside: *The Soul of Care* for the experience behind the organizing work.

Question to carry into practice: Does our information help the household—or make it responsible for another system?

Related chapters: 2, 7, and 11.

5. Handbook of Home Health Standards: Quality, Documentation, and Reimbursement

Tina M. Marrelli

Professional home-health reference; sixth-edition description reviewed.

The question: How do home-health professionals connect assessment, care planning, documentation, and service responsibilities?

What it offers. This is the professional counterpart to the family guide, not a longer version of the same book. The sixth-edition description covers assessment, interdisciplinary care planning, documentation, patient and caregiver considerations, and coverage and reimbursement topics. It identifies nurses, therapists, supervisors, managers, and related operational roles as intended users.[130]

Its distinctive contribution. Operational specificity. It is a reference to consult for professional work, not the first book to hand a family seeking reassurance.

A CarePhysics application. A home-health team could review one approved care-planning workflow, checking whether relevant information is accurate, accessible to the responsible professionals, and unnecessarily entered more than once. The service lead owns the process; clinical and compliance reviewers approve their respective parts.

This entry does **not** establish the sixth edition as a current reimbursement authority. Verify the applicable edition and check present clinical, documentation, and payer requirements before using operational material. A handbook does not promise payment or expand anyone's scope of practice.

Read alongside: *Being Mortal* to keep personal goals visible within professional processes.

Question to carry into practice: Does the record support the care being provided, or has completing the record become the apparent purpose?

Related chapters: 7, 8, 10, and 11.

6. Creative Care: A Revolutionary Approach to Dementia and Elder Care

Anne Basting

Creative practice and narrative; originally published in 2020.

The question: How can people connect without making accurate recall the price of participation?

What it offers. Basting brings theater, improvisation, storytelling, and listening into care. Her approach includes open imaginative invitations and making room for contributions without requiring correct remembered details. The author presents the book as an account of finding, developing, and applying creative care within relationships and care settings.[131]

Its distinctive contribution. Something people can explore together in the present. It is

a useful starting point for activity teams, volunteers, and families seeking interaction rather than another discussion of symptoms.

A CarePhysics application. Offer a chosen picture or story and an optional invitation to comment, imagine, read, or listen. Provide appropriate assistance and let the person stop. A pleasant exchange need not end with a quiz, score, or required memory.

That is an original design application, not a formal reproduction of Basting's program. Do not convert a publisher's promotional claim into evidence that an activity improves cognition or slows dementia. R1 examines related activity research separately.

Read alongside: *Somebody I Used to Know*, keeping the person's perspective beside the activity designer's intention.

Question to carry into practice: What contribution is the person choosing—and have we left room simply to enjoy being here?

Related chapters: 5, 6, and 11.

7. Somebody I Used to Know

Wendy Mitchell, written with Anna Wharton

First-person memoir; 2018.

The question: What do we miss when we speak about a condition without hearing from someone living with it?

What it offers. Mitchell describes her experience of young-onset Alzheimer's, changing daily routines, identity, and efforts to continue living meaningfully. The memoir places her perspective at the center rather than presenting only a caregiver's or professional's interpretation. Anna Wharton's coauthor contribution is documented separately from publisher pages that feature Mitchell's name alone.[132]

Its distinctive contribution. A voice from inside one life. Read it not to acquire a standard profile of dementia, but to make more room for the person who may otherwise be discussed in the third person.

A CarePhysics application. Review a fictional meeting summary. Can the reader identify the person's stated preferences separately from relatives' concerns and staff observations? Where the person's perspective is missing, improve the process for hearing it rather than asking AI to fill the gap.

One memoir cannot represent every stage, condition, or person. Do not use the author's adaptations as a benchmark that another person must meet.

Read alongside: *The Soul of Care*. The two perspectives can deepen inquiry without either becoming the final account of a different household.

Question to carry into practice: Whose account has become authoritative because it was the easiest one for us to obtain?

Related chapters: 1, 4, and 6; Reference Chapter R3.

8. The Checklist Manifesto: How to Get Things Right

Atul Gawande

Narrative and organizational inquiry into reliability.

The question: How can capable people make essential actions less dependent on memory and circumstance?

What it offers. Gawande explores checklists as supports for complex work, drawing examples from medicine and other fields. The book connects preparation and essential steps with teamwork; its subject is not simply creating longer lists. The publisher provides both a description and an opening excerpt that show its focus on the difficulty of executing complex care.[133]

Its distinctive contribution. A practical way to examine omissions without assuming that more individual expertise solves every coordination problem.

A CarePhysics application. Design a brief first-visit check around a few necessary confirmations: the person understands the purpose, relevant assistance is arranged, the receiving worker knows what has been accepted, and changes have a responder. Test it with staff before expanding it.

That local check is not a validated clinical checklist. Preserve established safety procedures and involve the appropriate professionals. A completed box is not proof that the intended service happened.

Read alongside: *The Fearless Organization*. Invite the team to examine both the process and whether someone can point out a missing or unsuitable step.

Question to carry into practice: What must not be forgotten—and who is able to say that it has been?

Related chapters: 7, 10, 12, and 15.

9. Compassionomics: The Revolutionary Scientific Evidence That Caring Makes a Difference

Stephen Trzeciak and Anthony Mazzarelli

Research-based argument for the importance of compassion in healthcare; 2019.

The question: Why should compassion belong in decisions about care quality rather than be treated as an optional courtesy?

What it offers. Trzeciak and Mazzarelli assemble research and clinical stories to argue that compassion matters to patients, professionals, and organizations. The publisher's description addresses patient outcomes, organizational costs, and professional well-being. These are the authors' arguments to examine, not one universally transferable result.[134]

Its distinctive contribution. It brings the human encounter into discussions that might otherwise focus only on technical performance or finances.

A CarePhysics application. Choose one recurring encounter and ask the people receiving care whether their concern was recognized and addressed. Support staff with preparation time, useful language, and a route to help. Examine what changed alongside workload and unresolved needs.

Trace any quantitative claim to the underlying study before using it in a proposal. Do not promise that a brief phrase saves a life, reduces costs, or prevents burnout. Compassion is not a replacement for clinical skill, adequate staffing, or available services.

Read alongside: *The Fearless Organization*, connecting the intended quality of the encounter with the conditions in which staff work.

Question to carry into practice: Where does our commitment to compassion become an observable response?

Related chapters: 4, 10, and 11.

10. The Fearless Organization: Creating Psychological Safety in the Workplace for Learning, Innovation, and Growth

Amy C. Edmondson

Organizational learning and leadership; 2018.

The question: Can people say what the team needs to hear?

What it offers. Edmondson examines the interpersonal conditions under which people can ask questions, raise concerns, contribute unfinished ideas, and acknowledge mistakes. The book connects psychological safety with learning and offers practical approaches to establishing it, alongside accountability and organizational goals.[135]

Its distinctive contribution. It looks behind the instruction to “speak up” and toward the response people encounter when they do.

A CarePhysics application. Invite a staff member, volunteer, participant, or caregiver to identify a difficulty in one workflow. Record who will consider it, what action was accepted, and when the contributor will hear the result. Provide a private route where appropriate. An AI assistant may organize feedback; it should not secretly turn contributions into individual performance rankings.

Treat this as a leadership and learning resource, not a certificate that a workplace has become safe. Open conversation does not eliminate clinical standards, professional responsibilities, or the need to address harmful conduct.

Read alongside: *The Checklist Manifesto*. A process can be examined and improved only if concerns about it are heard.

Question to carry into practice: What happened the last time someone told us our design was making the work harder?

Related chapters: 10, 11, 13, and 14.

11. The Design of Everyday Things

Don Norman

Human-centered design; revised and expanded edition, 2013.

The question: Is the person struggling—or have we made the task unnecessarily difficult to understand?

What it offers. Norman examines how visible cues, feedback, and conceptual models help people understand what they can do and what happened after they acted. The revised edition also considers human error, real development constraints, and the pressures surrounding product design. The author's published preface explains those additions.[136]

Its distinctive contribution. A way to look at an ordinary failure and investigate the design before blaming the person. It is relevant to a screen, a printed invitation, or the route through a service.

A CarePhysics application. Ask an intended user to find the right contact or distinguish a requested visit from a confirmed one, with their usual assistance available. Observe where the design obscures the answer. Change the instruction, control, or feedback and try again.

The unfamiliar-remote analogy belongs here: knowing the purpose does not make unfamiliar controls obvious. The book is not a substitute for current accessibility requirements or testing with the people served.

Read alongside: *Deep Medicine*, examining the whole experience around any proposed automation.

Question to carry into practice: What are we asking the person to remember that the design could make clear?

Related chapters: 2, 6, and 8.

12. The Power of Moments: Why Certain Experiences Have Extraordinary Impact

Chip Heath and Dan Heath

Experience design through research interpretation and stories; 2017.

The question: Which moments deserve deliberate attention rather than being left to chance?

What it offers. The Heath brothers organize memorable positive experiences around elevation, insight, pride, and connection. Their account examines how people might create meaningful moments in education, work, services, and personal life. The publisher's available opening explains that interest in both understanding such experiences and designing them.[137]

Its distinctive contribution. It directs attention to beginnings, transitions, recognition,

and shared experiences that could otherwise become routine transactions.

A CarePhysics application. Plan a first welcome so a person encounters someone prepared to meet them, a clear explanation, and an activity they may choose. Ask what would feel comfortable. A quiet introduction may fit better than public recognition or a surprise.

Do not infer that a memorable event guarantees a lasting health benefit. For a person living with dementia, the value of an enjoyable moment need not depend on later recall. Nor can a special welcome compensate for repeated missed services.

Read alongside: *Creative Care* for participation and *The Checklist Manifesto* for the dependable arrangements around it.

Question to carry into practice: Which ordinary transition could become more respectful or meaningful without becoming a performance?

Related chapters: 5, 6, and 13.

13. Deep Medicine: How Artificial Intelligence Can Make Healthcare Human Again

Eric Topol

Medical technology and human-centered care; 2019.

The question: What should assistance make possible for the relationship between the person receiving care and the professional?

What it offers. Topol argues that AI could take on work that competes with human attention and thereby make more room for listening and connection. The book considers a broad range of medical applications; its human-centered ambition is distinct from the performance of any particular system.[138]

Its distinctive contribution. A purpose against which to examine technological progress: not merely whether a tool is capable, but what its use could make possible for people.

A CarePhysics application. Test one bounded drafting task using approved sources. Name the reviewer, measure preparation and correction time, and ask whether the final material helps the next conversation. Keep decisions and accountable care with the appropriate people.

Read the 2019 discussion in its historical context. It is not an inventory of currently available products or evidence that every modern assistant saves time, improves diagnosis, or reduces costs. R1.4 examines selected task-specific research separately.

Read alongside: *The Design of Everyday Things* and *Being Mortal*, combining usability with the question of whose goal the technology serves.

Question to carry into practice: What human attention will we protect if the tool does reduce some of the work?

Related chapters: 8, 9, 10, and 13.

Further readings that connect directly with R2

Motivational Interviewing: Helping People Change and Grow — William R. Miller and Stephen Rollnick, fourth edition, 2023. A practice-oriented text with demonstrations and cases organized around engaging, focusing, evoking, and planning. Choose it for developing a collaborative communication practice, not collecting persuasive phrases. Pair it with supervised learning and appropriate evaluation; reading alone is not demonstrated competence.[112]

The Behaviour Change Wheel: A Guide to Designing Interventions — Susan Michie, Lou Atkins, and Robert West, 2014. A structured guide moving from understanding a behavior to selecting intervention and implementation options. Choose it when a team needs a disciplined alternative to assuming every problem requires more education. R2 explains COM-B and the distinction between a framework and the effectiveness of an intervention designed with it.[139]

Social Physics — Alex Pentland, 2014. A perspective on how ideas move through relationships and become part of collective behavior. Pair it with *The Fearless Organization* to ask both how knowledge travels and whether people feel able to contribute. Our commissioned review grades the broader perspective **Emerging-to-moderate**, with important limits on transfer to care and on claims that more interaction is always beneficial.[140]

The wider behavioral collection includes Ryan and Deci's *Self-Determination Theory*, Rogers' *Diffusion of Innovations*, Milkman's *How to Change*, Thaler and Sunstein's *Nudge*, Centola's *Change*, Cialdini's *Influence*, and Fogg's *Tiny Habits*. Its original ranking belongs to that research commission; it is not a universal ranking against the books in this chapter.

The Goal: A Process of Ongoing Improvement — Eliyahu M. Goldratt and Jeff Cox, third edition, 2004. This management novel follows a plant manager confronting a threatened closure and introduces TOC through a story about interconnected work. The authors and edition are confirmed by the publisher's public description.[141]

Our reading suggestion: pair it with The Checklist Manifesto and The Fearless Organization. Ask where local efficiency fails to improve the whole service, then hear from the people affected before choosing a change. R2.5 offers a bounded care adaptation. This is a supplementary reading profile, not a cover-to-cover review, a clinical study, or a reason to judge people by production targets.

R4.4 — What These Books Have in Common

The shared questions are more useful than a claim of complete agreement

The following is our synthesis of the documented perspectives, not a joint position endorsed by the authors. Not every book addresses every theme.

The person's life is larger than the care task. Read Gawande's concern with goals, Kleinman's account of caregiving, and Mitchell's first-person perspective together. They invite different kinds of attention to what matters beyond a diagnosis or completed

intervention.[128]

For CarePhysics, the design question is what the person wants the support to protect: a relationship, a chosen activity, privacy, independence, or something else they name.

Relationships need a place inside the work. *The Soul of Care*, *Creative Care*, and *Compassionomics* approach the human encounter through memoir, creative practice, and an argument about research. Their genres differ, but each gives the relationship substantive attention.[127]

Our application is to make that attention visible: address the person, pause for the answer, respond to the concern, and make an honest commitment. A warmer sentence without the corresponding action is not enough.

Good intentions need a workable arrangement. The practical caregiver guides and *The Checklist Manifesto* offer different ways into preparing and organizing care.[126]

Ask who accepts the task, what they need, and what happens when the arrangement changes. Do not turn the primary caregiver into the coordinator of every offer. A resource recommendation becomes useful only when it connects with something the person can actually do or receive.

Difficulty can expose a design problem. Norman directs attention to the interaction between people and the things designed for them. The Behaviour Change Wheel adds a structured inquiry into what needs to change before an action can occur.[136]

Together they give us reason to ask about unclear instructions, unsuitable timing, unavailable support, and unnecessary steps before reaching for a label about the person's motivation.

People need a way to contribute what they know. Edmondson's focus on speaking up and Pentland's interest in idea flow support different questions about knowledge within a group. Neither is permission to harvest private conversations or turn staff interaction into surveillance.[135]

Our proposed practice is to welcome ideas from patients, participants, caregivers, volunteers, and frontline teams; review them; credit contributors appropriately; and show what changed.

Tools should be judged by the human purpose they serve. Read Topol's aspiration for assistance alongside Norman's attention to usable design. That pairing invites scrutiny of the full experience, not only an impressive function.[138]

Purpose, love, trust, compassion, and community are not additional performance indicators to infer from a dashboard. In CarePhysics, they guide what we choose to ask, provide, protect, and review.

R4.5 — Important Differences Make the Shelf Stronger

These pairings raise useful questions; they are not claims that the authors disagree with one another.

Read together	The question created by the pairing
Being Mortal + **The Checklist Manifesto**	Which safety and coordination steps need consistency, and which goals must remain the person's own?
The Soul of Care + **A Guide for Caregiving**	How do we recognize the meaning of caregiving while making its practical demands more manageable?
Creative Care + **The Power of Moments**	Can the encounter have value now without requiring durable recall, public participation, or a dramatic event?
The Fearless Organization + **Handbook of Home Health Standards**	How can professionals question the process and still uphold the standards and responsibilities relevant to their work?
Deep Medicine + **The Design of Everyday Things**	Does automation improve the whole task, or move difficulty into checking, correction, sign-in, or follow-up?

The pairing is useful when it prevents a one-sided application.

Do not make a checklist so rigid that it prevents someone stating a preference. Do not make personalization so improvised that nobody confirms essential information. Do not use compassion to excuse unsafe practice or use formal documentation to dismiss a person's experience.

A family's cultural practices, beliefs, resources, and relationships should shape the local application through conversation. Books help prepare questions; they do not authorize assumptions about the next person. That is the distinction developed in R3 and the project's cultural-humility guidance.

The books also have different emotional demands. A person may welcome a reflective account at one time and need a brief practical answer at another. Offer reading as an option, with an appropriate human route alongside it.

R4.6 — Short Reading Routes

These are editorial starting combinations, not tested interventions or required courses. Begin with one useful selection rather than assigning the whole shelf.

Reader or team	Start here; then add another perspective	One question for discussion
Family caregiver dealing with dementia	*The 36-Hour Day*; then *The Soul of Care*	What information is useful now, and what practical support is still missing?
Family or friend providing care at home across conditions	*A Guide for Caregiving*; then selected *Being Mortal* material	What needs organizing, and whose priorities should shape it?
Skilled home-health team	A professionally reviewed, applicable edition of the *Handbook*; then *The Fearless Organization*	Where can someone question a process that is not working?
Day Center team or volunteer	*Creative Care*; then *Somebody I Used to Know*	Does the person have a real way to choose, contribute, listen, or stop?
Health-system leader	*The Checklist Manifesto*; then *Compassionomics* or *The Fearless Organization*	What conditions make both reliable work and a humane encounter possible?
Community or state partnership	*The Soul of Care*; then *Social Physics*	Which lived need should guide the network, and who helps knowledge become usable support?
Content or technology team	*The Design of Everyday Things*; then *Deep Medicine*	Which task should become easier, and what human work must remain visible?

Provide legitimate access to the chosen material and protected time for staff learning. Check the actual availability and suitability of audio, print, translated, or accessible versions before promising them. A discussion can begin with a permitted short excerpt or a team's original source-linked notes.

Do not use completion as a measure of compassion. Ask what the reader noticed and whether it suggests a worthwhile change.

R4.7 — From Reading to a Better Encounter

Begin with the person's question

> **In Context — Before the first home-support visit**
>
> This standalone fictional example demonstrates our synthesis. It is not an event from any listed book, a clinical protocol, or an addition to the established family's chronology.
>
> Amelia has agreed to explore support at home. The coordinator is preparing the first visit with her and, with permission, her daughter.
>
> "I know you've talked about the tasks," Amelia says. "What I don't know is what happens when somebody comes through the door."
>
> Her daughter asks a different question.
>
> "If the usual worker can't come, do I start calling people?"
>
> The draft welcome pack explains the organization but answers neither question clearly.
>
> The team does not need to tell Amelia which books it has been reading. It needs to use the ideas to improve what she encounters.

Turn perspectives into specific choices

The lived-experience books suggest a question for the design meeting: have we included the person's account, or only the family's and the service's?

The practical guides prompt review of the arrangements. The design books prompt a test of the explanation. The reliability and team-learning books prompt attention to accepted responsibilities and corrections.

Those are our applications of the profiles—not a combined intervention validated by the authors.

The team prepares an original first-visit page:

Your first visit

We will confirm who is coming, when they are expected, and the agreed purpose of the visit.

The worker will introduce themselves and discuss the planned assistance with you before beginning. You can explain a preference, ask a question, or raise something that does not fit.

The service will explain which tasks it can provide, which need another professional, and how a change can be requested.

Before the visit ends, you should know what has been agreed and whom to contact. If the arrangement changes, the service uses the contact route you chose.

We will confirm the actual contact details and response expectations with you. Urgent concerns follow the appropriate urgent-care route, not an ordinary feedback message.

The page cannot go into use until the organization can provide what it promises. A named service lead verifies staffing and coverage; relevant professionals verify task boundaries and instructions.

A short **video** can show the introduction and an appropriate question. An **article** explains details people can revisit. An optional **survey or interactive question** asks what would help prepare the visit and identifies who reads the answer. A **message** confirms actual arrangements. A **telephone call, virtual meeting, or planned encounter** deals with what the standard material cannot answer.

A tile can collect related material; a pathway connects it to people and actions. Use the same recognizable design functions—purpose, main idea, demonstration, chosen next step, questions or connection, and follow-through—without making every medium identical. Urgency overrides that pattern; validated instruments retain required wording and scoring.

Use AI to help prepare—not to make the promise

An approved assistant could work from the team's original reading notes, appropriately usable source material, and verified local procedures:

Compare these ideas for the first-visit task. Distinguish the author's argument, the research behind it, and our proposed application. Draft options that preserve the person's choices and the service's actual limits. Identify missing information, the responsible reviewer, and a way to test usefulness. Do not invent book quotations, clinical instructions, service availability, or family preferences.

The knowledge collection should keep research, design guidance, local facts, fiction, and private context distinct. Retain sources, authors, review dates, approved uses, and corrections. The workflow is **retrieve → add local context → prepare options → human review → test → revise**. A book upload is not model training or proof that an assistant will follow the material reliably.

Properly applied, this assistance can be a gift: less repetitive assembly and more room to ask what Amelia needs. Count review and correction work before claiming time saved.

Where an organization has approved and tested the function, an assistant may help people revisit routine information or prepare questions at any hour. It must distinguish that availability from human service hours and offer a real route to a person. Clinical decisions, urgent assessment, and accountable care remain with the appropriate people.

Optional live assistance or post-visit reflection can help bring forward an unanswered question or an idea. Explain the recording and sharing arrangements, allow decline, and preserve disagreements. A patient, participant, caregiver, volunteer, or frontline worker may supply the useful change; AI should not take credit for it or become a hidden

evaluator.

These are proposed roles. The dated Day Center export documents some related educational, feedback, and practice features, but also states that family education delivery is not evidence of completion and partner follow-through is not automatic. No claim of universal deployment follows from this example.

Give the improvement resources and a way to be judged

Plan staffing, preparation, interpretation, accessibility, privacy, training, costs, and absence coverage. A volunteer or family member should not inherit a professional responsibility because a reading exercise identified a gap.

For one first-visit process, establish a baseline and a defined review period. Examine whether people can identify the purpose, contact, and next step; whether questions receive substantive responses; and whether agreed support is actually delivered.

Report the denominator: everyone offered the revised process, not only people who returned a favorable survey. Include nondigital routes and people who declined the optional activity. Count staff time, family coordination, corrections, and unresolved needs. A named leader must be able to change or pause the process.

Keep reach, understanding, first action, adoption, useful participation, outcomes, and attributable impact separate. Willingness to recommend, actual referrals, and received services are separate too. Those distinctions are part of the research review informing this book, not something a book recommendation can bypass.

Genus supplies technology. Partners retain their care, staffing, programs, professional decisions, relationships, and voice. A useful reading group should make the service better—not imply that the service belongs to the technology provider.

R4.8 — Sources, Editions, and What to Keep Current

Know what was actually reviewed

For this draft, the profiles rely mainly on author and publisher descriptions and contents. Selected text was also examined: the published openings of *Being Mortal* and *The Checklist Manifesto*, the opening of *The Power of Moments*, and Norman's published revised-edition preface and design essay. The behavioral-book entries also draw on the evidence reviewed here-graded research and primary book descriptions.

No claim is made that all thirteen complete books were read for this chapter. Detailed claims beyond the accessible material, specific quotations, and page references require the relevant text before publication. Publisher praise is not independent evidence of efficacy.

The underlying studies belong in the evidence register. Do not give a whole memoir or popular book a clinical evidence grade. Preserve grades from the source reviews for the particular conclusions they assess, and use R1 to examine findings and limits.

Preserve the edition and its limits

Record the author credits, full title, publisher, edition, and ISBN of the copy actually used. A new printing, paperback, or format date does not necessarily mean that its clinical or operational content has been updated.

The eighth edition of *The 36-Hour Day* was published in September 2025. The home-health handbook source examined here describes the sixth edition; it is not established here as a current operational authority. These are different source situations and should remain visible.[126]

Before using a book's clinical, legal, funding, accessibility, or technology material in a service, obtain appropriate current review. A classic can remain useful for a design question while particular examples or requirements need updating.

A reading recommendation does not itself establish permission to upload, adapt, or redistribute a complete commercial work. Use legitimate copies and material authorized for the intended purpose. Attribution and permission are separate questions.

The original 2023 list remains part of the manuscript's history. This selection does not silently confirm uncertain entries in that earlier bibliography or assign its claims to newly selected books.

One thing to try

Choose two books that approach your current problem differently: a practical guide and a firsthand account, or a reliability book and a design book.

Prepare one source-linked idea from each. Ask someone receiving the service and someone providing it what those ideas miss about the actual situation.

Agree on one original change, the person responsible, the support required, and how you will examine the result. Credit the contribution that makes the design better, whether it came from a book, a caregiver, a participant, a volunteer, or a colleague.

Your team's question is:

What did this reading help us notice—and what are we prepared to do differently because of it?

The book is a beginning, not the last word

Return to the manager choosing a book for everyone.

The team now has more than a reading list. It has different routes into the work: one source for a practical question, another for an overlooked perspective, another for the conditions around a reliable encounter.

The family caregiver does not need to finish the shelf before asking for help. The volunteer does not need to become a clinician to offer appropriate companionship. The organization still has to provide the people and resources behind its promises.

A good book can change what we see.

The next responsibility is to bring that understanding back to the people in front of us—and listen to what they add.

Next: R5 — Connected Outcomes

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R5 — Connected Outcomes: Social Physics Applied to Healthcare

Honoring the Social Physics Foundation—and Bringing Complementary Knowledge into Care

At a Glance

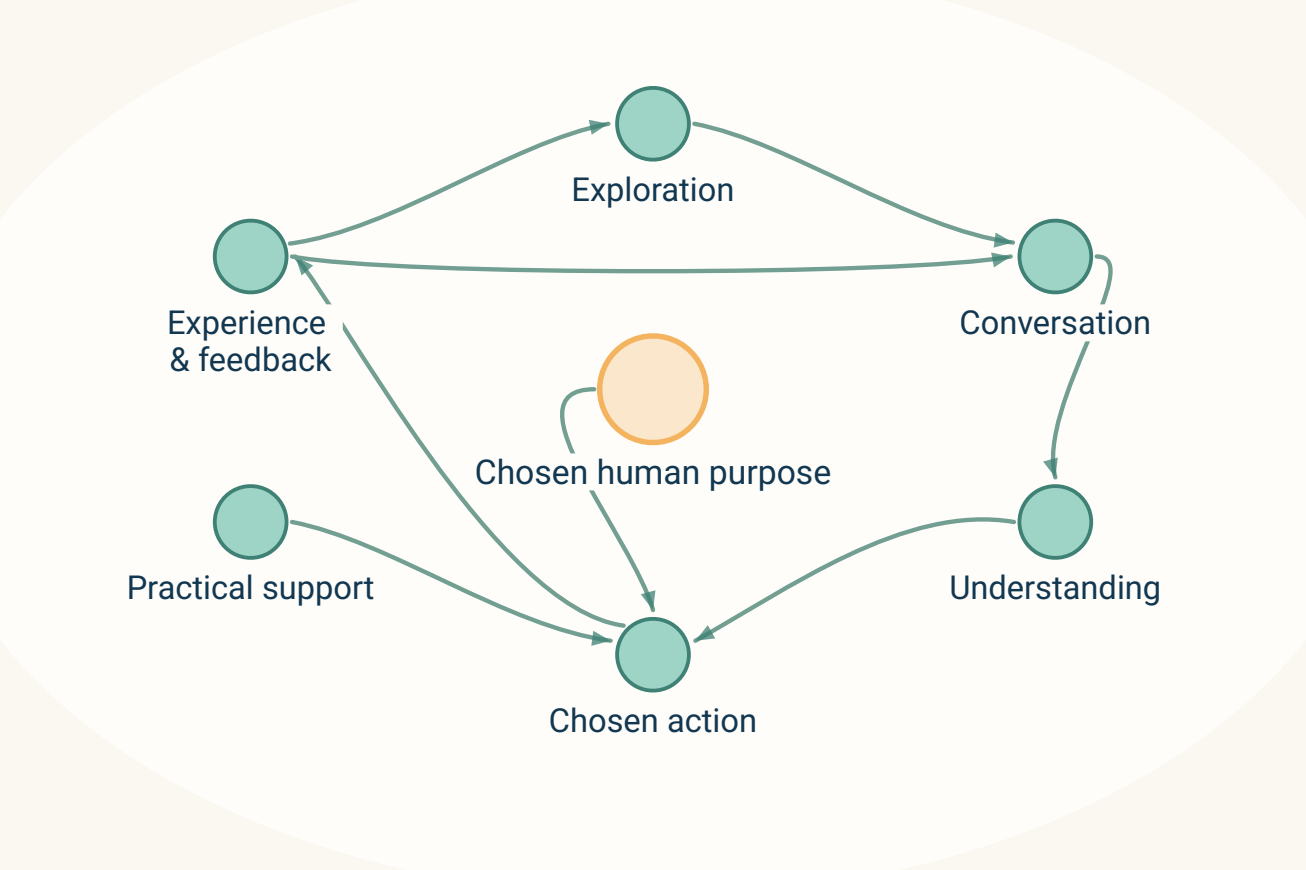
The central idea: Social Physics helps us see the relationships through which ideas become action. Complementary health knowledge helps us design the support around that action—and examine what it makes possible.

What you'll explore: An appreciation of Alex Pentland and his collaborators, the social direction their work illuminates, and how that perspective can work alongside behavioral models, communication methods, professional experience, and tested care programs.

Design and AI: Follow useful knowledge into a conversation, a chosen next step, a shared responsibility, and a learning process. Explore assistance that makes human wisdom easier to use while keeping judgment, permission, and accountability with people.

Put it to work: Examine one existing connection: what it is meant to support, which complementary help belongs around it, and how the people involved will know whether it helped.

> *"Social physics is about idea flow, the way human social networks spread ideas and transform those ideas into behaviors."*
>
> — MIT's description of Alex Pentland's *Social Physics*.[5]



Supplementary illustration — Knowledge travels through people

Exploration brings discoveries from other people and sources into conversation. Conversation helps people interpret what the discovery means for them. The person's own human purpose guides their choice of action. Understanding informs the choice without requiring agreement or action. Practical support addresses the conditions needed for the chosen action to be workable. Examine people's experience and feedback after an action is tried. Return that learning to the conversation with the people involved. Carry useful experience forward so others can explore it with its context attached. This is the book's proposed application of Social Physics alongside complementary care knowledge. The combination's outcomes require evaluation; relationships may also matter simply for belonging and enjoyment.

R5.1 — A Path Worth Following

Some contributions do more than offer a method. They give others a different place from which to begin.

CarePhysics approaches *Social Physics* in that spirit.

Alex Pentland and his collaborators directed attention to how patterns of interaction shape the movement of ideas and their translation into behavior. Their research used observations of social activity and experiments to examine relationships among communication, group organization, and action. The contribution was not simply another recommendation to connect. It was a way to investigate what happens through those connections.

That is groundwork worth honoring.

For healthcare, it opens a valuable line of inquiry. Alongside asking what a person knows, we can ask how knowledge reaches them, whom they want to discuss it with, whose experience could help, and how the people involved can act together.

Consider a care-planning conversation. A clinician brings professional knowledge. A social worker understands available support. A caregiver explains the difficult part of the evening. A participant offers a preference that changes the proposed activity. A frontline colleague identifies what the team can realistically provide.

Our opportunity is to make room for those contributions and connect them with a decision someone can use.

The social perspective does not diminish individual expertise. It invites us to examine how expertise becomes available beyond the person who holds it. For this book, that is an important reason to place Social Physics beside the independently developed work of Bandura, Rogers, Centola, health-behavior researchers, and communication and care professionals. Each tradition contributes questions of its own.

The original CarePhysics manuscript acknowledged researchers, clinicians, caregivers, families, patients, chaplains, and others whose knowledge shaped its purpose. Its intention was to help organizations bring their expertise and resources into meaningful encounters. This reflection continues that acknowledgment.

We are not completing an unfinished theory. We are bringing complementary bodies of knowledge into the same practical setting.

Social Physics helps us see the social pathways of action. CarePhysics asks how we can design care that makes good use of those pathways.

The appreciation is therefore both intellectual and practical: understand the contribution, preserve its meaning, and carry it into work that can be examined with the people it is intended to help.

R5.2 — The Social Direction: Discover, Interpret, Learn Together

Exploration opens the circle

In Pentland's account, exploration concerns reaching beyond familiar sources to encounter different people, ideas, and possibilities. Engagement concerns the interaction through which ideas can be interpreted, reinforced, coordinated, and acted upon. These are related functions, not synonyms for opening content or accumulating contacts.

For a care organization, exploration might begin when a nurse learns about a community service previously missing from the discharge conversation. It might come from a caregiver who knows a useful local resource, a volunteer with a practical idea, or another team willing to share something it tried.

The design question is how to make those discoveries available to the people who could

use them.

A contact list can be part of the answer. So can a professional introduction, a short demonstration, a reviewed story, or time to speak with someone who understands the setting.

Engagement gives discovery somewhere to go

Now imagine a person learning that a Day Center exists.

The next useful conversation might concern the activities, the assistance provided, the cost, or what an introductory visit involves. Another person may already understand the service and want help arranging transport. Someone else may prefer to consider another option.

The information has reached them. The conversation helps establish what it means for them.

This is the proposed care application of exploration and engagement: not sending more material until someone complies, but connecting discovery with an opportunity to understand, question, choose, and obtain appropriate help.

The social direction is also visible inside a team. A colleague can bring a promising approach from elsewhere; the people doing the work can examine whether it fits, identify what must change, and decide how to try it. The useful knowledge moves outward and returns with experience attached.

The research review informing this book identifies this combination—discovering ideas and having relationships through which to work with them—as Social Physics's particularly valuable contribution to the care discussion.

Social learning includes the return journey

In our application, the person receiving support does not stand at the end of an information pipeline.

A participant can improve the invitation. A patient can explain why an instruction will not work at home. A caregiver can reveal a burden the organization has overlooked. A volunteer can make a demonstration clearer.

That gives the organization a design responsibility: provide a route for the contribution, consider it, and return with what happened.

A conversation can also be worthwhile simply because people enjoy it. Belonging, friendship, and shared pleasure do not have to produce another care task. Connected outcomes includes those experiences while asking separate questions when an organization promises navigation, respite, or improved health.

We are looking for connections that serve a human purpose—not a requirement to make every relationship more productive.

R5.3 — Complementary Knowledge, a More Complete Response

The social perspective gives us a wider view. Other foundations help us make decisions within it.

Their relationship is not a competition for the best explanation of everything. It is a practical division of attention.

Understand what makes action possible

COM-B, developed by Susan Michie, Maartje van Stralen, and Robert West, examines capability, opportunity, and motivation. The Behaviour Change Wheel connects that analysis with choices about intervention design.[2]

This adds a useful question to a promising introduction: what needs to be in place for the person to act?

If the explanation is unfamiliar, offer clarification. If a skill is required, provide appropriate instruction and practice. If transport or an available place is missing, investigate that resource. The social connection may help reveal the need and reach someone able to address it.

The same inquiry belongs inside the organization. A worker may understand the referral process but lack time or coverage to complete it. The response then concerns the conditions of the work, not another reminder about caring.

Let purpose remain the person's own

Self-Determination Theory, associated with Richard Ryan and Edward Deci, examines autonomy, competence, and relatedness. It distinguishes self-endorsed participation from action driven mainly by external control, while recognizing both enjoyment and personally valued reasons for doing something.[3]

In care, those questions help us use relationships respectfully.

Pat might choose a reading group because the conversation interests him. Ellen might welcome a service because it gives her time for something of her own. Neither needs to adopt the organization's preferred description of success.

An invitation to contribute can reveal purpose. It can also become pressure if someone feels they must be useful to deserve a place. Our design should leave the person free to lead, listen, rest, or decline.

Motivational interviewing contributes a collaborative way to explore mixed feelings and personal reasons. It helps a professional ask what matters rather than argue someone toward a predetermined decision. Its role is different from solving an unavailable-service problem.

Make the next step understandable and manageable

Social Cognitive Theory directs attention to interactions among personal factors,

behavior, and environment. Demonstration and supported practice offer concrete ways to work with learning needs; they are techniques, not the whole theory.

A prospective participant might want to see what a visit involves. A caregiver learning a consequential care skill needs appropriate professional preparation and an opportunity to demonstrate readiness. A person using an unfamiliar screen may simply need someone to show the relevant control.

Fogg's Behavior Model adds attention to motivation, ability, and a prompt at the moment of action. In our proposed application, it helps turn an overwhelming invitation to organize care into one chosen, useful beginning—such as requesting a conversation.

The receiving service must still make the conversation happen.

Give the encounter a familiar design

Communication and learning-design methods help the team decide what an article should explain, what a video should demonstrate, what a question is for, and how someone can respond.

The CarePhysics pattern gives these formats a common structure: **why it matters → main idea → demonstration → chosen next step → questions or connection → what follows**. Urgent instructions come first; validated questionnaires retain their wording and scoring; an enjoyable activity need not end with a task.

Keep the way through familiar while adapting the assistance. Our remote-control analogy concerns unfamiliar design, not Pat's symptoms: knowing the purpose does not make a different set of controls obvious.

These foundations developed in their own right. Together, they help us examine the relationship, the person's reasons, the practical conditions, and the experience being offered. Their contribution is visible in a better-designed response—not in how many model names appear in the plan.

R5.4 — Seeing the Contributions Together

> **In Context — The family's pathway, viewed again**
>
> This reflection looks back at the established fictional family. It adds no new clinical event, responsibility, or measured outcome.
>
> Pat's fall brought him to the hospital. The questions that followed belonged to more than one conversation.
>
> Clinicians remained responsible for assessment. Casey helped the family understand the transition and appropriate contacts. Sam made room for Pat's preferences and Ellen's concerns. Lena and the Day Center team explored fit and learned from the day Pat actually experienced.
>
> Maya and Daniel contributed within responsibilities they accepted. Their love did not make their availability unlimited. Emma and Noah remained grandchildren,

In Context — The family's pathway, viewed again

with adult support for enjoyable time together.

The recurring social-worker meeting made those different contributions discussable: what mattered, what had been observed, what remained uncertain, and who could act. That is the narrative function of the meeting—not a claim that a single coordinator knows or owns everything.

Seen through Social Physics, the story invites attention to the movement of knowledge between these people. Seen through the complementary models, it also invites questions about choice, understanding, resources, and the practical next step.

The ten CarePhysics principles organize those questions in their established order.

Holistic Care begins with the person and the household's circumstances. **Awareness** makes relevant information and uncertainty understandable. **Behavioral Influence** examines a feasible, self-endorsed next step. **Communications** makes room for listening, disagreement, and clear commitments. **Community** connects the household with people and resources beyond it.

Engagements shapes each worthwhile encounter. **Pathways** joins those encounters over time. **Technology** makes the relevant part accessible. **Care AI** assists with preparation and the use of reviewed knowledge. **Scoring** asks what helped, what created difficulty, and what should change.

The principles do not need to be displayed to the family every time they are used.

A tile may hold a short welcome video, an article, and an optional question. A verified contact can be saved in a phone book or printed on a card. A telephone call, virtual meeting, or planned visit supplies the personal conversation. The pathway explains who responds and how the next arrangement is confirmed.

The video should show the actual offer, not an idealized service. The article can preserve necessary detail. The question needs a responder and appropriate privacy. Optional content should not become an obstacle to speaking with a person.

The source communication guide emphasizes this consistency of meaning across channels rather than identical wording.

The later failed ride belongs in the reflection because it exposes a practical condition. Pat wanted to attend and the family was ready. More information would not have moved the vehicle. The partners needed to clarify what happened, communicate with the family, and review their responsibilities.

One subsequent completed day was worth recognizing. It did not resolve every future journey or the separate additional-Tuesday request.

The social perspective remains useful in both moments: when a connection helps, and when the people around it must repair an arrangement.

> **In Context — The family's pathway, viewed again**
>
> Love is visible in that work—in direct attention, an accepted responsibility, a limit honestly stated, or room for someone else to rest. The writing guide places those actions at the heart of the book, without making self-sacrifice the proof of love.

R5.5 — When the People We Support Shape the Support

Pat's request to hear the afternoon choices earlier is a small but important example of knowledge moving in the other direction.

He did not ask for a new program. He identified something about the timing of the existing choice.

Lena could take that suggestion to the team. Staff could explain what was feasible and where the conversation would fit. Pat could then say whether the arrangement helped.

The contribution began with him. The work of implementing it belonged to the people who accepted it. The result needed to be examined with those involved.

That is a useful pattern for health systems, home-care organizations, volunteers, and community services to adopt: make it possible for someone receiving support to improve the way it is offered.

An AI assistant could help record an idea or locate relevant guidance. It should preserve whose idea it was and distinguish a suggestion from an accepted action. A reviewed lesson might later inform a staff huddle, demonstration, article, or pathway.

The dated Day Center materials describe staff wins and observations alongside family feedback and editable notes. They provide examples of contribution routes, not evidence that every contribution produces improvement.

The learning becomes more substantial when the organization records what it considered, who decided, what actually changed, and what happened on review. Its result might be to continue, adjust, stop, or leave the current practice unchanged with a stated reason.

Celebrate a useful change at the level the evidence supports. A person reporting a better experience is something to acknowledge; it is not automatically a generalizable clinical finding.

Keep difficult and unchanged results too. Ask permission before sharing a story, and preserve the lesson without carrying unnecessary private details into another setting.

This gives appreciation a practical form. Researchers are credited for their ideas. Staff are credited for their expertise. Participants, patients, caregivers, and volunteers are credited for what they contribute.

Knowledge travels with its sources, and the people who helped create it can see that they were heard.

R5.6 — AI Can Help Human Wisdom Travel

At Genus, the research and working materials behind CarePhysics are used to help prepare features, articles, videos, questions, and support experiences. This is an internal working practice described in the project's source material, not a claim that using the collection proves effectiveness.

The same approach can serve another organization's voice and expertise.

A health system might combine selected research with approved clinical instructions. A Day Center might add current program facts and reviewed activity guidance. A home-care organization might contribute a useful staff explanation and the procedure it must preserve.

The assistant's task is to make the appropriate knowledge easier to work with.

Before a meeting, it could organize authorized questions, retrieve guidance, and prepare a draft that keeps differing accounts visible. Sam reviews support-planning material within his role; clinicians review clinical matters; Lena confirms Day Center facts.

The process is **retrieval → local context → draft or options → human review → testing → revision**. Research, design guidance, local facts, fictional examples, and permissioned personal information remain distinguishable. Sources, owners, review dates, permitted uses, and corrections stay attached. Uploading a book is not model training or proof of reliable retrieval.

Help while a question can still be answered

> **In Context — A prompt for the facilitator**
>
> *This is an optional, hypothetical live-assistance workflow, not another event in the family's story or a verified deployment claim.*
>
> During an agreed meeting, the assistant offers a quiet suggestion:
>
> A question about who will contact the family if the arrangement changes remains unresolved. Would it be useful to clarify that before closing?
>
> The facilitator checks with the people present. The appropriate person accepts a defined action—or explains what remains to be arranged. The draft summary reflects that answer.
>
> The assistant has helped focus attention. It has not decided what someone feels or declared that the meeting succeeded.
>
> In a 2023 nonclinical randomized study, Sharma and colleagues tested HAILEY's just-in-time writing suggestions with **300 peer supporters** on TalkLife. Assisted replies improved on the study's measure of conversational empathy. The result supports investigating bounded conversational assistance; it does not establish reliable emotion detection, impartial mediation, or improved clinical outcomes in spoken care meetings.[78]

In Context — A prompt for the facilitator

Immediate post-encounter feedback can extend the learning. Patients, participants, caregivers, staff, clinicians, and volunteers can be offered separate ways to describe what helped and what remained unanswered. Explain recipients and privacy limits, permit later or nondigital responses, and allow people to decline.

AI can help organize the accounts without deciding which person is right. WHO's guidance emphasizes defined tasks, stakeholder involvement, and human responsibility while identifying risks from inaccurate or biased outputs and overreliance.[1]

Protect private notes before they enter a shared workflow. Do not infer emotions or beliefs from tone, appearance, or silence. Keep live prompts limited, optional, and easy to dismiss so the people remain the focus.

Properly applied—with relevant knowledge, guidelines, rules, and review—AI can be a gift. It can help reduce repeated searching and drafting, preserve a useful explanation, and provide more individually relevant support.

A tested assistant can also offer approved routine information when questions arise outside office hours and help someone prepare for a human conversation. State actual human response times and the separate urgent route. Around-the-clock information is not continuous professional care.

Measure the whole task, including checking and corrections. The value of assistance is what it enables people to do with greater attention and less unnecessary work—not how much text it produces.

R5.7 — The Same Foundation, Different Communities

The application should become more specific as it reaches a person or organization.

A health system may use the social perspective to improve a clinical-to-community introduction: what information travels, who accepts the next responsibility, and how the family knows what happened.

A home-care or rehabilitation team may focus on a professionally reviewed demonstration, supported practice, and an appropriate contact between visits. The household's knowledge about routines can help shape the arrangement without replacing professional guidance.

A Day Center may connect chosen participation with caregiver support. An independent-living community may begin with a clear introduction to assistance people can request without committing to a larger service.

A community or state partnership may learn that repeated access problems require changes in transport, staffing, language assistance, or funding. Shared learning should help identify those decisions, not disguise a resource gap with more persuasive content.

These are proposed directions, not one prescribed network for every household.

Ask about beliefs, culture, language, privacy, preferred supporters, access, and what the person wants care to protect. Do not infer those answers from a name, age, neighborhood, or diagnosis. The reference guidance in R3 develops that person-led approach.

A person may choose family involvement, a private professional conversation, or support from a trusted community group. Someone with few personal connections should receive an appropriate institutional route to help rather than first being asked to build a network.

The people providing that support need preparation and resources too. Budget for staffing, training, interpretation, accessibility, review time, coordination, and technical help. Give volunteers clear roles and a responder. Establish coverage so the pathway does not depend on one constantly available navigator.

The Social Physics review identifies both network exclusion and overload of a person connecting multiple services as risks to address. It recommends attention to reciprocity, alternative routes, and the burden carried by each person.

Genus supplies technology; partners retain care, staffing, programs, relationships, professional decisions, and voice. A sent referral is not a completed handoff. Make permissions and accepted responsibilities visible, along with what happens when a request remains unanswered.

The goal is a better-supported network, not a larger set of obligations imposed on the people already doing the caring.

R5.8 — Learning What the Combination Achieves

The appreciation for this groundwork should lead us to thoughtful tests, not automatic claims.

Different studies illuminate different parts

Social arrangements can change a behavioral response. In their 2013 paper, Ankur Mani, Iyad Rahwan, and Alex Pentland analyzed a physical-activity experiment from MIT's Friends and Family study. Participants experienced direct rewards, peer-activity visibility, or rewards to peers based on their activity. The peer-reward condition showed the largest short-term increase in the phone-recorded activity measure. The study examined a defined social-incentive arrangement, not clinical care or the acceptability of applying pressure to families.[142]

Network structure can affect adoption. Damon Centola's randomized online-network experiment placed more than 1,500 participants in constructed health communities. Adoption of the introduced online tool was greater in clustered networks than in the comparison networks. This related work provides evidence about behavioral diffusion in that setting, not a clinical outcome or a result belonging to Pentland's study.[27]

Adding structured care support can improve a specified outcome. Gitlin and

colleagues' ADS Plus cluster-randomized trial involved **203 caregivers across 34 adult day-service sites**. Trained staff added education, validation, referrals, problem-solving, and self-care support. Adjusted depression scores were lower in the added-support group at twelve months. The sample was predominantly female and college educated; 22.7 percent were lost to follow-up. The attendance comparison did not meet the conventional statistical-significance threshold.[44]

ADS Plus is useful for this reflection because it tested additional, structured support around an existing service. It did not test the complete CarePhysics synthesis, AI, or an isolated social-connection feature.

Programs can help on some measures without improving others. The 2025 D-CARE trial enrolled **2,176 person–caregiver pairs** and compared health-system dementia care, community-based dementia care, and usual care over eighteen months. It found no significant group differences in its primary outcomes of participant behavioral symptoms and caregiver strain; caregiver self-efficacy was higher in the intervention groups.[60]

A separate analysis of the same trial found higher caregiver satisfaction with the interventions while several other participant and caregiver outcomes did not differ significantly. These were different programs and comparisons from ADS Plus. The findings help refine the question of what support achieves, rather than settle the value of all coordinated care.[143]

The grades in the author-held research review also remain distinct: Moderate for SDT intervention evidence, Emerging for the named Fogg approach, and Emerging-to-moderate for the broader Social Physics perspective. These are the review's judgments, not a new grade for their combination.

Make "amplify" a question we can answer

In this reflection, amplification describes the possibility that complementary support makes an approach more useful by addressing conditions another component leaves untouched.

To establish a combined benefit, specify **compared with what, for whom, over what period, using which resources, and on which outcome**. Demonstrating an effect greater than the separate components requires a design that can estimate those components and their interaction on a stated scale. Percentages from unrelated studies cannot be added together to establish it.

The principles address different potential breaks in a care experience; their effects are not assumed to multiply.

For a local pathway, record the baseline, population, versions used, data source, denominator, review period, and responsible owner. Network research may require analysis of shared conditions and effects spreading among connected people, rather than treating every observation as independent.

Separate reach, understanding, a first chosen action, adoption, useful participation, services received, outcomes, and attributable impact. Willingness to recommend, actual

referrals, and a referred person receiving help also remain different events. Include family and staff effort, safety, privacy, equity, and available service capacity.

Use suitable validated instruments when the claim requires them and preserve their wording and scoring. Report unanswered requests, missing information, withdrawals, and adverse or burdensome experiences—not only completed successes. Never rank how much a family cares or infer staff compassion from participation records.

The dated Day Center export makes some practical boundaries explicit: bookings are not attendance, educational delivery is not evidenced completion, and documentation time requires local measurement. An assistant must work within those facts.

A useful finding gives someone authority to continue, revise, pause, or expand the work. Evaluation should help the service become more dependable, not merely make the report more impressive.

R5.9 — Carrying the Groundwork Forward

The best tribute to a body of work is to understand what it contributes and use it carefully enough that others can build on the result.

Social Physics gives this book an important social direction: look at how knowledge moves, how people interpret it together, and how relationships shape what becomes possible. Complementary health research, professional judgment, and lived experience add different strengths to the same care situation.

CarePhysics brings those contributions into questions an organization can act on: what matters, what should be explained, what must be demonstrated, who can help, what responsibility is accepted, and how we will learn whether the support was useful.

One thing to try

Choose one existing connection—a referral, a welcome, a family conversation, or a staff learning exchange.

Ask a person receiving the support and a person providing it what the connection is intended to make possible. Identify one complementary change: clearer information, a different conversation, appropriate practice, a practical resource, or an accepted responsibility.

Name an owner, provide the support required, and return to examine what happened. Preserve contributor credit and an honest account of the result.

The question is:

What becomes possible when useful knowledge reaches the people who can understand it, choose how to use it, and help one another follow through?

In the family's story, the screen holds the page. Pat, Ellen, Emma, and Noah supply the relationship. The care around them is intended to protect more opportunities for ordinary time together—not turn that time into another task.

That is the direction worth carrying forward.

A connection opens an opportunity. Thoughtful, practical support helps people use it. A meaningful outcome is what they are better able to understand, choose, receive, contribute, or enjoy.

We honor the groundwork by bringing it into the care people can actually experience—and by leaving the work open to what they teach us next.

Next: R6 — The Wisdom We Carry Forward

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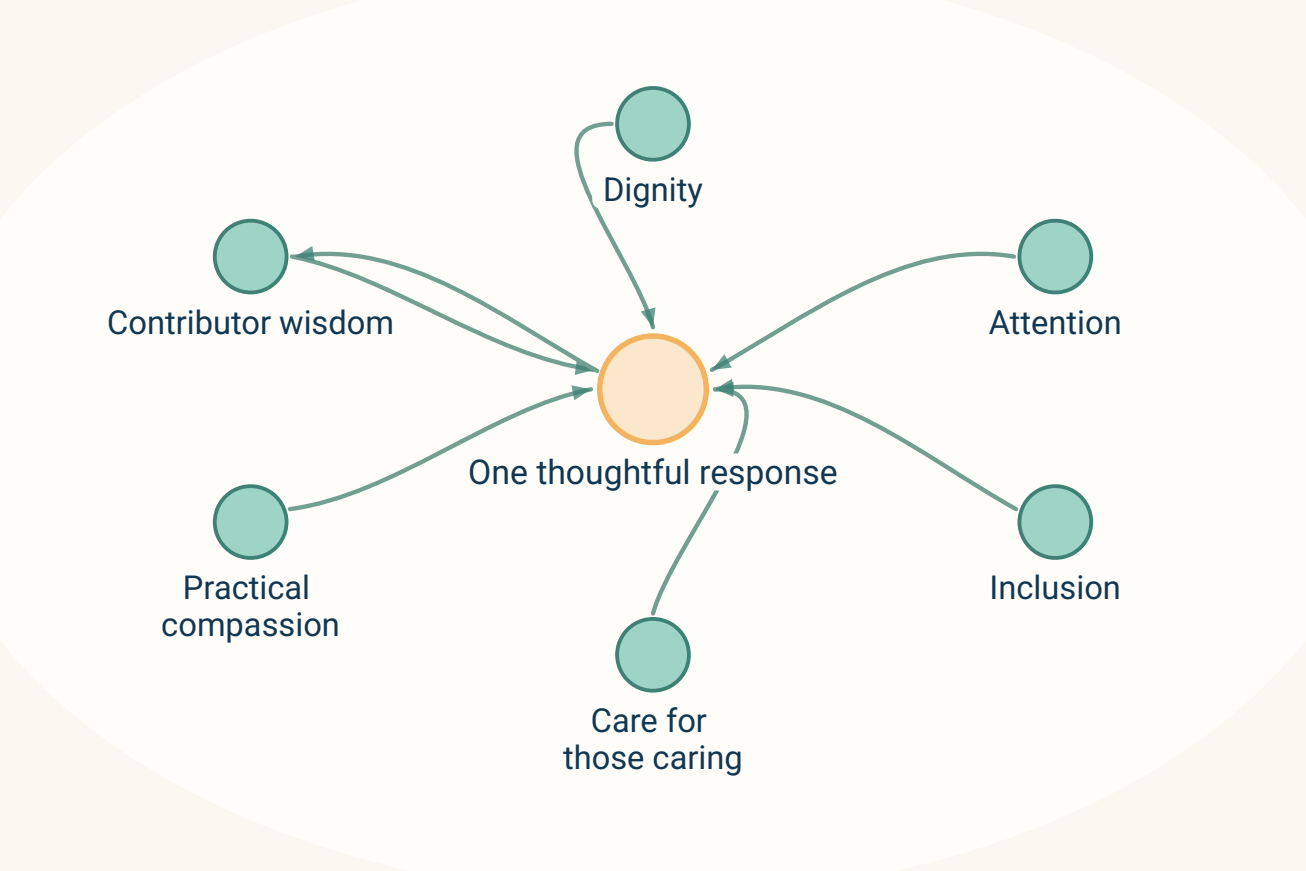
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R6 — The Wisdom We Carry Forward

Voices That Remind Us Why We Care



Connection map — Let a useful thought change a response

Dignity asks that the response recognize a person's value before what they can contribute. Attention makes room to hear rather than prepare an answer too soon. Inclusion asks who is affected but missing from the conversation. Care for those caring asks what they could set down if support changed. Practical compassion asks what help is actually received after kind words. Contributor wisdom can change how the next response is prepared. Return to contributors with what their wisdom helped change and preserve their credit. These are selected invitations from the chapter's wider circle of voices, not a compassion score or a requirement to feel inspired.

At a Glance

The central idea: We honor useful wisdom by letting it change how we see a person—and what we do next.

What you'll explore: Eight voices whose work invites us to consider dignity, attention, love, inclusion, rest, practical compassion, hope, and community. Their perspectives differ. Each offers something worth bringing into the work of care.

Bring it into your setting: Find a thought for a family conversation, a first visit, a team discussion, or

an organizational decision. The aim is encouragement, not another list of obligations.

Carry it forward: Make room for the wisdom of patients, participants, caregivers, volunteers, and frontline teams. Preserve their words, respect their privacy, and show what their contributions helped change.

A Wider Circle of Wisdom

Throughout this book, we have selected quotations from people whose work offers insight into care, communication, learning, and the human condition. Their words have helped introduce questions that deserve more than a passing answer. Yet a few lines cannot hold the contribution of a life, and no book can make room for every voice worth hearing. This chapter widens the circle. It brings additional voices into the conversation, considers the work behind their words, and asks what they might inspire in how we care for one another. Alongside them, we honor the patients, participants, caregivers, volunteers, and frontline teams whose wisdom is often shared without ever appearing in a book.

You may recognize some of these names. Others may introduce a perspective you have not considered before. Read them as invitations, not instructions to feel a particular way.

Their work comes from different places: hospice care, education, feminist thought, disability rights, spiritual practice, medicine, and community organizing. We should not erase those differences to make everyone appear to have said the same thing.

What follows is our reflection on how their contributions can complement CarePhysics. Their words are attributed; the care examples are ours. None of these quotations is an endorsement of the framework or evidence that a service works.

You do not need to finish the chapter with eight new commitments. One thought may be enough. It may help you approach a person differently. It may remind you that you deserve support too.

R6.1 — You Matter Before Anything Else

“You matter because you are you.”

— **Cicely Saunders**, as remembered by St Christopher’s Hospice.[144]

Saunders’s hospice work joined attention to physical symptoms with psychological, social, and spiritual suffering. St Christopher’s account describes her concept of *total pain* and her commitment to professionals bringing their different skills together around the individual.[145]

The short sentence above carries no entrance requirement. It does not say that a person matters because they are recovering, independent, agreeable, or able to contribute.

That is a place from which to begin Holistic Care.

Before the plan, there is someone whose life the plan is entering. Ask how they want to be addressed. Speak to them rather than only to the person beside them. Learn what they look forward to, what they want explained, and what would make this encounter more comfortable.

A person can need considerable assistance and still have preferences worth hearing. They can change their mind about an activity. They can want company without wanting to perform for the group.

For an organization, the invitation is practical. Design the welcome, the room, the schedule, and the response route so that this attention is possible. Give the team the preparation and support needed to act on what they learn.

For a family caregiver, there is another way to receive the sentence: it includes you. Your health, friendships, privacy, and ordinary enjoyment do not become unimportant because someone else needs help.

Our earlier chapters asked what matters to the person. Saunders's words remind us why the answer deserves a place in the care.

What would show this person that they matter before they have done anything for us?

R6.2 — Attention Is Something We Can Give

"Listening is where love begins: listening to ourselves and then to our neighbors."

— **Fred Rogers**, *The World According to Mister Rogers*, quoted by the Fred Rogers Institute.[146]

Rogers worked in children's television, where his deliberate pauses and attentive exchanges made room for another person. The Institute's archival reflection connects his outward attention with his own practice of stillness and reflection. His observation about listening includes ourselves as well as others.[146]

The application to adult care is not to borrow a children's presentation style. It is to consider what we make possible when we stop filling every space with an explanation.

> ### In Context — The question underneath
>
> This and the later scenes are fictional teaching examples, separate from the book's continuing family.
>
> A visitor to a Day Center asks whether she has to stay for the entire introduction.
>
> The staff member begins explaining the schedule, then stops.
>
> "Is there something about staying that concerns you?"
>
> "I don't want to be rude if I decide it isn't for me."
>
> "You can tell us that. Looking around is not an agreement to attend."
>
> Now the schedule can be discussed in the light of the actual question.
>
> Listening did not require a more impressive answer. It required noticing that the prepared answer might be addressing the wrong concern.
>
> This is where Awareness, Communications, and Engagements meet. A useful

> **In Context — The question underneath**
>
> explanation responds to what the person needs to understand, not only what the organization is ready to say.
>
> A team also needs permission to pause. A script can support someone without requiring them to complete it regardless of the answer. A leader can make time for a question instead of treating every departure from the agenda as a delay.
>
> And listening to ourselves can include recognizing that we are tired, uncertain, or in need of help before continuing.

What might we hear if we were not already preparing our answer?

R6.3 — Love Becomes Visible in What We Do

“There can be no love without justice.”

— **bell hooks**, from “To Love Again: The Heart of Feminism” in *Feminism Is for Everybody*, as quoted in the publisher’s description.[147]

Writing about feminist politics, hooks connected love with freedom from domination, equality, and mutual respect. The sentence belongs within that argument, not merely in a collection of comforting remarks about kindness.[147]

For care, it invites a demanding but hopeful question: does our concern show up in the way decisions are made?

We may describe a service as welcoming. Who can actually use it? We may encourage someone to express a preference. What happens when the preference is inconvenient? We may praise a caregiver’s devotion. Have we made any of the work easier to share?

Love becomes visible in the answer.

Consider a family planning conversation. Instead of letting the person with the most time on the call become responsible for everything, the adults discuss what each can realistically accept. The person receiving care remains part of the decision. Private concerns have an appropriate route.

Or consider an organization that learns its invitation assumes every household has a nearby relative and a smartphone. It revises the invitation and provides another way to reach the service. The words change because the offer changes.

These are proposed applications of the challenge hooks presents. They connect love with autonomy, access, and responsibility rather than affection alone.

We can begin without pretending that every difficult arrangement will be settled. Ask whose voice is missing, whose work has become invisible, and which decision we have the authority to change.

The purpose is not to judge whether a tired family has loved well enough. It is to make

caring less dependent on someone continually surrendering their own needs. That distinction runs through the book's writing guidance and support chapters.

Where should our stated concern become a different decision?

R6.4 — Belonging Requires a Real Place at the Table

"Disability only becomes a tragedy when society fails to provide the things we need to lead our lives…"

— **Judy Heumann**, in a 1987 interview recalled by journalist Joseph Shapiro in 2023.[148]

Heumann challenged exclusion from education, work, and public life. In the interview passage, she named employment opportunities and accessible buildings as examples of what society should provide. Her disability-rights work asked people to examine the barriers around a person, not regard that person's life as a tragedy.[148]

The invitation to care organizations is more substantial than making room for someone after the plan is complete. It is to involve the people affected while the plan can still change.

In Context — The invitation is not enough

A home-support organization invites service users to review its new first-visit process. The invitation offers only an online meeting and asks people to complete a written questionnaire beforehand.

One participant phones.

"I can talk with you. I can't use that form."

The coordinator offers a telephone conversation without the questionnaire. The participant explains that the most difficult part of the existing process is not the visit itself. It is discovering who will respond when the arrangements change.

The team now has a different design question—and someone who wants to help examine the answer.

Belonging includes an effective way to contribute. It also includes the freedom not to join a committee in order to receive a usable service.

For CarePhysics, this connects Community with accessible Technology and meaningful choice. Ask about language, format, timing, and preferred involvement. Do not infer those preferences from an identity or diagnosis.

Provide a named response to the contribution. Explain what changed, what could not change, and why. If an access problem requires staffing, equipment, or money, bring it to someone able to address that resource need.

A person's presence at the table should be capable of changing what happens there.

Who is affected by this decision but missing from the conversation?

R6.5 — The People Who Care Deserve Care Too

“Rest is my natural state. It is my birthright.”

— **Tricia Hersey**, in a *Here & Now* interview, April 21, 2022.[149]

Hersey’s work through The Nap Ministry and *Rest Is Resistance* connects rest with dignity and challenges systems that treat people as instruments of production. Its foundations include Black liberation and womanist thought—a tradition centering Black women’s lives and perspectives. The work is not simply a recommendation to sleep so that we can produce more afterward.[150]

That distinction matters in a book about care.

Someone should not have to justify rest by promising to become a more efficient caregiver. A worker’s need for a break should not depend on being sufficiently exhausted to earn sympathy.

In our application, the question becomes what support would allow the person to set something down.

For a caregiver, that may mean appropriate assistance being provided while they choose how to use the time. No report of how productively the break was spent is required.

For staff, it may mean removing duplicate entry, providing coverage, or arranging protected time for preparation. For a volunteer, it may mean a bounded role and a straightforward way to say they are unavailable.

Encouragement without those arrangements can become another expectation. An organization should not put a message about rest on the wall while depending on people to finish essential work at home.

Chapter 11 asks who supports the people on whom the care plan depends. Hersey’s contribution helps us resist a narrower answer in which support is valuable only because it extracts more work later.

You can care deeply and need a limit. You can be committed and need someone else to take over an agreed task. Neither requires an apology for being human.

What could someone set down because we changed the support around them?

R6.6 — Compassion Needs Something Practical Behind It

“The idea that some lives matter less is the root of all that is wrong with the world.”

— **Paul Farmer**, as quoted by Partners In Health.[151]

Partners In Health, which Farmer co-founded, places equal worth alongside solidarity, accompaniment, and partnership in describing its work. Accompaniment means continuing alongside people as they pursue care, rather than regarding the initial recommendation as the end of the responsibility.[151]

For CarePhysics, that turns compassion toward the practical arrangements that make help reachable.

A person may understand a recommendation and still be unable to act. Before offering more encouragement, ask whether the obstacle is cost, transport, language, timing, an unanswered request, or something else. Different barriers call for different responses.

A hospital and a community service can agree who will receive a request, who will contact the person, and what happens if the service cannot accept it. A home-care organization can explain how a change is handled without making a family call every possible replacement themselves.

Where the support is unavailable, say so and keep the need visible. A reassuring message cannot provide a missing worker or vehicle. The next responsible action may be to investigate another option, revise the arrangement, or bring the gap to a funding or service-planning discussion.

Compassion therefore belongs in budgets, response capacity, training, and partnership agreements as well as conversations.

It also belongs in honesty. Do not ask a family to depend on a promise nobody has accepted. Do not describe a sent referral as received care.

The contribution Farmer's words invite us to consider is not only whether we feel concern for someone. It is whether our choices reflect equal concern when their needs are costly, complicated, or easy to overlook.

What help is actually received after our compassionate words are spoken?

R6.7 — Hope Does Not Require an Easy Life

"It's possible to live a good life, even though it isn't an easy life."

— **Rachel Naomi Remen**, in conversation with Krista Tippett.[152]

Remen spoke about her own experience of illness and her work as a physician when she made this observation. In the same conversation, she distinguished curing from the wider human work of helping people live with illness, loss, and uncertainty. The reflection did not dismiss medical treatment; she acknowledged its importance in her own life.[152]

There is room in that perspective for hope without a prediction.

Care can support something worthwhile today even when the future is uncertain. The worthwhile thing belongs to the person: a conversation, a practical decision, quiet company, an activity, or simply time without another demand.

> **In Context — A different kind of visit**
>
> A family member arrives with a familiar game. The person they have come to see looks at it, then toward the window.

> **In Context — A different kind of visit**
>
> “Would you rather sit here?”
>
> “For a while.”
>
> They put the game away. There is no need to rescue the visit by completing the activity they brought. They remain together, and the conversation starts when it starts.
>
> The scene is small. It does not resolve the illness or establish a clinical outcome. It shows a choice that the people involved can recognize as their own.
>
> We should not ask someone to find a lesson in suffering before offering support. Grief does not owe us an optimistic conclusion. A difficult day need not be described as a missed opportunity for growth.
>
> Instead, ask what could make the present more manageable, comfortable, or connected. Listen to the answer without requiring it to be inspiring.
>
> Meaningful participation includes enjoyment and rest. Sometimes hope lies in knowing that there is still something to choose—and someone willing to help make that choice possible.

What would make today more worthwhile without pretending that everything is all right?

R6.8 — Begin Where You Can Make a Difference

“In order to change society, we have to transform ourselves.”

— **Grace Lee Boggs**, in Roadtrip Nation’s interview profile.[153]

Boggs’s community work in Detroit connected personal change with collective action. In her writing on community-building education, she described people working to reshape their neighborhoods and schools while also changing through that work. The emphasis was not on individuals improving themselves in isolation from the conditions around them.[154]

For a care organization, we can take that invitation into our own practices before asking everyone else to change.

When people cannot reach us, examine the route. When staff raise the same difficulty repeatedly, examine what our response has been. When a partnership produces more referrals but no additional capacity, examine the plan rather than celebrating its activity.

Start with a question shared by the people affected. Give them an appropriate way to contribute, including those who cannot attend a formal meeting or comfortably use the chosen technology.

Then choose a change that someone has the authority and resources to make. A small

beginning is not a reason to ignore a larger injustice; it is a place to begin learning and accepting responsibility.

This is the connection to shared learning and the first meaningful pathway. We can improve one introduction, one response process, or one recurring encounter while retaining an honest account of what remains unresolved.

A community or state group can help carry those findings into decisions that one local organization cannot make alone. Local experience deserves to inform the larger discussion, not disappear beneath an average.

The encouraging possibility is that we need not arrive with every answer. We can begin with a real question, listen across roles, and let what we learn change our own work.

What should we change about our own way of working before asking others to change?

R6.9 — The Wisdom That Never Appears on a Book Cover

The people quoted here have public records of their work. Much of the wisdom care depends on arrives another way.

A participant explains why an activity would be easier to choose at a different time. A patient corrects an assumption in the instructions. A caregiver identifies the arrangement that repeatedly creates extra work. A volunteer discovers a clearer way to show someone where to go.

These are kinds of contribution to invite—not testimonials we can invent or assume every organization has already collected.

CarePhysics has acknowledged families, patients, caregivers, researchers, and care professionals as contributors since its earlier manuscript. That gratitude should remain part of how the work is done, not only its opening pages.

Ask who noticed the useful idea. Make it possible for them to explain it. Record what was considered, what was tried, and what changed. Return to the contributor with the result, including when the proposal could not be implemented or did not help.

A local success deserves recognition without being made into a universal claim. An unfavorable finding deserves attention without making its contributor seem unhelpful.

Permission matters. Someone may welcome use of the lesson while keeping their name or personal story private. Another may want appropriate credit. Ask rather than assume.

The dated Day Center materials describe ways for staff and families to contribute observations and feedback. The larger invitation is to make such contributions part of a reviewed learning process, not simply a collection of favorable comments.

You do not need a published quotation to offer something worth hearing. A careful observation, a candid question, or a better way to explain a task can give the next person a better starting point.

What has someone receiving or providing care taught you that deserves to be carried forward?

R6.10 — Carry One Thought into the Next Encounter

There is no requirement to turn this chapter into a program.

Choose a thought that stays with you. You may keep it privately, discuss it with someone, or use it to examine an ordinary part of care. It need not become a public pledge.

For a team, one reflection could begin a voluntary discussion during protected work time. For a content creator, it might inform an original article or a short demonstration of a respectful conversation. An optional question could invite people to identify a part of the service they would change.

Keep the source and original context with any quotation. Distinguish the speaker's words from your interpretation. A poem, interview, or philosophical argument should not be relabeled as clinical evidence.

If the material invites a question or request for help, name the responder and explain what follows. Provide appropriate language and access alternatives. Familiar structure can make the invitation easier to use without requiring everyone to respond in the same way.

Assistance that protects the human purpose

An approved AI assistant could work with reviewed passages and an organization's own guidance to prepare discussion questions or draft an original care example. A person checks the quotation, its context, and the proposed application before use. Do not ask the assistant to impersonate the speaker, invent an endorsement, or alter words inside quotation marks.

Keep sources, owners, review dates, permitted uses, and corrections. Separate research, reflective writing, local service facts, fiction, and private information. The proposed workflow remains retrieval, local context, drafting, human review, testing, and revision; uploading a book is not model training.

Used with appropriate knowledge, guidelines, and rules, assistance can reduce repeated preparation and help a team give more attention to people. That is an opportunity to test, not a reason to expand its role without review. Genus supplies technology; partners retain their care, staffing, programs, and voice.

Let the thought change something real

For one service change, compare the experience with the current process over an agreed period. Name who reviews it. Ask whether people understood the offer, could use it, and received the support. Count all requests due for response, not only those successfully answered. Include staff effort, family workload, safety, privacy, and access.

Reading, sharing, or praising a quotation is not a measure of compassion. Willingness to

recommend, an actual referral, and a received service are different results. No family or staff member should be ranked by enthusiasm for this chapter.

Inspiration should leave people with room to act, ask for help, or rest—not another standard they fear they cannot meet.

A leader may respond by making time. A professional may ask a better question. A family may agree on one bounded responsibility. A participant may help redesign an invitation. A person who has carried too much may recognize that their own need for support belongs in the conversation.

None needs to be grand to be worth doing.

We honor these voices not only by remembering their words, but by making more room for their wisdom in how we care for one another.

Next: R7 — Words from the Front Line

Notes

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Return to text

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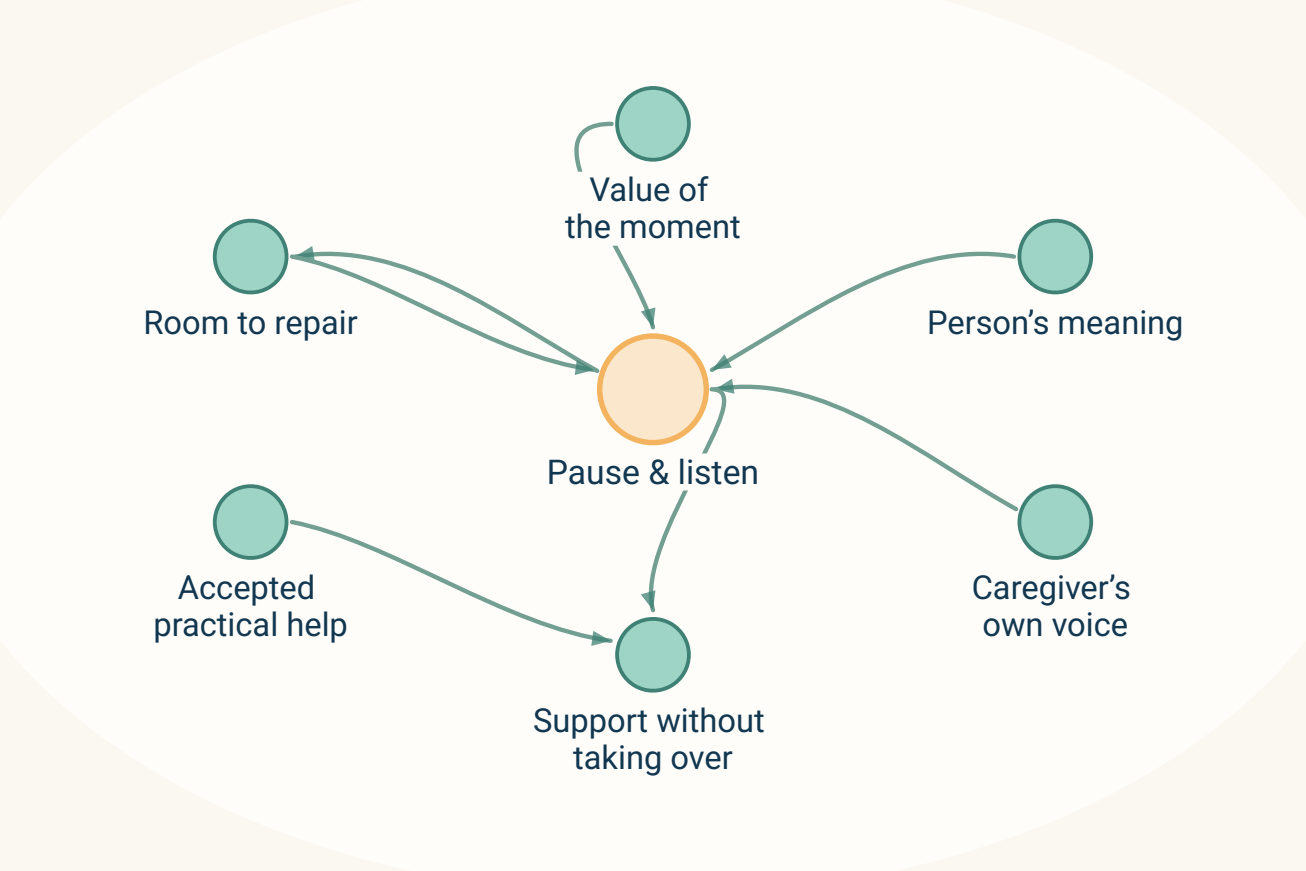
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R7 — Words from the Front Line

Small Sentences That Give Us Room for Grace



Connection map — Give the next response room to change

Notice what this moment does and does not need to accomplish before responding. Ask what the person means rather than assume the same words mean the same thing to everyone. Hear the caregiver's account of their own life. Listening helps identify support that leaves a chosen part with the person. Accepted practical help can make that support usable. A pause can make room to return to a sentence that needs repair. Repairing the conversation means listening again rather than defending the original response. The chapter includes two autobiographical family recollections and ten fictional reflections. These are invitations to reflect, not outcome evidence or a demand for a perfect conversation.

At a Glance

The central idea: An ordinary sentence can give us a reason to pause, a different way to understand, and room to respond with greater care.

What you'll explore: Two recollections from my own family and ten fictional reflections from the lives of people receiving and providing care. Together, they invite us to consider the value of a moment, the need to be heard, the support behind a promise, and the grace to begin again.

Carry it with you: Choose a thought that speaks to your situation. You do not need to apply every

reflection, produce a perfect conversation, or turn a difficult day into an uplifting story.

Something We Needed to Hear

We have all heard words that made us pause. A child says something we had not thought to explain. A caregiver puts a difficult feeling into a few plain words. A nurse offers a sentence that makes room for us to be family rather than organize the next task.

We carry some of those words long after the conversation. They return when we need them, helping us hear a situation differently or be a little gentler with ourselves.

In the previous chapter, we considered people whose words have reached wide audiences. Here, we turn toward the kitchen table, the home visit, the Day Center, the hospital room, and the conversation between colleagues. The person receiving care belongs among these voices—not only as the subject of what other people say.

The words do not have to be famous to change what we hear.

The first two passages are my own recollections. The ten that follow are original fictional dialogue created for this chapter, with imagined contexts. They are not collected quotations, anonymous testimonials, or accounts of actual professionals. They offer situations in which you may recognize a question or remember a moment of your own.

We are not looking for hidden meanings we can confidently assign to strangers. We are making room to ask, to listen, and sometimes to revise the answer we were about to give.

Grace, here, means room to be human: to care deeply without always knowing what to say; to acknowledge a mistake; to accept help; and to recognize that an encounter can matter without resolving everything.

R7.1 — The Value of the Moment

The memories and the moment

“The memories are for me, the moments for my grandmother.”

> **In Context — Joe’s recollection**
>
> I remember my son saying those words. He understood that his grandmother could enjoy their time together even though she would not remember the encounter afterward. He could carry the memory. She could have the moment.
>
> Two people could receive different things from the same time together, and both could matter.

His words give me a way to think about what we ask of a visit. Must it lead to a story that can be retold? Must the conversation stay on course? Must the person remember who came or what they did before we regard the time as worthwhile?

My son's observation invites a different starting point: what is this time like for the people sharing it?

For another family, that might mean reading a little, listening to music, looking at a picture, or simply being nearby. The activity is an invitation. It can change or stop. A person need not demonstrate what they remember to earn the company.

This also offers grace to the visitor. You do not have to create an extraordinary experience every time. You can arrive as a son, daughter, grandchild, friend, or neighbor—not as someone responsible for producing an improvement.

Children in particular should remain family members, with adults providing the support they need. Their presence is not a treatment assignment.

My son's words do not tell us what every person experiences. They remind me not to make future recall the condition under which I value present enjoyment.

What are we asking this moment to accomplish that it does not need to accomplish?

The same words, different lives

"I just wanna go home."

> **In Context — Joe's recollection**
>
> My daughter said this when she was young and struggling. Later, I heard the same request from my father.
>
> Their situations were different. What connected the words for me was a longing I came to hear beneath them: a wish to return to when everything felt okay.
>
> In those conversations, talking about happy experiences—fishing, camping, a walk—helped ease some of the immediate stress and shift the conversation. We could speak about something familiar and good without first finding an answer to everything that was difficult.

That is how I understood those experiences. I would not turn that understanding into a rule about what everyone means by home.

Someone else may mean an actual place. There may be a practical concern, discomfort, or a question we have not answered. The request deserves attention before we decide that a different subject would be more helpful.

What I carry forward is not a technique for making someone stop asking. It is a reason to listen more closely.

The words may invite us to ask what feels unfamiliar, what is missed, or what the person wants us to understand. They may also remind us to offer company while a concern remains unresolved.

For my daughter and my father, recalling happy moments gave those conversations

another direction. It did not make their situations the same. It helped me recognize that answering the words and responding to the person were not always the same task.

You do not need to find a hidden explanation every time. Sometimes the thoughtful response is to admit that you do not yet understand and stay curious. Sometimes it is to bring in someone who can help with the actual need.

What might help us understand what this person means by “home” today?

R7.2 — Hear Before Answering

When the explanation is not the whole answer

“I know you explained it. I’m still scared.”

> **In Context — Fictional illustration: a patient and a nurse**
>
> The nurse has explained the next steps. The patient can describe them. As the conversation appears to be ending, the patient says these words.
>
> The nurse could repeat the explanation. Instead, she asks, “What feels most frightening right now?”
>
> The patient is worried about being at home when another question arises. Together, they review the appropriate contact and what to do when help cannot wait. The nurse checks whether something else remains unanswered.

The conversation does not have to end with a declaration that the fear is gone. It can end with the concern better understood and the relevant support made clearer.

In this scene, the patient was not asking the nurse to prove that she had already done her job. The patient was giving her another piece of information.

For those of us trying to help, there is grace in that distinction. Another question is not necessarily evidence that we explained badly. It may reveal the part we have not discussed yet.

For organizations, this means leaving room beyond delivery of the information. A video or article can prepare a conversation; it should not be treated as evidence that there is nothing left to ask.

Have we answered the question—or only finished the explanation?

When the caregiver is the person being asked

“When you asked how I was, I thought you meant him.”

> **In Context — Fictional illustration: a family caregiver and a social worker**
>
> A caregiver has described appointments, meals, and the difficult parts of the week. The social worker asks how she is doing.
>
> She begins another account of her husband's day.
>
> "I do want to hear about him," the social worker says. "I'm also asking about you."
>
> The caregiver pauses, then offers the sentence above.

The social worker gives her time and explains the available private route for concerns she does not want placed in a shared family update.

This is not an invitation to provide another report. It is an invitation to have an experience of her own.

The answer might concern sleep, friendship, work, worry, or an arrangement that has become too much to carry. It might be that she does not want to discuss it today. Either way, the question belongs to her.

A family can make the same distinction. A call can include the person doing the caring without turning them into a source of updates about someone else.

And when a caregiver does name a need, the next response matters. Help may require an agreed task, a professional conversation, or a service the organization must investigate. Being noticed is a beginning, not a substitute for what has been requested.

When did we last ask this person about their own life—and leave room for the answer?

R7.3 — Help Without Taking Over

Staying nearby

"I can do this part. Could you stay nearby?"

> **In Context — Fictional illustration: a Day Center participant and a volunteer**
>
> A participant is arranging place cards for a small group. A volunteer reaches to finish the stack so everything will be ready.
>
> The participant asks her to wait.
>
> "I can do this part. Could you stay nearby?"
>
> The volunteer leaves the cards within reach and asks which part he would like help with. They continue together, with him doing the portion he chose.

There is no need to stage a success or make the task a test. The useful change is that the

offer of help now fits the request.

Support and control can look similar when we are moving quickly. Finishing for someone may feel efficient while taking away the part they wanted to do. The question to ask is not simply whether assistance is needed, but what kind is welcome and appropriate.

This example concerns an ordinary activity. Care tasks with safety requirements need the relevant professional guidance. Preserving choice does not mean leaving someone without necessary assistance.

For a volunteer or staff member, the invitation is modest: ask before assuming the whole task is yours. For the person receiving help, there can be room to request both independence in one part and company in another.

Needing someone nearby does not cancel the contribution being made.

Which part does this person want to do, and what support would let that remain theirs?

Being the one who learns

“She showed me how to do it. For a while, I was the one learning.”

> **In Context — Fictional illustration: a home-care worker reflecting with a colleague**
>
> During an agreed household activity, a woman and her home-care worker arrange a few flowers in a jar. The worker begins placing them together.
>
> The woman suggests a different arrangement and shows how she wants the stems positioned. The worker follows her lead.
>
> Later, describing the exchange to a colleague without sharing private details, the worker says these words.
>
> The woman was receiving assistance. She also had something to offer. Neither fact displaced the other.

CarePhysics asks us to make room for contribution without requiring it. A person might choose to share a skill, recommend a story, explain a familiar routine, or suggest a better way to do something. They may also want to enjoy the company without teaching anyone.

In this example, the worker did not need to invent a special role or offer exaggerated praise. She needed to notice whose knowledge was relevant and be willing to use it.

The same invitation belongs in a health-system planning meeting or a community program. A patient or participant may know something about the practical experience that the team has not yet considered.

Let the knowledge change the work. Ask before recording or reusing a personal story,

and give credit in the way its contributor prefers.

What might this person show us if we stopped assuming all the useful knowledge was ours?

R7.4 — Leave Room to Be Family

A visit without an agenda

“Could you come over without a list, just this once?”

> **In Context — Fictional illustration: a parent and an adult child**
>
> The daughter’s list holds important things: a call to make, a form to review, an arrangement to confirm. She brings it because she wants to help and does not want to forget anything.
>
> Her father’s request is not a declaration that the work is unnecessary. He is asking whether there can also be time that belongs to their relationship.
>
> They look at what genuinely needs attention. A call can be made before the visit. Another task can be handled by someone who agrees to it. They decide which work will remain for a later conversation.
>
> Then they make room for a visit that is not organized entirely around getting through the list.

There is no failure of love on either side. The daughter is trying to carry responsibility. Her father is asking for ordinary company. Both deserve support.

The answer should not be another demand that the daughter somehow find more time. It may require the family or service to share the work differently.

This is one place an organization can help preserve relationships: make necessary arrangements clearer and remove avoidable coordination. The distinction remains important—love does not require one person to carry everything.

A relationship can include care without becoming only a set of care tasks.

What would need to be handled differently so this visit could contain more than arrangements?

Someone else has accepted this part

“You can just sit with her. We’ve got this part.”

> **In Context — Fictional illustration: a hospice nurse and a relative**
>
> The nurse has explained the care the team is providing during this visit and who is responsible. The relative keeps asking what else needs doing.
>
> The nurse offers the sentence above, then leaves room for a question.
>
> The relative can sit beside the person she loves. She can talk, listen, or be quiet. She does not have to invent a task to justify being there.
>
> The reassurance rests on the words *this part*. The team has accepted a specific responsibility. It has not promised unlimited coverage or suggested that no further question will arise.

That is why the statement can mean more than encouragement. Someone has made the room it offers possible.

The relative may choose to remain involved in a task. She may need a break herself. There is no required bedside performance, no perfect thing to say, and no obligation to turn the visit into a memory worthy of retelling.

For the organization, the question is what it can truthfully take responsibility for. For the family, it is whether that accepted help can be received without being treated as a failure of devotion.

Presence does not have to be constant to be sincere. And professional support should not make a relative feel that every moment away is a moment of care withheld.

What responsibility can we genuinely hold so someone else has room to be family?

R7.5 — Make Support Usable

Time away is not always time released

“I can take the afternoon off. I can’t seem to stop being on call.”

> **In Context — Fictional illustration: a caregiver reviewing a support arrangement**
>
> The afternoon is booked. Yet the caregiver keeps the phone close and continues checking what may need changing.
>
> Instead of telling him to relax, the coordinator asks which responsibilities still reach him and what he expects to happen if the arrangement changes.
>
> Some questions concern actual gaps: who answers the provider, who can approve an agreed alternative, and what happens if the usual person is absent. Another concern is that the caregiver has not yet seen how the plan works without his involvement.
>
> They separate what can be clarified now from what needs another person to accept

> **In Context — Fictional illustration: a caregiver reviewing a support arrangement**
>
> responsibility. They agree when to review the arrangement again.

The caregiver is not asked to switch off his concern on command. Nor is the service booked on the calendar automatically counted as relief he has experienced.

A useful review asks about the preparation, interruptions, and decisions surrounding the time away. It also asks what the caregiver would like the support to make possible.

For leaders, this is a reminder to examine the whole arrangement rather than only the hours supplied. For families, it makes room for a statement that might otherwise feel ungrateful: the help matters, and part of the work is still with me.

Both things can be true.

What is still being carried during the time we call a break?

The obstacle was not the explanation

“I knew where to go. I didn’t have a way to get there.”

> **In Context — Fictional illustration: a patient and a community navigator**
>
> The appointment did not happen. The patient received the directions and understood why the visit had been recommended.
>
> When the navigator calls, the patient explains that there was no workable journey.
>
> The navigator does not begin by repeating the address. They ask what assistance is needed and check the actual transport options, including cost and availability. They explain what still needs confirmation and when the patient will hear again.
>
> The conversation has identified the problem. It has not yet supplied the ride.
>
> That distinction matters to the person who must plan around the answer. A possible resource is not a confirmed arrangement, and a telephone number is not necessarily a journey they can make.

This reflects the barrier-first approach used throughout CarePhysics: different difficulties need different responses. Someone who lacks a practical opportunity does not need to be treated as though they lack motivation.

A community or state partnership may need to address a gap that no individual navigator can resolve. Keeping the unmet need visible is more useful than recording the person as uninterested.

The grace in this sentence is also for the person seeking help. Understanding what needs doing and being able to do it are not the same thing. A practical obstacle is worth naming without apology.

Are we explaining the next step, or helping make it possible?

R7.6 — Give Ourselves Room to Learn

A conversation can be repaired

“Can I say that again? It came out wrong.”

> **In Context — Fictional illustration: a nurse revisiting her wording**
>
> The nurse has said, “You should have called sooner.” As the conversation continues, she recognizes that it sounded like blame.
>
> She stops.
>
> “Can I say that again? It came out wrong. I’m sorry. Can you tell me what made it difficult to reach us?”
>
> The patient can explain, remain upset, or say they do not want to discuss it further at that moment. The apology does not require forgiveness in return.
>
> But the nurse has taken responsibility for her words and made another kind of conversation possible.

This is not a way to make a serious error disappear with a gentler sentence. If information was wrong, correct it. If care or a response was delayed, address what happened through the appropriate process. Repair includes action where action is needed.

For the everyday moment, though, we can leave room to try again. A parent, professional, caregiver, or volunteer need not defend an unhelpful phrase simply because it was the one that came out first.

A team should also be able to reflect on such an encounter without turning it into a public test of character. Ask what support, practice, or working condition would help next time.

Grace does not mean that our words have no consequences. It means we can acknowledge those consequences without deciding that improvement is no longer possible.

Is there a sentence we could return to—not to defend it, but to make room for a better response?

Let the useful part travel

“Tell me what worked. I want the next person to know.”

> **In Context — Fictional illustration: a team lead and a volunteer**
>
> A volunteer describes a first visit. Rather than explain every activity at the door, she asked what the visitor most wanted to see. The visitor chose a quieter place to begin and asked questions there.
>
> The team lead wants to understand the exchange, not simply add a positive story to the report.
>
> What did the visitor ask for? What did the volunteer offer? Which part would require a different arrangement on a busy day? Would the visitor be willing to say whether the approach was useful?
>
> The team can prepare a general practice example without sharing the visitor's private information. The volunteer receives appropriate credit, and the next person trying the approach knows the circumstances in which it was used.
>
> One encouraging encounter does not establish a universal method. It gives the team something worth considering and, where appropriate, trying again.

Include the difficult part too. A useful handoff can say that the person preferred another approach or that something could not be provided. Learning is not improved by keeping only the flattering accounts.

This is the knowledge-sharing purpose of CarePhysics at an ordinary scale: preserve what someone noticed, review the lesson, adapt it to the next situation, and return with what happened.

A small piece of wisdom should not have to be rediscovered by every person who joins the team.

What did someone learn today that could give the next person a better starting point?

When a Sentence Becomes Support

The twelve reflections point toward different responses. One asks for company. Another asks for a practical resource. Another asks us to notice a person we have overlooked. None is a phrase to apply automatically whenever a situation seems familiar.

Start with the person, their language, beliefs, preferences, and circumstances. Ask rather than assume. Preserve their right to want a different kind of help—or not to discuss something today.

For an organization, a sentence can become a design question. Is the invitation understandable? Can someone ask privately? Does a chosen next step have a responder? Are staff given the time, training, coverage, and resources needed to follow through?

A short article could explore one reflection. A clearly labeled demonstration video could show an imperfect conversation and its repair. An optional question in a tile could

prepare a call or virtual meeting, provided the organization names who receives it and what happens next. Offer appropriate telephone, print, language, and access alternatives. Familiar structure should make help easier to find, not require another task before it can be requested.

An inspirational message cannot substitute for staffing, transport, respite, or professional care. If a reflection exposes one of those gaps, let the finding reach someone who can address it.

Let Assistance Preserve the Meaning

A team preparing a voluntary discussion could ask an approved AI assistant to work from one of these reflections and its own reviewed guidance. The assistant might draft questions or an explicitly fictional practice scene. A responsible person checks the result before use.

Keep the labels attached. My family recollections should not acquire invented details. The fictional lines should not become anonymous testimonials. A summary should not turn “I would prefer a private conversation” into a claim about someone’s family relationships or cultural beliefs.

The knowledge-bank approach keeps sources, owners, review dates, permitted uses, and corrections visible. Relevant material is retrieved, placed alongside verified local information, developed into options, reviewed, tried, and revised. Uploading a chapter is not model training or proof that an assistant will use it correctly.

This kind of preparation can be a gift when it removes repetitive work and leaves more attention for people. Its usefulness still needs to be checked, including review effort. Genus supplies technology; the partner retains its care, staffing, program, voice, and professional responsibilities.

No one needs to disclose a private encounter to contribute to the discussion. Obtain appropriate permission for real words shared later, retain disagreements, and let contributors choose how they are credited.

Carry One Thought into Tomorrow

There is no need to complete twelve exercises. Choose one sentence that made you pause.

Perhaps it changes a question you ask. Perhaps it leads a team to examine an arrangement or helps you describe a limit. Perhaps, for now, it simply lets you recognize that you are not required to know every answer.

If a team tries a service change, name an owner, look at what happens now, and agree when to review it. Include everyone offered the changed process rather than only those who responded favorably. Ask whether help was understood and received, what effort it required, and whether it created a privacy, safety, or access problem. A reflection read or shared is not a measure of compassion or a clinical outcome.

Keep the larger distinction in view: a first action, ongoing useful participation, received support, outcomes, and attributable impact are different things. So are willingness to

recommend a service, an actual referral, and another person receiving help. Do not turn these passages into a ranking of families or staff.

For the reader, the invitation is more personal.

Recall something someone said that helped you hear differently. You may know the exact words, or only remember what the conversation opened up. Keep that distinction honest. The thought can remain private; it does not need to become content to matter.

There will be moments when the careful words do not bring the response you hoped for. Another person may remain afraid or upset. You may be tired, or discover that the needed help is not yet available. That is not an instruction to try harder indefinitely or to turn disappointment into gratitude.

It is a reason to look again, seek appropriate support, and give the next response a chance to be different.

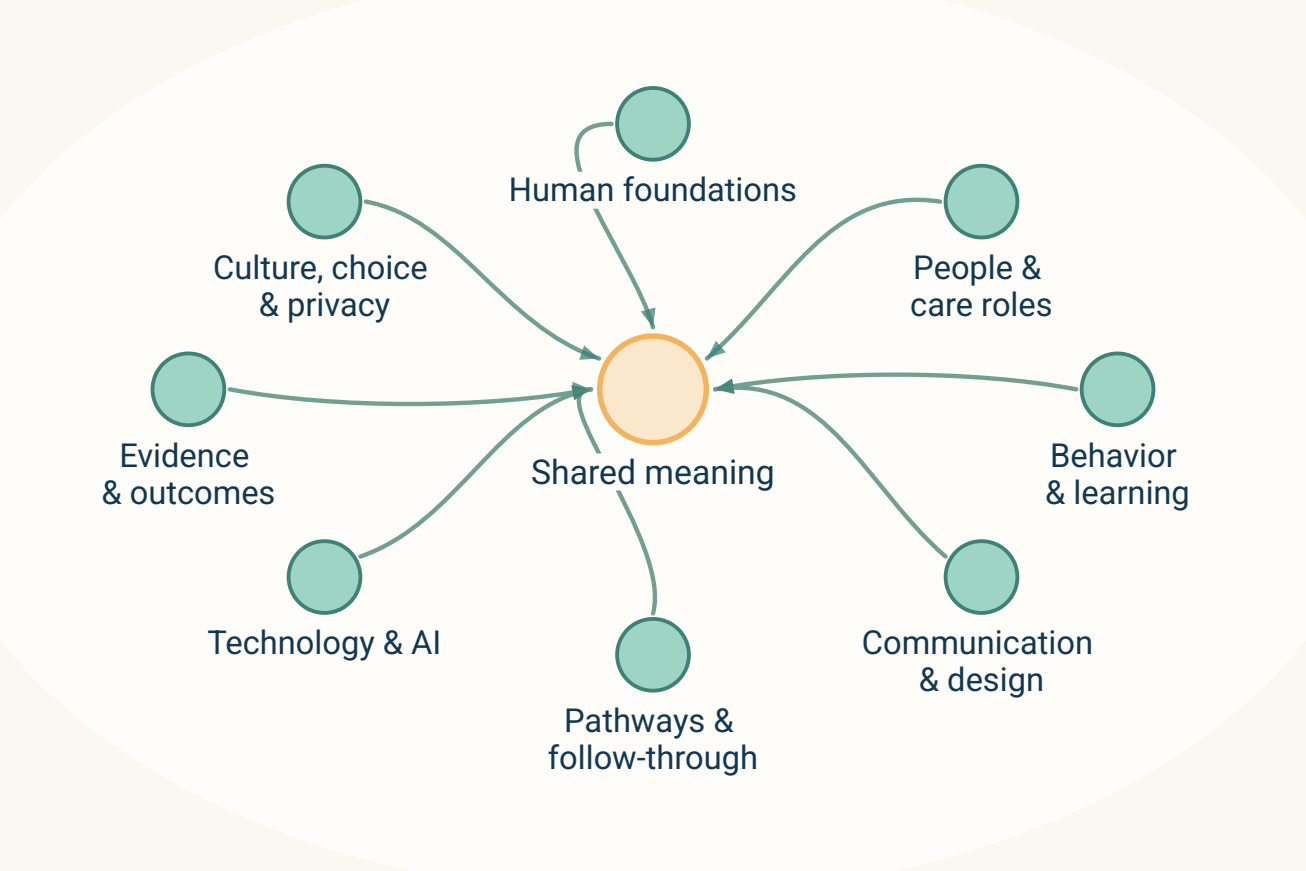
My son's words return us to the beginning: the memory he could carry, the moment his grandmother could enjoy. They did not need the same thing from the encounter for it to matter to both of them.

We can bring that generosity into the next conversation. Listen for what is being asked. Offer what we can truthfully provide. Ask for help with what we cannot carry alone.

Sometimes the words we carry forward are simply the ones that help us meet the next moment with a little more understanding—and give ourselves a little grace.

R8 — A Shared Language for Care

Terms, Meanings, and Useful Distinctions



Connection map — Shared words, useful distinctions

Human-foundation terms clarify the CarePhysics framework. People and care-role terms help clarify responsibilities and settings. Behavior and learning terms help distinguish the models being discussed. Communication and design terms help describe the experience being prepared. Pathway terms distinguish requests, coordination and follow-through. Technology and AI terms clarify assistance and knowledge stewardship. Evidence and outcome terms help distinguish what was observed from what can be claimed. Culture, choice and privacy terms make important boundaries and source status explicit. Definitions help people understand one another; they do not establish eligibility, availability, clinical advice or product effectiveness.

At a Glance

Use this section: Browse the eight subjects, look up a word in the A–Z finder, or follow a chapter reference for a fuller explanation.

The central idea: Shared language should make care easier to understand—not create another requirement before someone can ask for help.

An important distinction: Some entries explain CarePhysics's own usage; others summarize

established concepts or professional terminology. Definitions do not establish service availability, eligibility, clinical advice, or product effectiveness.

R8.1 — How to Use This Glossary

You should not have to guess what a word means before you can use an idea. This glossary explains the language used throughout CarePhysics, adding a short example or distinction where it helps.

The entries are grouped by subject and alphabetized within each group. The A–Z finder points to those same entries; there is only one definition to maintain, or one explicitly labeled set of meanings when a word has several uses.

In this book identifies an editorial meaning rather than a universal definition. The care-role descriptions explain functions, not professional licensing rules. Source citations support established concepts; targeted checks of public professional guidance supplement the manuscript where clinical, technical, or privacy terminology needs precision.

The short examples are hypothetical, not reports of a program's results. The glossary adds no events to Pat and Ellen's story.

The ten principles, in their established order

Chapter	Principle and chapter subtitle	Glossary group
1	**Holistic Care — See the Person**	A
2	**Awareness — Make Understanding Possible**	A
3	**Behavioral Influence — Support the Next Chosen Step**	A
4	**Communications — Help People Feel Heard**	A
5	**Community — Make Belonging Practical**	A
6	**Engagements — Make Each Interaction Worthwhile**	D

Chapter	Principle and chapter subtitle	Glossary group
7	**Pathways — Turn Good Intentions into Supported Progress**	E
8	**Technology — Make Help Easier to Reach**	F
9	**Care AI — Bring Human Wisdom Within Reach**	F
10	**Scoring — Learn What Helps**	G

Chapters 11–15 apply these principles. The reference chapters provide additional explanations and resources; they do not introduce more principles.

R8.2 — Terms by Theme

R8.2A — The CarePhysics Framework and Human Foundations

These entries describe the book's usage. Human commitments run through the principles; they are not extra principles or scores assigned to people.

Awareness. The second principle: helping people understand what is known, what remains uncertain, what happens next, and where to ask for help. Exposure to information alone is not understanding.

Behavioral Influence. The third principle: understanding barriers and supporting a feasible next step the person chooses. It is not a license to pressure someone into the organization's preferred decision.

CarePhysics. An evidence-informed framework of ten principles for designing care people can understand, choose, use, and share. It combines established ideas with local knowledge; it is not a set of literal laws or proof of product effectiveness.

Communications. The fourth principle: listening, explaining, asking, disagreeing respectfully, and making commitments understandable. The book uses the plural to include conversations, messages, and other forms of communication.

Community. The fifth principle: relationships and resources through which people can belong, receive support, and contribute. A directory can support community work but does not itself supply a dependable service.

Compassion. In this book, recognizing another person's difficulty and responding with concern and appropriate help. The practical response matters alongside the words.

Connected outcomes. The reflective phrase used in R5 for what people can better

understand, choose, receive, contribute, or enjoy when knowledge, relationships, and practical support work together. It is not a validated score or mathematical multiplier.

Contribution. Something a person chooses to offer: an idea, preference, skill, observation, or practical help. Contribution is an opportunity, not a condition of deserving care.

Dignity. Treating someone as a person of inherent worth, whose identity, preferences, boundaries, and voice matter regardless of illness, ability, or participation.

Grace. In R7, room to be human: to need help, acknowledge a mistake, rest, or try again without expecting a perfect encounter. It does not remove responsibility for correcting harm.

Holistic Care. The first principle: understanding the whole person and the circumstances around care, including health, relationships, practical resources, beliefs, strengths, and what matters to them.

Love. Concern made visible through attention, patience, honesty, boundaries, and practical help. In this book, love belongs to people; it does not require one person to carry everything.

Principle. A guiding commitment that helps examine a design or decision. The ten CarePhysics principles organize inquiry; the later application and reference chapters do not add new principles.

Purpose. The personally meaningful reason something is worth doing, preserving, or enjoying. A person's purpose may differ from an organization's target for participation.

Trust. Confidence earned through truthful information, respected boundaries, appropriate judgment, correction, and dependable follow-through. Calling a tool trusted does not establish that it is trustworthy.

R8.2B — People, Roles, and Care Settings

Role descriptions below explain their use in the book. Professional scopes, eligibility, staffing, services, and coverage must be checked with the responsible organization; a title alone does not settle them.

Activities of daily living. Basic personal tasks such as eating, dressing, bathing, using the toilet, and moving into or out of a bed or chair. Abbreviated ADL or ADLs; not the name of one particular assessment.[155]

Age-Friendly 4Ms. The framework of What Matters, Medication, Mentation, and Mobility in the Age-Friendly Health Systems initiative led by The John A. Hartford Foundation and IHI. It links assessment with action on all four elements. This book's 4Ms-informed applications are not claims of recognition or endorsement. See Chapter 1 and R1, sources CG4–CG7.

Care team. The people with agreed responsibilities in the person's support. In this book, the wider team may include professionals and chosen supporters, without making their duties or information access identical.

Caregiver strain. The demands and effects a caregiver experiences in relation to care. Ask about their own account; a busy schedule or service booking does not establish how strained or relieved they feel.

Caring for Caregivers (C4C). RUSH's caregiver-support model: identify caregivers, understand their needs, and assist through an individualized support process with follow-up. Caregivers' own health and privacy matter. This is a practice model, not evidence that a Genus feature improves outcomes. See Chapter 11 and R1, CG1–CG3.

Community partner. An organization or group contributing an agreed service, resource, or relationship. Partnership does not automatically transfer care responsibility or authorize information sharing.

Day Center. The book's preferred name for an adult day-services setting. Programs may offer daytime activities, meals, personal assistance, or health-related support; the actual services and eligibility vary. It is not simply another name for every community center.[156]

Family caregiver. A relative, partner, friend, or other close supporter who provides care outside a professional role. The term identifies a responsibility, not the person's whole identity or automatic decision-making authority.

Home care. Here, the broad term for support provided at home, including help with personal or household activities. Ask what the service includes; do not assume the term means skilled home health.[156]

Home health. Health services delivered at home, such as skilled nursing or physical, occupational, or speech-language therapy. The label does not establish which services a person qualifies for or who pays.[157]

Hospice. Care focused on comfort, quality of life, and support for a person approaching the end of life and those close to them. It describes an approach and service, not only a building; eligibility and arrangements require local confirmation.[158]

Instrumental activities of daily living. Activities supporting everyday life at home, such as preparing meals, shopping, managing money, and using communication devices. Abbreviated IADL or IADLs; distinct from basic personal-care activities.[155]

Mentation. Thinking and mental functioning. In the 4Ms framework, this domain addresses dementia, depression, and delirium. Observations are not diagnoses; appropriate clinicians assess and respond. See R1, CG4.

Navigator. In the book, a person helping someone understand options, address access barriers, and follow an agreed connection to support. Their training, authority, and responsibilities depend on the service.

Palliative care. Specialized care addressing symptoms, stress, and quality of life during serious illness. It may accompany treatment directed at the illness and is not limited to hospice or the end of life.[159]

Participant. A person taking part in a program, activity, or research study. Specify the setting: Day Center participation and research participation carry different arrangements and permissions.

Patient. A person receiving healthcare. Use the term where the clinical role matters, without reducing the person to that role or their diagnosis.

Person receiving care. A broad term for the individual whom the care or support is intended to serve. It keeps the person visible across clinical, home, and community settings.

Respite. Temporary care or support provided so the usual caregiver can take a break. In Chapters 10–11, usable respite means the support actually happened and the caregiver could use the time—not merely that it was booked.[160]

Social worker. A professional whose work may include psychosocial support, family conversations, resource navigation, and coordination, according to their qualifications and role. Sam's responsibilities in the story do not define every social-work position.

Volunteer. Someone offering time or skills in a voluntary role. Here, the role has agreed boundaries, preparation, and support; willingness does not substitute for required professional qualifications.

R8.2C — Behavior, Motivation, and Social Learning

These brief explanations point back to R2 and R5. A model helps frame a question; its name does not prove the effectiveness of a particular intervention.

Agency. A person's ability to take part in shaping their actions and circumstances, including with support. In the book, agency means more than being offered a choice nobody is prepared to honor.

Autonomy. In Self-Determination Theory, acting with a sense of choice and personal endorsement. Autonomy does not require doing everything independently.[3]

Behaviour Change Wheel. A framework connecting analysis of behavior through COM-B with intervention and policy options. It guides design; it is not itself a complete care intervention.

Capability. In COM-B, the physical and psychological ability needed for a specified behavior, including relevant knowledge and skills. This differs from whether resources are available or the person wants the action.

COM-B. Capability, Opportunity, and Motivation in relation to Behavior. It asks what enables or obstructs a specified action, rather than treating every difficulty as a motivation problem.

Competence. In Self-Determination Theory, experiencing effectiveness and developing mastery. In professional training, competence concerns meeting the requirements of a task or role. Feeling capable and demonstrating an assessed skill are different.[3]

Complex contagion. In network research, adoption that depends on reinforcing social signals rather than information passing through one contact alone. Here, contagion concerns the spread of behavior, not infectious disease.

Exploration. In Social Physics, encountering information, people, and approaches beyond the familiar circle. Discovery does not establish that a resource is appropriate or

available.

Fogg Behavior Model. BJ Fogg's model of motivation, ability, and a prompt coming together at the moment of action. In this usage, ability includes how easy or difficult the action is. See R2.3.

Idea flow. How ideas move through relationships and groups. The term concerns the movement and use of knowledge, not merely the number of messages transmitted.

Motivation. In COM-B, processes that direct behavior, including reflective intentions and more automatic responses such as habits. It is not a rating of how much someone cares.

Motivational interviewing. A collaborative conversation method that helps people explore their own reasons, concerns, and mixed feelings about change. It is not a script for securing agreement. See R2.5.

Opportunity. In COM-B, physical and social conditions outside the person that make action possible or prompt it—for example, available time, transport, or support.

Relatedness. In Self-Determination Theory, a sense of meaningful connection with others. Contact counts do not establish that someone feels understood or supported.[3]

Self-Determination Theory. Ryan and Deci's theory of motivation, including the psychological needs for autonomy, competence, and relatedness. It distinguishes personally endorsed action from externally controlled participation. Abbreviated SDT.[3]

Self-efficacy. A person's belief that they can perform a particular action. Confidence in performing a task is different from its observed performance or a professional competency assessment. See R2.4.[111]

Social Cognitive Theory. Bandura's account of reciprocal influences among personal factors, behavior, and environment. Learning from others is one component, not the entire theory.

Social learning. Learning through observing, discussing, and working with other people's experience. In this book, the lesson still needs review: social learning can spread errors as well as useful knowledge.

Social Physics. Alex Pentland's perspective on idea flow, patterns of interaction, and collective learning and behavior. Its use of engagement differs from a designed CarePhysics encounter. See *Engagement*, R2.4, and R5.

Social support. Emotional, practical, or informational help available through relationships. In care planning, identify what someone can actually rely on rather than assuming a large network supplies the needed help.

Theoretical model. An organized explanation of relationships among concepts that helps frame questions or predictions. It differs from an AI model and from a service model describing how care is organized.

R8.2D — Communication, Content, and Experience Design

These entries connect the design practices in Chapters 2, 4, 6, and 8. The glossary

preserves one meaning across formats without requiring identical wording.

Accessibility. Whether people with differing abilities and access needs can use the information, environment, or service, with appropriate support. A simpler sentence alone does not establish accessibility.

Adaptation. A deliberate change for a different person, audience, setting, or situation. Record what changes and preserve the facts, essential safeguards, and purpose that must remain. See R3 and Chapter 13.

Co-design. Developing an experience with the people who will receive or provide it, so their contributions can influence decisions—not merely asking for approval after the design is finished.

Content. The information or material used in an experience: words, images, video, audio, questions, or demonstrations. Content is one part of care, not the service or relationship itself.

Content pattern. The book's flexible sequence: why it matters, main idea, demonstration, chosen next step, questions or connection, and what follows. Urgency takes priority; recreation may end with enjoyment rather than a task.

Demonstration. Showing how an action, conversation, or tool works. It supports explanation but does not, by itself, establish competence, clinical benefit, or that a staged example is a real case.

Encounter. A particular interaction, such as a call, visit, meeting, or shared activity. A CarePhysics engagement is an encounter deliberately shaped around a worthwhile purpose; not every encounter is planned.

Engagement. CarePhysics design: an intentionally shaped encounter that offers value to the person; **Engagements** is the sixth principle. **Evaluation:** useful involvement or participation, defined for the particular task. **Social Physics:** interaction through which people interpret, reinforce, coordinate, and act on ideas. Do not combine these meanings into an unlabeled activity score.

Health literacy. The ability to find, understand, and use health information and services, together with how well organizations make that possible. It is not simply reading ability or a label for someone's intelligence.[161]

Interpretation. Language access: conveying spoken or signed communication in another language. **Analysis:** explaining what information may mean. A person's interpretation of an event should remain distinguishable from the observation itself.[14]

Personalization. Adapting a response to relevant, verified information and expressed preferences about an individual. It does not justify inventing beliefs, changing clinical facts, or using private information beyond its permitted purpose.

Plain language. Language organized and expressed so the intended audience can find, understand, and use the message. It preserves necessary information rather than replacing professional accuracy with informality.[161]

Prompt. Conversation: an optional question or cue. **Behavior model:** something that

signals an action at a particular moment. **AI:** instructions and other input supplied to guide a model's response. A prompt is not proof of agreement or a substitute for enforced permissions. [162]

Teach-back. Asking someone to explain relevant information or an action in their own words so the speaker can check the explanation. It is not a memory examination; appropriate written materials may remain available.[24]

Tile. In the book's content examples, a unit bringing related material together—such as a video, article, document, survey, interactive element, link, or question route. A tile is not a whole pathway or evidence that its contents were understood.

Translation. Rendering written material in another language. Care content needs appropriate review for meaning and use; a generated translation does not automatically preserve clinical instructions or an instrument's validity.[14]

Wayfinding. The cues that help someone know where they are, what they can do, and where to find help—in a building, document, interface, or service. Familiar labels matter as well as visual appearance.

R8.2E — Coordination, Pathways, and Follow-Through

These are working service terms. A status must identify the action, responsible party, and relevant date. "Completed" without that context can conceal an unmet need.

Accepted responsibility. A defined task or role that a named person or organization has agreed to carry, including its limits and timing. An assignment on a screen is not acceptance.

Backup plan. An agreed arrangement for when the usual person or service is unavailable. A name is not a functioning backup unless willingness, availability, preparation, and scope have been checked.

Bottleneck. A stage whose usable capacity is insufficient for the demand placed on it within a defined process. It may limit the overall result, but a visible queue alone does not establish the cause. See Constraint and R2.5.

Care plan. A person-specific account of assessed needs, goals, agreed care, responsibilities, and review arrangements. Clinical elements require the appropriate professionals; an educational pathway does not replace them.

Closed-loop communication. An exchange in which the recipient acknowledges the message and the sender checks that it was understood correctly. Closing that communication loop does not establish that the requested service occurred.[37]

Confirmation. Verification of a specific fact or commitment. State what is confirmed: receipt of a request, a booking, an arrival, or completion of an action.

Constraint. In TOC, the condition currently limiting a defined system goal. In this book's application, examine the support arrangement rather than labeling a person. Safety, privacy, and rights remain requirements, not constraints to discard. See R2.5.

Escalation. Passing a concern to the person or service with the authority and expertise

needed to respond. Urgent clinical concerns follow the appropriate urgent route, not the next routine review.

Fallback. An alternative route when the intended route cannot work—for example, a telephone option when digital access fails. It must be available and appropriate, not merely named.

Handoff. A transfer of relevant information and a defined responsibility to a receiving person or team, with acknowledgment and opportunity to clarify. Community handoffs transfer only the agreed role—not unlimited clinical responsibility.[88]

Human-experience map. In this book, a source-labeled account of what people say they understand, want, encounter, and find difficult across a defined care journey. Keep participant, caregiver, and staff perspectives distinct; mark untested interpretations rather than recording inferred emotions. See Chapter 7 and Appendix D4.

Journey mapping. Examining the stages of a care experience with the people receiving and providing it, then using that understanding to design or revise support. The map is a learning and design aid, not evidence that a service worked. See Chapter 7, R2.5, and Appendix D4.

Lead time. Elapsed time between specified start and end events. Name both: time from request to confirmation differs from time to actual service. State calendar or working time and report still-open requests separately. Lead time is not a delivery rate.

Local optimization. Improving one task or department without establishing that the whole intended result improves. Faster drafting may create a longer review queue; better source quality may instead reduce review work. Examine the complete experience, including effects on other people.

Pathway. A planned, adaptable sequence of information, encounters, and support around a meaningful need, with responsibility and next steps made explicit. **Pathways** is the seventh principle. A hypothetical sequence might include a tile, saved contact, call, virtual meeting, visit, and review—not just a fixed playlist.

Process map. A representation of events, decisions, responsibilities, and transitions in a defined process. It can be read alongside a human-experience map; neither alone proves the cause of a delay or the value of a proposed change.

Referral. A request or recommendation to another professional or service. Distinguish making the referral from its acceptance, scheduling, and the person actually receiving support.

Response route. The stated way to obtain a reply or help, including who receives the request, their availability, and what happens if no response arrives. A reply box alone is not a response service.

Service capacity. The people, time, places, equipment, and resources actually available to deliver a defined service. Demand, eligibility, and capacity are separate questions.

Service model. The arrangement through which a service is organized and delivered: its purpose, people, responsibilities, activities, and resources. It is not an AI model or a

theory of behavior.

Service received. The agreed support actually took place. A booked day is not an attended day; even verified delivery does not by itself establish usefulness or health benefit.

Status language. Requested: an action was asked for. **Received:** it reached the intended recipient. **Accepted:** a defined action was agreed. **Scheduled:** a time was arranged. **Delivered/completed:** the named action occurred. **Waitlisted:** awaiting an available opportunity. **Declined:** identify who declined what. **Unresolved:** a need or action remains open. No response is not the same as declining.

Theory of Constraints. Goldratt's management approach to focusing improvement on the limit to an agreed system goal. The Five Focusing Steps are explained in R2.5. CarePhysics uses a labeled, human-centered adaptation; the method is not an eleventh principle or proof of effectiveness.

Workflow. The practical sequence of work, information, decisions, and responsibilities within or between organizations. A pathway describes the supported care experience; workflow describes how people deliver and maintain it.

R8.2F — Technology, AI, and Knowledge Stewardship

The book uses these terms to describe bounded assistance and reviewed knowledge. A definition is not a claim that a Genus feature is available in every configuration.

AI assistant. An application using artificial intelligence to help with defined tasks, such as preparing questions, retrieving information, or drafting material. In the book's proposed care uses, permissions, sources, review, and human response routes are specified.

AI model. A computational model used to produce outputs from inputs. For the learned models discussed here, training adjusts internal parameters. It is a component of an assistant, not the complete service, its permission system, or the responsible professional.[162]

Care AI. The ninth principle: using AI to bring relevant knowledge into reach and assist the work around care, while people retain professional judgment, decisions, relationships, and accountability.

Configuration. The settings and arrangements for a particular use: sources, enabled functions, roles, permissions, review rules, and response routes. One configuration does not establish the capabilities of every deployment.

Deployment. Putting a system or workflow into actual use in a specified setting. Deployed does not mean universally available, clinically validated, or demonstrated to improve outcomes.

Generative AI. AI that produces content such as text, images, or audio in response to input. Producing plausible content does not establish that its statements are accurate.[162]

Human review. A responsible person checks an output for its intended use and can

correct, reject, or escalate it. The reviewer needs relevant competence, time, and authority; approval alone is not clinical validation.

Implemented. Built or established in the described system or process. The term does not, on its own, show live use, testing quality, broad availability, or benefit.

Knowledge bank. A maintained collection of reviewed sources, guidance, local facts, and approved examples, with ownership, dates, and reuse conditions. It is not the same as training an AI model.

Knowledge stewardship. Responsibility for selecting, reviewing, maintaining, correcting, and appropriately sharing knowledge. It includes preserving contributors' credit and withdrawing outdated material.

Model training. For the machine-learning systems discussed here, using data to adjust the model's internal parameters. Giving an assistant a document for a response is not the same operation.[162]

Proposed. An idea or workflow offered for consideration or testing. It is not a statement that the function has been built, deployed, or shown to work.

Provenance. The account of where information came from and how it was selected, changed, or reviewed. Provenance supports checking a claim; the presence of a citation does not make the claim correct.

Retrieval. Finding relevant material in an available collection for a task. Retrieval can supply context to an assistant without changing the underlying model; relevance, freshness, and permissions still need attention.[163]

Retrieval-augmented generation. A system design combining retrieval of relevant material with a generative model's response. Abbreviated RAG. It does not guarantee faithful use of the retrieved source.[163]

Review owner. The named person or organizational role responsible for keeping an item suitable for its approved use, including review dates, corrections, and escalation. Ownership of this task is not necessarily copyright ownership.

Technology. The eighth principle: choosing and designing tools around the care task and people's access needs. It includes appropriate help and alternatives, rather than assuming everyone must use the same device or account.

Tested. Examined under stated conditions. Always ask what version, task, users, criteria, and comparison were involved; tested is not an automatic synonym for effective or safe in every setting.

R8.2G — Research, Measurement, and Outcomes

These definitions support Chapter 10 and R1. Counts of activity, reported experiences, changes over time, and causal conclusions answer different questions.

Activation. In this book, the first meaningful action the person chooses, such as requesting a call. It is distinct from account registration and from validated measures of patient activation used elsewhere.

Adoption. Beginning to use the relevant service or approach. A request without subsequent use is not adoption; adoption alone does not establish continuing value.

Association. A relationship observed between variables. By itself, it does not establish that changing one causes the other to change.

Attributable impact. The part of a change that can credibly be attributed to an intervention. It requires an evaluation capable of addressing other explanations—not merely a favorable before-and-after result.

Baseline. The stated starting measurement or period used for later comparison. It is not automatically a control group and does not by itself establish causation.

Bias. A systematic influence that can distort data, measurement, or conclusions—for example, when responses come mainly from people with a favorable experience. More observations do not automatically remove bias.[104]

BRIEF health-literacy screen. A named health-literacy screening tool used in C4C to help understand communication and assistance needs. It is not a cognitive examination. Use the appropriate instrument instructions and distinguish it from an informal comprehension question. See R1, CG1 and CG13.

Burden. The effort, time, cost, distress, or other demands created by care or participation. Here, the burden is in the work and circumstances—not a label for the person receiving care.

Burden Scale for Family Caregivers, short form (BSFC-s). A 10-item measure of subjective caregiver burden. Its validation does not transfer to an unrelated four-item intake or altered wording. See R1, CG8.

Causation. A relationship in which a change in one factor produces a change in another. Establishing it requires a suitable design and justified assumptions, not correlation alone.

Clinical significance. Whether a finding is important enough to matter for health or care in the relevant situation. This is different from crossing a statistical threshold.[164]

Comparator. The alternative against which an intervention is evaluated, such as usual care, another approach, or no added intervention. What the comparator actually receives affects the meaning of the finding.

Confidence interval. A range expressing uncertainty around an estimate under stated statistical assumptions. A conventional 95% interval uses a method that would cover the fixed true value in 95% of repeated comparable studies; it is not a 95% probability that this particular interval contains it.[164]

Denominator. The total group or opportunities forming the base of a proportion. **Hypothetical example:** if 15 of 20 requests due for a reply received one, the denominator is 20—not only the 15 answered requests.

Effect size. The magnitude of a difference or relationship, expressed in a stated unit or standardized measure. A standardized value such as 0.3 is not automatically a 30% improvement.[165]

Equity. In the book's evaluations, attention to fair opportunity to reach and benefit from

care, including who is missing and which avoidable barriers remain. Equal invitations do not establish equal access.

Evidence grade. A judgment about support for a specified conclusion under a named system. The behavioral review uses **Strong:** substantial convergent support; **Moderate:** support with important limitations; **Emerging:** limited, new, or contextual evidence; **Plausible but untested:** a reasonable basis without direct testing of the application; and **Unsupported/contradicted:** an inadequately supported claim or evidence that weakens it. State which problem applies. These are source-specific judgments, not GRADE levels.

Evidence-based. Describes a practice or decision supported by relevant evidence. Ask which evidence supports which use. It is not a blanket certification; CarePhysics uses evidence-informed to retain the distinction between its foundations and proposed applications.

Evidence-informed. Using relevant research, professional judgment, and local knowledge to guide a decision while retaining their limitations. Describing CarePhysics this way does not mean every proposed application is proven.

Experience. How the person reports or describes an encounter, such as feeling heard or finding it useful. Distinguish their account from a caregiver's report or a staff observation.

GAD-2 / GAD-7. Two-item and seven-item anxiety symptom measures. A screening result supports an appropriate assessment and response; it does not independently establish a diagnosis. See R1, CG9–CG10.

GRADE. Grading of Recommendations Assessment, Development and Evaluation: a framework for judging certainty in a body of evidence for an outcome. Its levels are **high, moderate, low, and very low**. A certainty grade is not a score for a whole organization.[104]

Hypothesis. A stated, testable expectation or explanation. It remains a proposal to examine, not a result already found.

Jack Scale. CarePhysics's historical and proposed review scale from −5 to +5, with zero as neutral. The reviewed sources do not establish clinical validation. Missing information is not zero; the scale must not rank families or determine entitlement to support.

Meta-analysis. A statistical combination of results from sufficiently comparable studies. It may form part of a systematic review; pooling does not remove limitations in the underlying studies.

Null finding. A finding that does not establish the specified difference or effect. A nonsignificant result may be imprecise; examine the estimate and uncertainty rather than automatically concluding there is no effect.[164]

Observational study. A study that examines exposures and outcomes without researchers assigning the exposure under study. Associations may reflect other differences between the people or settings compared.[166]

Outcome. A result or change being examined, such as health, function, caregiver strain,

understanding, or quality of life. Name the outcome; the word does not imply improvement or prove what caused it.

Participation. Taking part in an activity, service, or study. Specify what occurred. Presence or a response does not alone establish enjoyment, understanding, or benefit.

PHQ-2 / PHQ-9. The two-item depression screener and nine-item depressive-symptom measure in the Patient Health Questionnaire family. The adopted clinical protocol governs follow-up and interpretation. See R1, CG11–CG12.

Qualitative study. Research that systematically examines experiences, meanings, or processes, often through interviews or observation. An informal comment is not automatically a qualitative study.

Quality of life. The person's perception of their life in relation to their culture, values, goals, and concerns. Specify whose account and which measure are used; attendance alone does not establish quality of life.[167]

Randomized controlled trial. A study using chance to assign participants to intervention and comparison conditions. In a **cluster-randomized trial**, groups such as sites are assigned, and analysis must account for that grouping. Abbreviated RCT.[168]

Reach. Whether the intended population had a reasonable opportunity to encounter the offer. Successful delivery is not evidence that the information was understood.

Reliability. Measurement: consistency under relevant conditions. **Service delivery:** dependability in carrying out agreed work. Consistency does not by itself establish that a measure captures the right thing or that a service improves health.

Safety. Attention to potential and actual harm associated with the service or change. Review errors, missed responses, inappropriate sharing, and other unintended consequences—not only reported successes.

Scoring. The tenth principle: evaluating the support and learning what helps. Scores and counts serve decisions; they are not verdicts on the person, family love, or staff commitment.

Screening. A defined initial check for a possible need or concern that may warrant fuller assessment. It is not automatically a diagnosis, and recording a score is not the same as providing support. See R1's measurement orientation and Appendix F.

Service delivery rate. The number of defined services actually delivered per stated period. Specify the unit—people, visits, or service hours—and keep these separate. A higher rate does not establish appropriate care or improved well-being. See Appendix F6.

Statistical significance. Meeting a specified statistical threshold for evidence against a tested hypothesis, under the analysis assumptions. It does not establish practical importance, eliminate bias, or give the probability that a claim is true.[164]

Systematic review. A review using explicit methods to identify, select, assess, and synthesize research addressing a defined question. It may or may not include meta-analysis.[169]

Throughput. Specify the usage. In operations, a throughput rate describes completed

units per unit of time. This book uses service delivery rate for care processes, not TOC's financial throughput-accounting measure. Waiting time and completion proportions are different quantities.

Time window. The defined period over which a count, experience, or change is examined. Reports using different periods are not automatically comparable.

Understanding. Grasping the relevant meaning, choice, or next step sufficiently to use it with appropriate support. Opening a document or finishing a video does not establish understanding.

Useful participation. Participation that serves something worthwhile to the person in the relevant setting. It can include asking, choosing, contributing, listening, or enjoying an activity—not simply maintaining a digital streak.

Validated instrument. A measurement tool with evidence supporting a specified interpretation and use in relevant populations and conditions. Validity is not universal: check the version, language, administration, and scoring before transferring it. An AI rewrite does not automatically preserve it.[170]

R8.2H — Culture, Choice, Privacy, and Source Status

These terms preserve both the person's voice and what a source can support. Brief explanations do not establish legal compliance or determine anyone's authority.

Author recollection. An account of what the author remembers. In R7, Joe's family passages have this status; they are not independently recorded testimony or outcome evidence.

Confidentiality. Protecting information against access or disclosure outside its authorized boundaries. Explain who may receive it and any relevant limits; confidential does not mean nobody else can ever see it.[171]

Consent. Agreement to a specified action. **Informed consent** involves understandable relevant information, an opportunity for questions, and a voluntary decision. Treatment, research, recording, and information sharing have distinct requirements; one agreement does not authorize everything.[172]

Cultural humility. Continuing to examine one's assumptions and learn from the person about their life, values, and preferences, while attending to power and partnership. It is not mastery of a cultural profile.[13]

De-identification. Removing or transforming identifying information to reduce the risk that a person can be identified. Applicable standards require more than deleting a name; even properly de-identified information can retain some identification risk.[173]

Decision-making capacity. The ability relevant to making a particular decision, including understanding information and considering its implications. The required assessment and authority depend on the situation and jurisdiction; a glossary or AI response does not determine capacity.[172]

Fictional illustration. An invented scene, character, or example used to explain an idea.

It must not become a testimonial, focus-group quotation, or measured result when reused.

Local facts. Verified information about the actual organization or setting, such as service hours, contacts, costs, capacity, and responsibilities. These facts need owners and review dates; research cannot supply them.

Observation. What someone noticed and recorded, identified by source and context. It is distinct from the explanation they infer and from an assessment or diagnosis.

Permissioned sharing. The book's term for sharing defined information with appropriate recipients for an authorized purpose. Applicable consent, law, policy, and technical access controls still govern; an invitation to one conversation is not blanket access.

Personal context. Information about an individual's circumstances, preferences, relationships, and care. Use only what is appropriate and authorized for the task; private context does not automatically belong in a shared knowledge bank.

Preference. What a person says they want or favor in the situation. Preferences may change and should not be inferred from group identity. A preference is distinct from clinical instructions and from what a service can provide.[13]

Privacy. Boundaries around a person's life, information, and access to them. Confidentiality is one part of protecting information; privacy also asks whether collecting or using it is appropriate in the first place.[174]

Private caregiver record. In this book's proposed design, a separately authorized place for the caregiver's sensitive information, available to the caregiver and appropriate professionals—not automatically to the participant or other relatives. Verify controls at collection, retrieval, sharing, and export. See Chapter 11 and Appendices B/C/J.

Professional assessment. An evaluation conducted by the appropriately qualified person within their role. It may consider the person's report and others' observations without treating every account as the same kind of evidence.

Proposed application. A suggested use of an idea or finding in care. A plausible design may be worth testing, but it is not a documented implementation or established benefit.

Research finding. A result from a particular investigation, interpreted in relation to its methods, population, comparison, and limitations. A memorable quotation or fictional scene is not a research finding.

Social determinants of health (SDOH). The social and material conditions surrounding health. An individual social-needs screen asks about relevant practical circumstances; it does not explain all structural causes or prove that a reported need has been resolved. Specify the local screening and response process. See R1, CG1.

R8.3 — Similar Words, Important Differences

The entries above provide the definitions. These comparisons show why keeping them separate matters in a care conversation or report.

Do not collapse these terms	A useful check
Engagement, encounter, useful participation	Are we describing the planned experience, the interaction that occurred, or whether involvement was worthwhile? See D and G.
Content, tile, encounter, pathway, care plan	An article may sit in a tile; a conversation is an encounter; a pathway connects steps; a care plan identifies the person's agreed care. None automatically replaces the others. See D and E.
Referral sent, handoff accepted, service received	What reached another organization, what responsibility did it accept, and what did the person actually receive? See E.
Communication closed, need resolved	Both parties may understand that no appointment is available. Communication can be complete while the need remains open. See E.
Human-reviewed, clinically validated, shown to improve an outcome	Who checked this item? What use was validated? What evaluation demonstrated a benefit? These require different evidence. See F and G.
Knowledge bank, retrieval, model training	Maintaining sources, selecting relevant material, and changing a model's parameters are different operations. See F.
Capability, competence, self-efficacy	Can the person perform the action? Do they experience effectiveness? Do they believe they can do this task? In professional practice, competence also has an assessed role-specific meaning. See C.
Model	Specify theoretical model, service model, or AI model. A framework about behavior is not a trained software component. See C, E, and F.
Prompt	Specify a conversation invitation, a cue for action, or input to an AI model. See D.
Capacity	Service capacity concerns available resources; decision-making capacity concerns a particular decision. Neither should be inferred from the other. See E and H.

Do not collapse these terms	A useful check
Participation, experience, outcome, attributable impact	Taking part, reporting an experience, observing a result, and establishing what caused it are different questions. See G.
Recommendation, referral, received support	Saying one would recommend a service, actually referring someone, and that person receiving help are separate events. See E and G.
Recollection, illustration, finding	Remembered words, invented teaching dialogue, and research results retain different source status in every reuse. See H.

An experience measure can itself be a study's prespecified outcome. The distinction is about the question being answered—not a rule that one kind of measure can never serve another role.

These distinctions apply across videos, articles, surveys, messages, and meetings. An assistant should preserve them rather than make a status sound more complete or an observation more certain.

R8.4 — Abbreviations and Names Readers May Encounter

Unfamiliar abbreviations should still be explained when they first appear in a chapter. This lookup is a return point, not a requirement to memorize them.

Short form	Expanded form or name	Where to look
ADL / ADLs	Activities of daily living	B
AI	Artificial intelligence	AI assistant and AI model, F
BCW	Behaviour Change Wheel	C; R2.2
BRIEF	BRIEF health-literacy screen	G; R1 public sources
BSFC-s	Burden Scale for Family Caregivers, short form	G; R1 public sources
C4C	Caring for Caregivers (RUSH)	B; Chapter 11; R2.5
CI	Confidence interval	G

Short form	Expanded form or name	Where to look
COM-B	Capability, Opportunity, Motivation–Behavior	C; R2.2
GAD-2 / GAD-7	Generalized Anxiety Disorder symptom measures	G; R1 public sources
GRADE	Grading of Recommendations Assessment, Development and Evaluation	G; R1.1
IADL / IADLs	Instrumental activities of daily living	B
IHI	Institute for Healthcare Improvement	B: Age-Friendly 4Ms
JAHF	The John A. Hartford Foundation	B: Age-Friendly 4Ms
MI	Motivational interviewing	C; R2.5
PHQ-2 / PHQ-9	Patient Health Questionnaire depression measures	G; R1 public sources
RAG	Retrieval-augmented generation	F
RCT	Randomized controlled trial	G; R1.1
SDOH	Social determinants of health	H; R1 public sources
SDT	Self-Determination Theory	C; R2.2
TOC	Theory of Constraints	E; Chapter 7; R2.5

Named learning and improvement methods

ADDIE. Analyze, Design, Develop, Implement, and Evaluate: a framework for developing and reviewing learning experiences. It organizes work; it does not guarantee an outcome. See R2.5.[48]

ARCS. Attention, Relevance, Confidence, and Satisfaction: John Keller's model for motivational design in learning. See R2.5.[50]

Backward design. Begin with the intended learning result, identify suitable evidence of learning, then plan the experience. Associated with Grant Wiggins and Jay McTighe; see R2.5.[47]

PDSA. Plan–Do–Study–Act: an improvement cycle for planning an appropriate test, trying it, examining what happened, and deciding what to do next. Necessary care, privacy, and research approvals remain separate. See Chapters 14–15.[55]

Organization and instrument names

AHRQ is the Agency for Healthcare Research and Quality; **NIA** is the National Institute on Aging; **NIH** is the National Institutes of Health; **NIST** is the National Institute of Standards and Technology; and **WHO** is the World Health Organization. They are source organizations, not CarePhysics tools.[161]

Katz ADL, Lawton IADL, and Hendrich II name particular assessment instruments, not interchangeable labels for daily activity or safety. Use the applicable instrument instructions and appropriate professional review; this glossary does not reproduce their items, cutoffs, or scoring. The dated Day Center record names these instruments but does not establish their suitability for every population or use.

Product names in the manuscript likewise identify particular offerings. Their presence is not a promise of current availability, integration, or effectiveness. Verify the relevant configuration and records rather than treating a glossary entry as a capability statement.

R8.5 — A–Z Finder

Browse a theme in R8.2 or select a linked term below. Each entry has one maintained definition. An arrow indicates an alternative lookup route, not that related concepts are interchangeable. Abbreviations and named learning methods are also explained in R8.4.

A: Human foundations • B: People and settings • C: Behavior and learning • D: Communication and design • E: Coordination and pathways • F: Technology and knowledge • G: Evidence and outcomes • H: Culture, privacy, and source status

0–9 — 4Ms (B).

A — Accepted (E); Accepted responsibility (E); Accessibility (D); Activation (G); Activities of daily living (B); Adaptation (D); ADDIE (R8.4); ADL / ADLs (B); Adoption (G); Age-Friendly 4Ms (B); Agency (C); AHRQ (R8.4); AI (F); AI assistant (F); AI model (F); AI prompt (D); ARCS (R8.4); Association (G); Attributable impact (G); Author recollection (H); Autonomy (C); Awareness (A).

B — Backup plan (E); Backward design (R8.4); Baseline (G); BCW (C); Behavior prompt (D); Behavioral Influence (A); Behaviour Change Wheel (C); Bias (G); Bottleneck (E); BRIEF (G); BRIEF health-literacy screen (G); BSFC-s (G); Burden (G); Burden Scale for Family Caregivers, short form (BSFC-s) (G).

C — C4C (B); Capability (C); Capacity, decision-making (H); Capacity, service (E); Care AI (F); Care plan (E); Care team (B); Caregiver strain (B); Caregiver, family (B); CarePhysics (A); Caring for Caregivers (C4C) (B); Causation (G); CI (G); Clinical competence (C); Clinical

significance (G); Closed-loop communication (E); Cluster-randomized trial (G); Co-design (D); COM-B (C); Communications (A); Community (A); Community partner (B); Comparator (G); Compassion (A); Competence (C); Completed (E); Complex contagion (C); Confidence interval (G); Confidentiality (H); Configuration (F); Confirmation (E); Connected outcomes (A); Consent (H); Constraint (E); Content (D); Content pattern (D); Contribution (A); Conversation prompt (D); Cultural humility (H).

D — Day Center (B); De-identification (H); Decision-making capacity (H); Declined (E); Delivered (E); Demonstration (D); Denominator (G); Deployed (F); Deployment (F); Dignity (A).

E — Effect size (G); Emerging (G); Encounter (D); Engagement (D); Engagement in Social Physics (D); Engagements (D); Equity (G); Escalation (E); Evidence grade (G); Evidence-based (G); Evidence-informed (G); Experience (G); Exploration (C).

F — Fallback (E); Family caregiver (B); Fictional illustration (H); First meaningful action (G); Fogg Behavior Model (C).

G — GAD-2 / GAD-7 (G); Generative AI (F); Grace (A); GRADE (G).

H — Handoff (E); Health literacy (D); Hendrich II (R8.4); Holistic Care (A); Home care (B); Home health (B); Hospice (B); Human review (F); Human-experience map (E); Human-reviewed (F); Hypothesis (G).

I — IADL / IADLs (B); Idea flow (C); IHI (B); Impact (G); Implemented (F); Informed consent (H); Instrumental activities of daily living (B); Interpretation (D).

J — Jack Scale (G); JAHF (B); Journey mapping (E).

K — Katz ADL (R8.4); Knowledge bank (F); Knowledge stewardship (F).

L — Lawton IADL (R8.4); Lead time (E); Local facts (H); Local optimization (E); Love (A).

M — Mentation (B); Meta-analysis (G); MI (C); Model training (F); Model, AI (F); Model, service (E); Model, theoretical (C); Moderate (G); Motivation (C); Motivational interviewing (C).

N — Navigator (B); NIA (R8.4); NIH (R8.4); NIST (R8.4); Null finding (G).

O — Observation (H); Observational study (G); Opportunity (C); Outcome (G).

P — Palliative care (B); Participant (B); Participation (G); Pathway (E); Pathways (E); Patient (B); PDSA (R8.4); Permissioned sharing (H); Person receiving care (B); Personal context (H); Personalization (D); PHQ-2 / PHQ-9 (G); Plain language (D); Plausible but untested (G); Preference (H); Principle (A); Privacy (H); Private caregiver record (H); Process map (E); Professional assessment (H); Prompt (D); Proposed (F); Proposed application (H); Provenance (F); Purpose (A).

Q — Qualitative study (G); Quality of life (G).

R — RAG (F); Randomized controlled trial (G); RCT (G); Reach (G); Received (E); Referral (E); Relatedness (C); Reliability (G); Requested (E); Research finding (H); Respite (B); Response route (E); Retrieval (F); Retrieval-augmented generation (F); Review owner (F).

S — Safety (G); Scheduled (E); Scoring (G); Screening (G); SDOH (H); SDT (C); Self-

Determination Theory (C); Self-efficacy (C); Service capacity (E); Service delivery rate (G); Service model (E); Service received (E); Social Cognitive Theory (C); Social determinants of health (SDOH) (H); Social learning (C); Social Physics (C); Social support (C); Social worker (B); Statistical significance (G); Status language (E); Strong (G); Systematic review (G).

T — Teach-back (D); Technology (F); Tested (F); Theoretical model (C); Theory of Constraints (E); Throughput (G); Tile (D); Time window (G); TOC (E); Translation (D); Trust (A).

U — Understanding (G); Unresolved (E); Unsupported/contradicted (G); Useful participation (G).

V — Validated instrument (G); Volunteer (B).

W — Waitlisted (E); Wayfinding (D); WHO (R8.4); Workflow (E).

Keep the Language Useful

When a team adapts this glossary, retain the intended meaning, source, reviewer, and version. Add verified local terms where needed, and mark unresolved differences instead of quietly replacing one concept with another.

An approved assistant can help writers use the same definitions across an article, video, survey, message, or conversation. People remain responsible for meaning, accuracy, local fit, and permissions. The glossary itself neither authorizes access to private information nor trains the assistant.

Try a small usability check: ask an intended reader to find a word and explain the entry in their own words. Record which entries remain confusing, including the help and access route used, and revise them. Finding a definition is useful; it is not evidence that a care outcome improved.

The purpose of shared language is not to make everyone speak like an organization. It is to help people understand one another—and know what happens next.

Next: Closing Reflection — The Future We Choose

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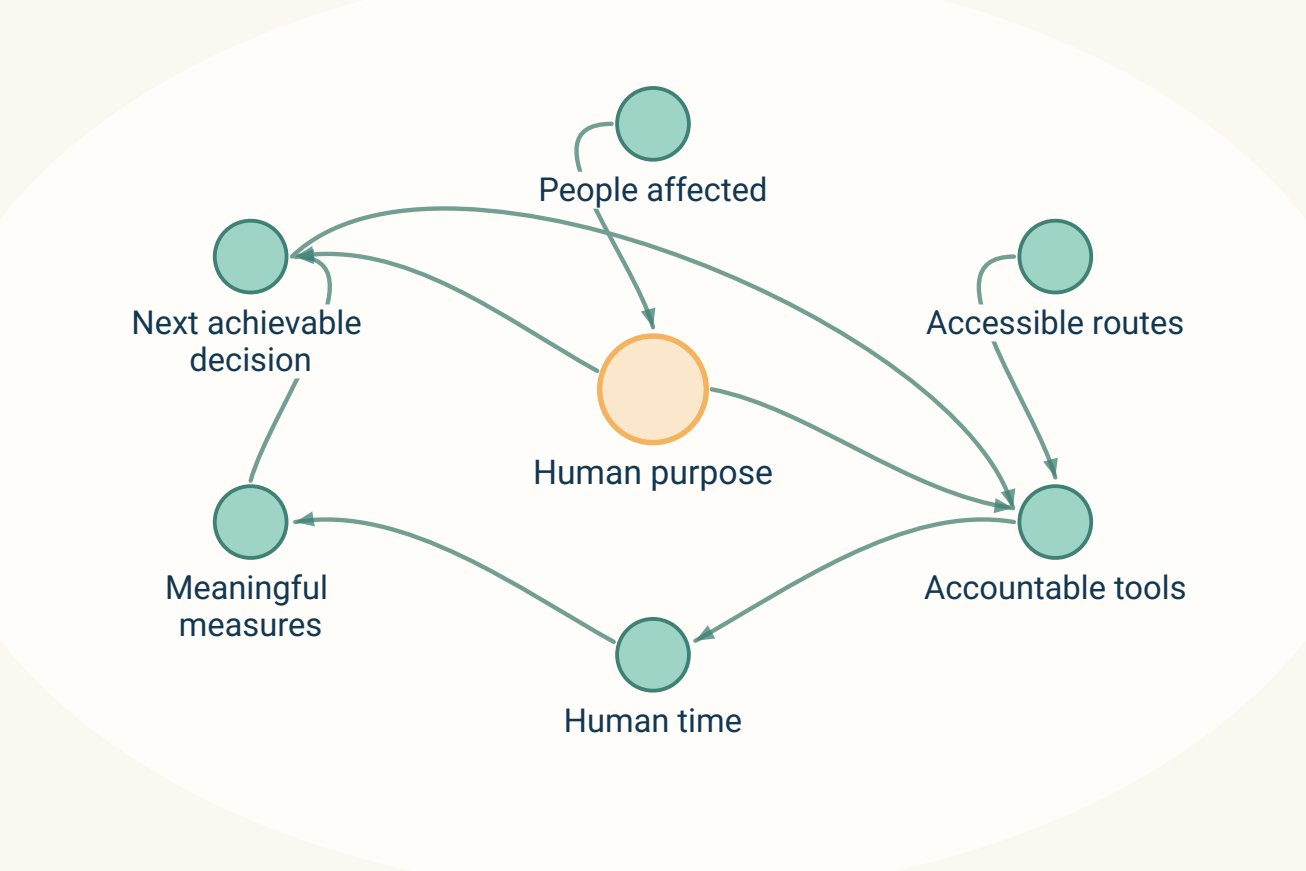
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Closing Reflection — The Future We Choose

More capable technology. More room for one another.



Connection map — Give the next tool a human purpose

People affected by a proposed tool help define its human purpose. That purpose directs the design of accountable tools. Accessible routes help determine whether people can actually use the tools. The proposed tools should aim to protect human time rather than consume it. Examine whether human time and other meaningful experiences actually changed. Meaningful measures inform the next achievable decision. Human purpose continues to guide that decision. The decision changes which tools and arrangements are tried next. The chapter's future examples are possibilities, not deployment promises, forecasts or established benefits.

The Next Five Years — A Window of Possibility

The next five years could bring into everyday care possibilities that once seemed decades away. Looking from 2026 toward 2031, we can imagine more capable robots supporting teams, transportation becoming easier to use, and medical devices fitting more naturally into the places we live.

The opportunity is not simply to welcome more capable machines. It is to be clear about

the kind of care we want them to help us create.

Perhaps a nurse will spend less of a shift retrieving supplies and more time hearing a concern. Perhaps a person who needs travel assistance will be able to choose an afternoon with friends without turning the journey into a family project. Perhaps a caregiver will finish the day without reconstructing the same information for several different people.

These are futures worth working toward.

There are visible beginnings. In May 2025, ChristianaCare described its use of collaborative robots and a research fellowship that gave bedside nurses a role in studying robotics in hospital work.[175]

The FDA's Home as a Health Care Hub initiative and Idea Lab examine how medical devices could fit people's homes, routines, and other technologies rather than operate as isolated pieces of equipment.[176]

Neither example supplies a timetable for every household or organization. They give us something concrete to learn from while we shape the next version.

The question is not only what the technology will become capable of doing.

What should become easier, more dependable, or more human because it is there?

The Star Trek Invitation — Imagine the People as Well as the Devices

Star Trek offers a useful image for this closing. Its official account of the franchise emphasizes an optimistic future associated with diversity, inclusion, acceptance, and hope.[177]

The remarkable devices are part of the appeal. But there is another part worth bringing into our conversation: different people using their knowledge to face a shared challenge.

That is the invitation we can take from the fiction. Imagine the people as carefully as the equipment.

Who belongs in the room? Who is heard when the plan is being developed? What does the person with the most powerful tool do when someone else knows something they have missed?

In care, we can bring those questions into design before a product is finished. Invite the person who will use it, the caregiver who knows the evening routine, the worker who understands the difficult handoff, and the community partner responsible for what follows.

Imagination becomes practical when a conversation changes a design brief, a budget, a service agreement, or a test. A hopeful description can give people something to examine together. Their questions can then make the proposal better.

We do not have to predict every invention to take part in that work. We can name what we want preserved: choice, dignity, useful help, and relationships with room for

disagreement and affection.

We can imagine a future with extraordinary tools and still make the most important part of the picture the people working together.

Quiet Technology, Visible Care

A useful ambition is technology that asks less of our attention while making appropriate help easier to reach.

Imagine fewer repeated forms, familiar controls, and relevant information available to an authorized professional before the conversation begins. The person should not need to understand every system behind the service to use the part that matters today.

But quiet does not mean concealed. People should understand what is being collected, what is shared, and who is responsible. The communication discipline developed throughout this book asks us to simplify the experience without hiding the human role or the handoff.

A robot can earn its place by doing a defined task well. An assistant can help prepare a question without pretending to be a clinician or family member. Neither needs to imitate love to support the people who bring it.

Let the technology be quiet in its operation and clear about its responsibilities.

For leaders, this raises a decision that belongs near the beginning of a project: when a tool genuinely returns time, what will we protect that time for?

Listening, direct care, preparation, learning, and rest should be possible answers. We can also use greater capacity to reach people waiting for help. What matters is making that choice deliberately, rather than assuming every saved minute must become another demand.

Glimpses of a Future Worth Building

> **In Context — Six imagined futures**
>
> *The following scenes are original future illustrations, not reports of deployed services or predictions that every capability will be available by 2031. They do not extend Pat and Ellen's clinical story. Each begins with something a person wants to do.*

> **A nurse stays with the person**
>
> A patient has another question. The nurse sits down to hear it.
>
> The supplies needed for the next part of the visit have already been requested. A logistics robot carries them to the agreed delivery point through a workflow the

A nurse stays with the person

team has tested. Staff confirm that the correct items arrived; the robot does not choose the treatment.

The nurse is still there when the patient explains what has been worrying him.

In this imagined hospital, the useful innovation is not only movement down a corridor. It is the opportunity to reduce an avoidable interruption. The nursing team helps decide which tasks belong in the workflow and whether it actually gives them more room for care.

An ordinary task remains someone's own

In an assisted-living community, a resident is preparing to show a small group how she arranges flowers.

An assistive robot brings the agreed materials to a position she can reach. A staff member has checked the setup and remains available for the help she requests.

The resident chooses the flowers. She changes the arrangement. When someone asks why she places one stem apart from the others, she explains.

The machine has helped move materials. The knowledge and the pleasure of sharing it belong to her.

A similar design might support a community-center workshop or an ordinary activity at home. The aim is not to complete every task for someone. It is to preserve the parts they want to do and provide suitable assistance around them.

The journey makes the day possible

A man wants to meet a friend at a Day Center's open community event. He uses a wheelchair and needs a travel arrangement he can trust.

An accessible automated service, authorized for the route and suitable for his needs, provides a clear way to confirm the journey. He can book through an accessible interface or a staffed telephone service. He knows how to identify the vehicle, obtain the boarding assistance he needs, and reach a person during the trip.

His mobility device is secured appropriately. The destination and arrival assistance are confirmed. Someone has accepted responsibility for the return arrangements and for helping if the plan changes.

He arrives to see his friend.

The achievement is not simply that a vehicle drove itself. It is that the whole journey became usable.

The journey makes the day possible

The U.S. Department of Transportation's 2022 Inclusive Design Challenge explored prototypes addressing vehicle location, boarding, securement, interaction, and exit. Those design questions offer a starting point, not proof that accessible automated travel is now available everywhere.[178]

The home remains a home

A woman completes an agreed measurement using a medical device selected with her care team. It fits comfortably within her routine and sends the relevant reading through the authorized system.

She does not copy the number into another form. She can see whether it was received and understands when the team reviews readings, what is not continuously monitored, and whom to contact with a concern.

The device does not decide how she feels. During the next conversation, she explains something that the measurement does not capture. The clinician considers both.

Elsewhere in the home, an accessible control adjusts the lighting she chooses. There are ordinary switches and a workable plan for equipment or connection failure. Clinical equipment has an appropriate place; it does not dictate the appearance and rhythm of every room.

Home is still where she lives, welcomes people, and closes the door when she wants privacy.

A question gets a useful beginning at any hour

Late in the evening, a caregiver remembers a nonurgent question about an upcoming support visit.

An approved assistant retrieves the organization's current guide, explains what the visit includes, and helps her prepare the question she wants a person to answer. It identifies the source rather than improvising a service promise.

She chooses to send the question. The assistant states when a human response is expected and keeps a submitted request distinct from an accepted appointment. The separate urgent-help route is easy to find.

At the next conversation, the professional has the question in advance. The caregiver can explain what matters rather than begin by reconstructing the inquiry.

The assistant was available when the thought occurred. A person remains

> **A question gets a useful beginning at any hour**
>
> responsible for the care and the answer requiring judgment.

> **Connection is easier to choose**
>
> At a community center, a participant wants to share a story with a relative who lives away. A familiar display supports the call and puts the chosen material where both can see it.
>
> A volunteer helps with the setup, then steps back. The participant chooses whether to read, talk about a picture, or move on to something else. No private care information appears on the shared screen.
>
> Later, the same kind of accessible tool might help someone join a group discussion or arrange a conversation with a friend. Introductions are offered with permission, not generated as obligations.
>
> When the conversation ends, the screen can go quiet. There is no streak to preserve and no demand for a report.
>
> The technology helped make the encounter possible. The people decided what to make of it.

Better Feedback, Better Conversations

These scenes bring two kinds of information together.

Technical feedback might tell the team that a reading arrived, a delivery was completed, or a journey was interrupted. Human feedback explains whether the arrangement was understandable, comfortable, wanted, and useful.

Our design should give each its proper place. A reassuring dashboard should not dismiss a person’s concern. A pleasant conversation should not be reported as proof that a clinical measure improved.

Connect the information with a response: appropriate review, a conversation where needed, an accepted next action, and follow-through.

The ten principles remain useful here. Holistic Care starts with the person. Awareness and Communications support understanding. Behavioral Influence asks about a chosen, feasible action; Community brings relevant relationships and services into reach. Engagements and Pathways organize the experience. Technology and Care AI assist the work. Scoring helps us examine it. This is complementary design, not a formula that guarantees multiplied effects.

The knowledge should also travel back from the encounter. A participant might suggest a better invitation; a caregiver might identify duplicated work; a volunteer might improve

the demonstration. Staff can explain what the proposed change would require.

An approved assistant could organize those ideas and prepare options from reviewed research and local guidance. A responsible person checks the sources, feasibility, and permission to reuse the material. The team tries an appropriate change, credits its contributors, and returns with what happened—including when the result was unhelpful.

Keep research, local facts, fictional examples, and private context distinct. Retain owners, review dates, approved uses, and corrections. Retrieval, drafting, human review, testing, and revision are separate steps; uploading this book does not train a model or establish that it will apply the knowledge reliably.

WHO's AI guidance likewise calls for defined tasks and stakeholder involvement and warns about inaccurate outputs and inappropriate delegation. These responsibilities belong inside the design, not outside the hopeful picture.[1]

With relevant knowledge, clear guidelines, practical rules, and accountable people, AI can be a gift: less repetitive preparation and more useful support around the next human conversation.

The Words We Use Help Set the Direction

Every reader can contribute to this future through the questions and expectations they bring into a conversation.

When we describe a technology, begin with what someone is trying to do. Explain the actual assistance. Show who remains responsible and what happens next.

Compare two possible design ambitions. One begins, "Replace the caregiver." Another asks, "Which repetitive tasks could we take off the team while preserving skilled care and time with people?" The second gives us a more specific job to investigate.

Similarly, rather than making continuous observation the goal, ask which agreed information would help the right person respond. Rather than asking how to get everyone onto the platform, ask how people can understand and try useful support, including through appropriate alternatives.

These are not softer words for an unchanged product. The service must earn the description. Our communication guide makes that distinction explicit: an attractive explanation cannot supply an absent capability or completed handoff.

Use the same discipline in a video, article, survey, message, or demonstration. Explain why the offer matters, make the main idea clear, show the relevant action, offer a chosen next step, identify the responder, and explain what follows. Preserve essential clinical wording and urgency.

Invite questions before asking for adoption. A caregiver worried about privacy, a resident who dislikes the controls, or a nurse who identifies additional work is contributing to the design—not standing outside progress.

Hopeful language should widen that conversation. It should help people picture

something worth trying without making enthusiasm a test of courage, kindness, or professional commitment.

We can be enthusiastic about the possibility and exact about the promise.

Build a Future People Can Actually Enter

The future we describe should include people living alone, people renting their homes, and households with limited income, connectivity, or service choices.

Ask about language, beliefs, culture, access needs, preferred supporters, and the kind of assistance a person welcomes. The answer belongs to that person, not a demographic label.

Design with those circumstances from the beginning. The FDA's Idea Lab offers one example of that direction: its development included conversations with patients and care partners, professionals, and technology developers, as well as visits to housing settings. The resulting resource is a design initiative, not evidence that the access problem has been solved.[179]

For each service we hope to build, include the ordinary conditions of dependability: installation, cleaning where relevant, maintenance, repair, staff training, accessible controls, and a safe response when equipment, power, or connectivity fails.

Ask who pays, who answers, and who covers an absence. Give reviewers time to review. Include appropriate permissions and an understandable way to change them. Preserve a route to necessary support when someone declines optional technology.

A family should not discover that the promised assistance has made them the unpaid technical support team. A professional should not be held responsible for an automated process they cannot inspect or interrupt.

Community and state groups can help by funding the service around the tool, supporting shared learning, and addressing gaps that one organization cannot close. A capable connection cannot substitute for unavailable care.

Genus supplies technology. Partners retain their care, staffing, programs, relationships, professional decisions, and voice. The future described here is a shared invitation, not a product roadmap.

Let Progress Mean Something People Recognize

When an innovation is introduced, ask questions people can answer from experience.

Was the service easier to reach? Could the person influence the arrangement? Did unnecessary work decrease after setup, checking, and maintenance? Was there more room for direct care, contribution, enjoyment, or usable time away? Who remained excluded or carried additional work?

Technical reliability and clinical safety need their own evaluation. So do communication and relationships. The same project may improve one part and reveal a problem in

another.

For an actual test, establish a baseline, a defined population and denominator, a review period, and an owner able to change the process. Use a comparison suited to the claim. Preserve validated instruments where used, and include missing responses, adverse experiences, and burdensome results.

Keep reach, understanding, first action, adoption, useful participation, service receipt, outcomes, and attributable impact distinct. Willingness to recommend, an actual referral, and another person receiving support are different events too.

More trips, readings, or conversations may be useful process information. Their value still depends on what they made possible.

Evidence is how we discover which parts of the hoped-for future deserve to grow.

Help Give the Future Its Purpose

This book began with people: the questions care brings into a family, the professionals and communities willing to help, and the knowledge we can learn to use together.

Its closing invitation belongs to all of them.

A person receiving care can name what they want protected. A caregiver can reveal work that the plan has overlooked. A volunteer can offer an idea. A professional can improve an encounter. A designer can make help easier to reach. A leader can provide the resources and protect the human time the new tool is meant to create.

You do not need to predict the next breakthrough to contribute.

Take one question into the next conversation:

In five years, what would I like to be easier for the people we serve—and what human connection should that make more room for?

Let the answer influence one achievable decision. Bring the people affected into it. Learn enough to decide what should follow.

We welcome what you discover, including the ideas, corrections, and unanswered questions this book has not yet made room for. Our generation's opportunity is not only to create more capable tools. It is to carry human wisdom forward with them.

Return to the futures we imagined: a nurse stays to hear a question; someone reaches a friend; a resident has something to teach; a caregiver has a clear answer and a person to turn to. A family spends an evening together without making every conversation about care. This is the future I hope we choose—more room to listen, contribute, and belong.

More Room to Be a Family.

Notes

1. World Health Organization (2024). WHO releases AI ethics and governance guidance for large multi-modal models. January 18. Source

Return to text

175. ChristianaCare, “ChristianaCare Charts New Course With Nurse Robotics Research Fellowship,” May 12, 2025. Provider account of collaborative-robot use and nurse involvement in a research fellowship; not evidence of quantified savings or clinical benefit. Source check recorded in the original draft: September 27, 2026. Source

Return to text

176. FDA, “Home as a Health Care Hub.” Official initiative and Idea Lab description; design direction, not demonstrated clinical effects. Source check recorded in the original draft: September 27, 2026. Source

Return to text

177. StarTrek.com Staff, “Take the Chair, Make an Impact” This Star Trek Day on September 8, September 3, 2024. Cultural analogy only; not an endorsement or causal innovation claim. Source

Return to text

178. U.S. Department of Transportation, “On Anniversary of ADA, USDOT Announces Winners of its First-Ever Inclusive Design Challenge,” July 26, 2022. Historical prototype competition, not current nationwide service availability. Source

Return to text

179. FDA, “Frequently Asked Questions for the Home as a Health Care Hub.” Development input is not evidence of improved access or health outcomes. Source

Return to text

Appendices and Practical Tools

Put the Knowledge to Work



Connection map — Choose the tool for the need

Use Appendix A to examine evidence and Appendix J to distinguish an idea, capability, deployment and demonstrated benefit. Use Appendix B to understand what the person and chosen supporters want known. Use Appendix C to define an assistant's role and Appendix I to review errors and learning. Use Appendix D to connect a chosen next step with people, resources, confirmation and alternatives. Use Appendix E to prepare a social-worker review conversation and record actual agreement. Use Appendix F to examine benefit, burden, safety, access and what should change. Use Appendix G to establish accepted partner responsibilities and confirm follow-through. Use Appendix H to review understandable content and maintain its knowledge sources. This is the single shared overview for Appendices A–J. The tools are adaptable planning aids, not validated clinical questionnaires, legal agreements or proof of program effectiveness.

Begin with the need—not the form

A useful tool should help someone ask a better question, make a clearer decision, or carry an agreed responsibility. It should not become another obstacle between a person and help.

The chapters have shown what that work can look like. These appendices turn the planning tools into records you can adapt for your setting. They are intended for health systems, home-care organizations, Day Centers, community partners, families, and the people who support them. You do not need to reproduce Pat and Ellen's pathway or adopt a particular technology to begin.

Choose one situation: an introduction that leaves people uncertain, a caregiver who needs practical support, a resource that needs review, or a handoff nobody can confirm. Start with the relevant tool, involve the people affected, and decide who can act on what you learn.

These are **adaptable planning aids**, not validated clinical questionnaires, legal agreements, or evidence that a program works. The fields below develop the book's proposed tools. Required professional procedures and records remain in place; refer to them rather than creating competing instructions.

A family can use selected questions in conversation without completing every field. A staff member can help record the agreed part. Leave room for "not known," "not discussed," and "prefer not to answer." Do not turn an empty box into a guessed fact.

The aim is not a completed collection of forms. It is support that someone can understand, choose, and receive.

Choose the tool that fits

Appendix	Tool	Use it when you need to…
A	**Evidence Register**	Understand what supports a claim and where its limits belong.
B	**Person + Family "What Matters" Profile**	Learn what the person and their chosen supporters want understood.
C	**Assistant Role Card**	Define an AI assistant's task, sources, permissions, review, and limits.
D	**Pathway Map**	Connect a chosen next step with people, resources, confirmations, and alternatives.
E	**Social-Worker Review Meeting Pack**	Prepare a useful conversation and record what people actually agree.

Appendix	Tool	Use it when you need to…
F	**Benefit–Burden–Safety Measurement Plan**	Examine usefulness, effort, safety, access, and what should change.
G	**Partner Handoff Agreement**	Establish what each organization accepts and how follow-through is confirmed.
H	**Content, Tile, and Pathway Review**	Prepare understandable material and maintain the knowledge behind it.
I	**AI Safety and Learning Log**	Respond to errors, preserve useful ideas, and verify the resulting changes.
J	**Genus Capability and Evidence Matrix**	Distinguish an idea, a documented capability, a local deployment, and demonstrated benefit.

The A–J identifiers follow the appendix plan. Related planning cards bring the later chapter outputs into this collection: the project charter and backup plan sit in D, staff support in E, shared learning in F, and organizational knowledge stewardship in H. These are proposed working versions of the chapter tools, not additional principles.

Give each working copy a clear home

For whichever tool you use, record its **purpose, version, date, named owner, relevant reviewer, next review point, approved storage location, and intended recipients**. Add backup coverage where the work depends on a response.

Reuse verified information from the appropriate record instead of asking people to repeat it unnecessarily. Keep private accounts in the appropriate restricted location; a “private” heading inside a document shared with everyone is not a separate channel.

The questions can stay familiar while the language, format, timing, and assistance change. Ask what works for this person. Do not infer beliefs, preferences, or family roles from a demographic label. Protect time for enjoyment and rest as well as action.

Appendix A — Evidence Register

Keep the source and the claim together

Use with: The research sections throughout the book and Reference Chapters R1, R2, R4, and R5.

Create one entry for a claim or finding you intend to use. A source may support several entries, but a broad book title or a folder of papers should not stand in for the evidence behind a specific sentence.

Keep the source, setting, study design, finding, limitation, application, and review status connected. Check product-specific evidence separately.

A1. The evidence entry

Field	What to record
Question and proposed claim	The question being addressed and the exact statement you propose to use.
Source and location	Author or organization, title, publication date, edition where relevant, stable identifier, and the passage supporting the claim.
Access and review	What was actually read: full text, selected sections, abstract, or another source's account. Name the reviewer and date.
Evidence type	Theory, professional guidance, qualitative study, observational study, trial, review, local observation, or product documentation.
Population and setting	Who was included, where the work occurred, and relevant exclusions or differences from your audience.
What was examined	The actual intervention or exposure, comparator, outcomes, and follow-up period. For guidance, record its scope instead.
Finding and uncertainty	What the source found, with the relevant estimate or qualification. Include missing follow-up and conflicting findings when they affect interpretation.

Field	What to record
Evidence judgment	Any grade reported, the grading system, and the conclusion it applies to. Do not invent a grade for an ungraded source.
What it does not establish	The tempting conclusion the evidence cannot support—for example, attributing a service result to software alone.
Proposed local application	What you might change, what resources it requires, and what must be tested locally.
Product-specific evidence?	Yes, no, or not established; identify the exact product, version, task, and evaluation when applicable.
Approved use and maintenance	Where the claim may appear, wording approved by the relevant reviewer, conflicts still open, and triggers for revision or withdrawal.

Keep the behavioral review's evidence judgments separate from other systems such as GRADE. R1 and R8 explain the differences. A theory, a trial result, and a documented feature answer different questions.

A2. Check the transfer into practice

Complete three sentences before writing a benefit claim:

The source establishes: [finding within its actual scope].

Our application proposes: [the design or service change].

Before claiming that it helped here, we need: [the appropriate local evidence].

If sources disagree, retain the disagreement and refer it to the appropriate reviewer. Do not let a more attractive summary silently become the source of truth.

Decision this tool supports: Use the claim as written, narrow it, seek better evidence, or leave it out.

Appendix B — Person + Family “What Matters” Profile

Learn what the care needs to protect

Use with: Chapters 1–5 and 11, and Reference Chapter R3.

Begin with the person receiving care. Invite other people’s accounts according to the person’s preferences and appropriate authorization. The caregiver’s experience belongs in its own right, not only as information about someone else.

Build the profile through relevant conversations rather than requiring every topic at first contact. Its foundation is the person-and-family profile in the appendix plan.

B1. The profile

Field	Question or record
What matters now	What would make the coming days or weeks more manageable or worthwhile?
Identity and relationships	How does the person wish to be addressed? Which relationships and roles do they want recognized?
Enjoyment and contribution	What do they enjoy now? What might they like to share, try, or continue? Contribution remains optional.
The person’s concerns	Their account, using their words where recorded accurately. Distinguish a quotation from a paraphrase.
The caregiver’s needs	What support do they want for themselves? Keep private details in a separately authorized record.
Other accounts	Who reported or observed what, when, and in which setting? Do not merge differing accounts.
Professional guidance	Relevant, verified guidance and its source, date, and responsible professional. Do not turn observations into diagnoses.

Field	Question or record
Routines, culture, and beliefs	What does the person want considered? Ask; include only what is relevant and appropriately shared.
Communication and access	Preferred spoken and written language, format, timing, assistance, and a usable nondigital route.
Practical conditions	Transport, time, cost, environment, service availability, and other circumstances affecting the proposed support.
Chosen involvement	Who may join which conversation or receive which information? Who has actually accepted a task?
Unknowns and review	What needs clarification, who will address it, and when the person can correct or revisit the profile.

Use the profile to change the offer. If someone requests a telephone conversation, identify who will arrange it. If a preferred service is unavailable, keep that gap visible rather than recording the preference as fulfilled.

B2. Shared-understanding note

After a relevant conversation, prepare only the information suitable for its intended recipients:

What we know: [verified information and its source].

What we are asking: [questions and uncertainties, attributed appropriately].

What happens next: [the action the person chose and any action accepted by others].

Who can help: [actual contact, role, availability, and alternative route].

This carries forward the Awareness chapter's practical output. It should make the next conversation easier, not become another account the family must maintain alone.

B3. Barrier and next chosen step

For one proposed action, record **what makes it worthwhile to the person; what remains unclear; what practical help or skill is needed; what concerns deserve discussion; and what they choose next**. Name who can address each unresolved barrier. This adapts Chapter 3's guide without using it as a diagnostic score.

B4. A 4Ms-informed action map

This original planning aid draws on IHI's assess-and-act approach. It is not an IHI assessment form or a recognition checklist. Use the applicable professional guidance and involve the person in each relevant decision.

Element	What should the local plan make clear?
What Matters	The person's stated health and life priorities; the action or arrangement changed because of them.
Medication	The current professional guidance, who is responsible for medication review/support, and what requires clinical follow-up. A list alone is not a review.
Mentation	Relevant observations, their sources, and qualified assessment or support for thinking and mood concerns. Keep uncertainty visible; route urgent changes appropriately.
Mobility	What the person wants to do, the assistance and environment needed for safe movement, and who provides or reviews that support.

For each relevant row, add a named owner, agreed action, review date, and what remains unresolved. See R1, CG4–CG7; the mapping does not establish clinical effectiveness or Age-Friendly recognition.

B5. Two people, appropriately separate information

Keep the caregiver's private account in its separately authorized record. A shared plan may record an agreed request for support without exposing private screening answers or individual-session details. Before collection, identify permitted recipients, the response owner, confidentiality limits, and the safe route when this record cannot enforce separation. Do not add private answers to this worksheet simply because both people are part of the care journey. RUSH's separate-record example is documented publicly in R1, CG3.

Decision this tool supports: What should be explained, adapted, offered, or left for another conversation?

B6. Practical concerns and a route to help

Use only the questions relevant to the person. This is a navigation aid, not legal, financial,

or clinical advice. A private matter can stay in a restricted record while the shared plan records only an agreed action.

Planning field	What to record
Concern in the person’s words	The cost, work, housing, future-planning, or access question they choose to raise; source and date.
Preferred conversation	Who they want involved, preferred language and format, and what may remain private.
Appropriate resource	The qualified professional or service contact able to address the question. Verify the role, availability, cost, and eligibility rather than assume them.
Accepted follow-through	Who accepts the next contact, by when, how the person will hear back, and the alternative if it cannot proceed.
What is still open	Missing information, unconfirmed assistance, or unresolved needs. Record whether the professional conversation or actual help occurred.

Appendix C — Assistant Role Card

Give the assistance a useful job and a responsible home

Use with: Chapters 8, 9, and 13; R1's AI research section.

Start with the human task. "Help a staff member prepare a reviewed first-visit explanation" is more useful than "improve care with AI."

This role card develops the source template's separation of task, information, authorization, review, escalation, and evaluation. It is a planning document—not evidence that the required controls are implemented.

C1. Define the role

Field	What must be decided
Human purpose and task	Who benefits, what work needs assistance, and what the output should help a person do.
Authorized users	Which roles may use the function, for which purpose, and with whose support.
Approved sources	Specific reviewed materials and maintained local facts, with owners and dates.
Personal context	What information is needed and authorized. Use no personal records for generic examples.
Allowed outputs	A draft, explanation, question set, source comparison, or proposed action. State which may be shown to whom.
Outside the role	Decisions reserved for people: clinical judgment, capacity assessment, unauthorized disclosure, or changes to care not properly approved.
Review and action authority	Who reviews each kind of output, what they check, and who can approve a consequential action. Include coverage and review time.

Field	What must be decided
Permission and controls	Recording, access, sharing, retention, and correction arrangements, reviewed by the appropriate leads. Written instructions do not replace actual access controls.
Uncertainty and conflict	How missing or conflicting information is displayed and who resolves it. The assistant must not invent agreement.
Human response	Actual contact methods and service hours, plus the appropriate urgent route.
Fallback and interruption	How people obtain support if the assistant is unavailable, unsuitable, or paused.
Evaluation and maintenance	Accuracy, usefulness, total effort, access, safety, version, owner, review date, and reasons to revise or stop. Link Appendices F and I.

An assistant may help someone prepare questions outside office hours without implying that a professional is available at that time. Describe only the availability the organization can actually provide.

C2. A reusable drafting assignment

Using the approved sources and verified local facts, prepare [specified draft] for [audience and purpose]. Keep research, local information, personal reports, and proposed examples distinct. Identify the source behind factual statements and show what remains unknown. Preserve disagreement and the person's choices. Do not add clinical instructions, invent quotations, or treat a request as an accepted commitment. Send the draft to [reviewer] before [permitted use or action].

Adapt the assignment to the configured system and test it. Uploading a book is not model training or proof that its instructions will be followed. A maintained collection and a reliable retrieval system are separate deliverables.

With the right knowledge, rules, and review, assistance can remove repeated preparation and give people more room for attention. Measure the review and correction work before claiming that time has been saved.

C3. Test the caregiver boundary before real use

This is a proposed acceptance test, not a claim that the controls already exist. Use fictional records containing both a private caregiver disclosure and an agreed shared request.

For every role, test the stored record, search/retrieval, meeting preparation, notifications, printable packets, exports, and family-facing summaries. Confirm that an unauthorized recipient cannot see the private answer directly or infer it from a generated tip. A family-summary assistant should not receive the private content as input in the first place.

Record the exact version, roles, test results, failed routes, and the owner who can pause collection or sharing. Verify urgent-response and correction procedures with the appropriate professionals. Until the boundary is enforced, sensitive assessment belongs in an approved separate process; a prompt instruction is not access control.

C4. Check the constraint before proposing more output

Use this proposed assignment when an assistant helps plan a feature, resource, or workflow. Start with generic or fictional material; use personal information only when authorized and necessary.

Before recommending more content, reminders, automation, or features, establish the intended human result. Identify possible limiting conditions supported by the permitted information, distinguish them from symptoms, and state what remains unknown. Name who can act. Propose a proportionate change and a way to evaluate its effect on the whole experience, including work transferred to other people.

The reviewer should be able to choose less content, a staffing decision, a clearer responsibility, another service, or further investigation. Do not infer motivation, distress, or staff commitment from usage and delays. Caregiver-private assessment answers must remain outside unauthorized operational analysis. R2.5 supplies the method; this assignment is not a claim that a configured agent can reliably identify constraints.

Decision this tool supports: Is this a bounded, supported task the organization is prepared to test and maintain?

Appendix D — Pathway Map

Connect the experience, not just the content

Use with: Chapters 3, 6–8, 11, and 15.

A pathway may include a tile, a saved contact, a call, a virtual meeting, a planned visit, and a review. It should identify the responsibility and practical support between those encounters—not simply their order.

D1. First Pathway Project Charter

Complete this before inviting people into a new process. It translates Chapter 15's project charter into a working card.

Field	What to agree
Purpose and population	One meaningful need, the people and setting, and what they want the support to make possible.
Scope	Where the pathway begins and ends, what existing care continues, and what this project will not undertake.
People shaping the design	Intended users, caregivers where appropriate, frontline staff, volunteers, and relevant professionals and partners.
Owners and roles	Named project lead, service owners, appropriate reviewers, and accepted partner responsibilities.
Suspected limiting condition	What is currently preventing the agreed support from working? Distinguish the observed problem from its suspected cause.
Evidence and alternatives	Dates, permitted observations, demand and usable capacity; what is missing and which other explanations remain plausible.
Authority and safeguards	Who can change the arrangement, what resources they need, and how safety, privacy, choice, continuity, staff breaks, and family workload remain protected.

Field	What to agree
Resources	Staffing, protected preparation time, training, access assistance, technology, costs, funding responsibility, and coverage.
First test	The version to try, appropriate approvals, test conditions, baseline, observation period, and review date.
Decision and continuity	Who can continue, change, pause, or expand the process, and how existing participants retain appropriate support if it changes.

State the purpose in ordinary language:

For [people in this situation], we propose [defined support] so they can [meaningful result]. We will examine [benefit], [burden], [safety], and [access] during [period], with [person] responsible for the decision.

This is a proposal to examine, not a prediction that the result is assured.

D2. Repeat this card for each stage

Stage field	What to record
Starting situation	What begins this stage and what the person needs or wants now.
Relevant knowledge	Approved information needed for the next choice, with its source and any unresolved question.
Encounter or material	Article, video, tile, survey, call, meeting, visit, or activity—and the job it performs.
Choice	Available options, including appropriate alternatives, pausing, or declining optional participation.
Action and responsibility	What happens next, who has accepted it, and who receives the information or support.
Permission	What information may move, to whom, through which approved route.

Stage field	What to record
Timing and confirmation	When action is due and what event confirms receipt, acceptance, scheduling, or delivery. Record these separately where needed.
Exception and review	What happens after silence, a changed preference, unavailable service, or absent worker; who reviews the result.

The source pathway map includes triggers, goals, information, owners, receivers, confirmations, fallbacks, and measures. This card keeps those fields usable without requiring a very wide worksheet.

D3. Shared-care commitment and backup

For one responsibility, record **the task and its limits; the person who accepts it; the period covered; the preparation required; how completion is communicated; who handles changes; and the backup that has actually been agreed**.

Also ask: **What coordination work does this remove, and what work does it add?** Do not automatically leave reminders and backup arrangements with the primary caregiver. The adults' responsibilities remain separate from children's family relationships.

Before using the pathway, rehearse one ordinary route and one interruption with fictional information. Check whether someone still owns the next action when the usual person is absent. Do not introduce deliberate errors into live care as a practice exercise.

Decision this tool supports: Is the next piece of support complete enough for someone to rely on?

D4. Human-experience and journey map

Choose one segment of care and use this card for each important stage. Describe the current route before drawing the proposed one. Keep participant, caregiver, and staff accounts distinguishable; do not combine private disclosures into a shared map.

For each stage	Record and check
Event and sequence	What happened, when, and what was expected next. Distinguish request, acceptance, delivery, and review.

For each stage	Record and check
Whose experience?	The person’s or role’s account, its source and date, and permission for this use. Use their meaning, not a guessed emotional label.
Understanding and purpose	What they say they wanted to do, understood, or wanted clarified. “Not yet asked” remains visible.
Existing help and effort	Useful support already present; calls, travel, paperwork, waiting, and work required from each role.
Missing or uncertain	What is not known, what has not been confirmed, and alternative explanations of a difficulty.
Proposed response	A change in content, timing, language, human contact, practical resources, or responsibility; what must remain protected.
Owner and review	Who can authorize and deliver the change, required resources, what will be checked, and when contributors hear the result.

Fictional example: a first-visit request reached the center, but the family did not know whether a callback was expected. The map records both the receipt event and the family’s account. The team investigates ownership and timing before concluding that the invitation needs more persuasive wording.

Use the map with D1’s constraint fields and Appendix F’s measures. A map helps select and examine a change; it does not itself resolve a service gap.

Appendix E — Social-Worker Review Meeting Pack

Arrive prepared, leave with an understood next step

Use with: Chapters 4, 9, and 11.

This pack follows the recurring meeting's purpose: hear different accounts, preserve uncertainty, agree appropriate actions, and review whether the support helped. A social worker may facilitate within their role; clinical questions stay with the appropriate clinicians.

E1. Prepare the conversation

Field	What to bring
The person's priorities	What they want to discuss or decide, and how they wish to take part.
The caregiver's priorities	Their needs and questions, with a separate route for matters not appropriate for the shared meeting.
Chosen participants	Who is invited, for what role, and with what appropriate permission.
Relevant accounts	Dated, attributed observations and reports; identify where people describe the situation differently.
Professional guidance	Current, relevant instructions and the professional responsible for them.
Decisions and open questions	What might be agreed today, what requires someone else, and what will not be decided here.
Access and preparation	Language assistance, format, timing, accessibility, and any support needed to participate comfortably.

Use the familiar rhythm: **notice → ask → understand together → agree → support → review**. A concern needing prompt professional attention follows its appropriate route;

it does not wait for the next routine meeting.

If AI helps prepare a draft, label the sources and review it before the conversation. Conflicting accounts are information to discuss, not a problem for the assistant to erase.

Select meeting evidence from the shared plan, not automatically from the caregiver's private assessment. Obtain the relevant authorization for any specific disclosure; a shared meeting invitation is not blanket access to individual-session records. See Chapter 11 and Appendix C.

E2. The meeting closeout

For each decision, record **what was agreed; by whom; what remains unresolved; the person accepting the next action; the due or review point; who may receive the summary; and how an error can be corrected**.

A proposed closing question is:

Before we finish, is anything in this summary different from what you understood? What is the next thing each of us has actually agreed to do?

Do not label a conversation successful merely because nobody objected. Offer a suitable route for later questions. An unanswered concern retains a responsible follow-up route, not an empty field.

E3. Separate staff and volunteer support plan

For the people delivering the service, record **the work expected; time and staffing required; preparation or supervision needed; the person who responds when help is needed; absence coverage; work that can be removed or shared; and the date for reviewing workload and usefulness**.

Keep this separate from family-private records. Ask staff and volunteers what the process makes easier or harder, and how they want useful contributions acknowledged. Support is not a hidden individual ranking. This develops Chapter 11's separate staff-support plan.

Decision this tool supports: What have people understood and accepted, and what support makes those commitments realistic?

Appendix F — Benefit–Burden–Safety Measurement Plan

Decide what the findings can change

Use with: Chapters 10, 14, and 15, and Reference Chapters R1 and R8.

Choose measures that help decide whether to continue, adapt, stop, or expand a service. Include benefit, burden, safety, access, a baseline, responsibility for review, and the people's own accounts.

F1. The measurement plan

Field	What to define before the review
Human purpose	What matters to the people receiving or providing the support, and which question the evaluation should answer.
Population and setting	Who is included, who may be missed, and which access routes are available.
What is being tried	The actual service, content, staffing, and workflow version—not only its name.
Baseline and comparison	What happens now and what comparison can support the intended conclusion. Record missing baseline information honestly.
Benefit	A specific result to examine: understanding, received support, useful participation, caregiver relief, or another relevant outcome.
Process	What action should occur and how it will be confirmed. Do not substitute this measure for the intended benefit.
Burden and resources	Family effort, travel, cost, staff preparation, review, correction, duplicate entry, and after-hours work.

Field	What to define before the review
Safety and privacy	Errors, missed responses, inappropriate pressure or sharing, and the responsible route for addressing concerns.
Equity and access	Who could not use the offer, who withdrew, and what is known about the reason. Do not infer demographics or preferences.
Measure specification	Unit, numerator and denominator where relevant, data source, instrument/version, language, respondent, and handling of missing information.
Period and review	Enrollment and follow-up periods, frequency, named reviewer, and the decision the result can change.
Action criteria	What prompts investigation, correction, pause, or expansion; who has authority; and how ongoing care is protected.

Use a few measures well. Do not require every family to complete a new survey when an authorized existing record can answer the operational question. When a validated instrument is appropriate, use its required wording and scoring rather than an AI rewrite.

F2. Keep different results separate

Distinguish **reach, understanding, a first chosen action, adoption, useful participation, outcomes, and attributable impact**. Also distinguish a willingness to recommend, an actual referral, and another person receiving help. The behavioral review uses these distinctions to prevent activity counts from becoming unsupported benefit claims.

Hypothetical arithmetic example: Twelve requested conversations were due during a review period. Eight occurred, two were still awaiting a response, one person declined the conversation, and one outcome remained unknown. Report eight of twelve completed conversations, with the other categories visible. The two unanswered requests still need an owner. This count says nothing by itself about caregiver strain or health improvement.

Use the nine original outcome areas as questions to investigate: culture of care, integration of social needs, care equity, community connections, relationships, quality of life, reduced burnout, improved care outcomes, and organizational sustainability. They are not nine guaranteed effects.

The Jack Scale remains a historical and proposed review tool, not an established clinical assessment. These appendices do not use it to rank families, staff, or entitlement to help.

F3. Decision and remeasurement record

Record **the finding and date; evidence and uncertainty; the contributor's account; the decision; the named decision-maker; the change actually made; its date; and the later result**. Log reasons for no change as well as changes made. Keep unfavorable and burdensome results.

A report that ends with "the team will review" needs a named person and a review point. This follows the dated improvement-register specification, which also distinguishes that register from the product itself.

F4. Shared Learning Brief

Prepare a version another organization can understand without unnecessary private records:

Our question and setting: [need, population, resources, and access conditions].

What we offered and changed: [actual intervention and versions].

How we examined it: [baseline, comparison, measures, period, missing information].

What happened: [favorable, unchanged, adverse, and burdensome findings].

What we cannot conclude: [uncertainty and other plausible explanations].

What happens next: [decision, owner, next review].

Sources and contributors: [credit, permissions, funding interests, and approved sharing].

Use common definitions before comparing organizations. A service shortage deserves a resource decision, not a ranking of the families unable to obtain care.

F5. Caregiver assessment and reassessment card

Complete this card before collecting sensitive assessment data. It is a local planning tool, not a new questionnaire or a requirement to administer every instrument named in R1.

Planning field	What must be specified
Purpose and measure	The caregiver's need; tool, version, language, permissions, population fit, and the professional interpreting it.

Planning field	What must be specified
Starting point	What baseline means here: enrollment, first assessment, or another defined event. Record the actual date.
Return points	Dates and their anchor event. RUSH's published example includes one and three months after completion or other agreed times (CG1–CG2); do not substitute a different schedule silently.
Response and safety	Named reviewer, review window, agreed assistance, and appropriate urgent escalation. Do not postpone a needed response until the next assessment.
Choice and missingness	A route to decline a nonmandatory question or ask privately; distinguish declined, not asked, missing, and answered. Follow instrument rules; do not impute zero need.
Privacy and access	Where answers are stored, who can access them, what may enter a shared plan, and the tested exclusions from AI inputs and family outputs.
Evaluation and ownership	Denominator, follow-up coverage, burden, access, adverse findings, and the person authorized to change the process. Local pre/post change is not proof of cause.

F6. Pathway flow and unresolved demand

Use these optional local measures for a constraint-focused project. Keep the caregiver outcomes and privacy arrangements in F5. The definitions below are proposed planning conventions, not a validated questionnaire or a TOC certification. IHI's outcome, process, and balancing-measure approach provides the wider evaluation discipline.[75]

Measure	Definition to agree	Protection against a misleading result
Time to substantive response	Elapsed time from a defined request event to a response addressing the need or agreeing its next handling.	An automatic receipt is not necessarily substantive. Report the starting date, working/calendar time, and unanswered requests.
Time to confirmation; time to service	Measure separately from the same defined starting event to an accepted arrangement and to actual delivery.	Do not rename an intake date as a referral date. Specify the endpoint and include missing dates.
Service delivery rate	Defined appropriate services actually delivered per week or another stated period.	Keep people, visits, and service hours distinct. This is not financial throughput or a measure of care quality.
Unresolved demand	Open requests at the review date, their age, stage, known reason, and responsible responder.	Do not erase a waiting person by closing a record, transferring it to another queue, or calling no response a decline.
Handoff reliability	Due handoffs reaching a specified stage divided by all handoffs due for that stage in the review period.	Recipient acceptance, confirmation, and service receipt are separate stages; retain unknown and overdue outcomes.
Total effort and human result	Staff and family coordination, setup, review, correction, travel, cost, and the relevant experience or outcome.	Pair process improvement with safety, privacy, access, appropriate priority, and the person’s chosen goals.

Hypothetical arithmetic example. Of 12 requests due for a substantive response, eight received one, two are waiting, one person declined further contact, and one outcome is unknown. The response proportion is 8/12. Five visits delivered that week means a delivery rate of five visits—not eight responses or 8/12 visits. These counts alone establish no clinical or caregiver benefit.

Report completed-case waiting times alongside the ages of open requests; show longer waits when the sample supports that description. Define missing, declined, not applicable, and still waiting separately. Preserve clinically appropriate priorities. Investigate whether faster service came from shifting work, narrowing access, or shortening a conversation that people needed.

Verify data availability before promising a measure. Missing referral or completion dates must remain missing. Appendix J records the dated field limitations; check later versions rather than invent dates or assume measurement is automated.

Retain F1's measure definitions, comparison, period, source, effort, reviewer, and action threshold. Examine adverse, unequal, and burdensome findings as well as benefits. A pre/post pattern informs learning without proving cause. Decide whether the support is useful, safe, accessible, and sustainable enough to continue; see R1's measurement guidance.

Notes

75. Institute for Healthcare Improvement. Model for Improvement: Establishing Measures. Guidance on outcome, process, and balancing measures. Source

Return to text

Appendix G — Partner Handoff Agreement

Transfer a defined responsibility—not just a message

Use with: Chapters 5, 7, and 12.

This is an operational planning aid, not a substitute for contracts or appropriate professional and privacy review. Start with one recurring handoff and the relevant people on both sides. The source template specifies purpose, permitted information, status, responsibility, response, fallback, and closeout.

G1. The partner agreement

Field	What the partners agree
Shared purpose and scope	What the person wants help with, what each organization provides, and what falls outside the arrangement.
Fit and availability	What eligibility, assistance, capacity, timing, and costs must be verified for an individual request.
Named contacts	Responsible people on each side, contact methods, hours, and absence coverage.
Information and authorization	What needs to travel, why, who may receive it, the approved route, and the relevant authorization.
Acceptance	The event confirming that the receiving service has accepted a defined next action.
Response expectations	Agreed timing for acknowledgment, a substantive response, and an update when the request remains unresolved.
Delivery confirmation	What establishes that the conversation, assessment, journey, visit, or other agreed service occurred.
Change or failure	Who acts after silence, cancellation, refusal, lack of capacity, or a changed preference.

Field	What the partners agree
Urgent concerns	The separate approved clinical or urgent route; ordinary referral queues do not replace it.
Family communication	Who tells the person what happened, through their chosen route, and who answers the next question.
Resources and review	Staffing, coordination time, costs, responsibilities, and when the partners examine recurring difficulties.

Agree who tracks the request before acceptance and who follows the accepted action afterward. A coordinator's role does not make them responsible for everything another service provides.

G2. One-request handoff record

Record **the request and date; receiving contact; information permitted to travel; acknowledgment; accepted action; scheduled event; delivered service and confirming source; remaining need; next owner; and the update given to the person**.

Use R8's status language. "Received" is not "accepted." "Scheduled" is not "delivered." A provider can answer promptly that it has no capacity while the person's need remains unresolved.

Suggested wording for an incomplete arrangement:

We have [verified status]. We have not yet confirmed [outstanding part]. [Named person] is checking [next action] and will contact you through [agreed route] by [agreed time]. Your appropriate contact before then is [verified contact].

Use that wording only after someone accepts the commitment. Keep related needs—such as the visit and the journey—separately confirmed when different providers own them.

Decision this tool supports: Does the person receive a responsible response while the partners establish what help is actually available?

Appendix H — Content, Tile, and Pathway Review

Make the experience understandable and the knowledge maintainable

Use with: Chapters 2, 6, 8, and 13; Reference Chapters R2–R8 as relevant.

Begin with one audience, situation, and purpose. Do not start by asking how much content an assistant can generate. Design turns an organization's knowledge and resources into something a person experiences.

H1. Engagement and content brief

Design question	What to prepare
Why does this matter?	The recognizable situation and potential value to the person—not only the organization's goal.
What is the main idea?	The essential explanation, with appropriate detail available and facts preserved.
What should be demonstrated?	An action, conversation, or choice that benefits from being shown. Label staged examples and preserve necessary human work.
What can the person choose?	A specific, feasible next step, including an appropriate alternative, request for help, pause, or decline.
Where do questions go?	The actual responder, access route, timing, privacy arrangements, and permissioned sharing.
What follows?	Accepted responsibility, confirmation, review, and how the person can report whether it helped.

This is the book's flexible pattern, not a requirement to put six headings on everything. Urgent messages begin with the urgent action. An activity can end with enjoyment. A validated questionnaire keeps its required wording and scoring.

Give each format a job. A **video** can demonstrate. An **article** can explain details. A **survey** can ask a question linked to a decision and a response. A **message** can

communicate the relevant update. A **call or meeting** can address the person's circumstances. A tile can collect those resources; the pathway connects them with support.

H2. Review before use

Review area	Evidence of readiness
Accuracy and source	Facts match approved sources; research findings, local facts, and proposed examples remain distinct.
Human fit	Intended users helped examine language, format, beliefs, timing, and relevant assistance. No demographic assumption substitutes for a stated preference.
Understanding and access	People can locate the main point and help route using appropriate support. A nondigital alternative is identified where needed.
Choice and dignity	Participation is not framed as proof of love or cooperation. Adult language, privacy, and the right to decline are respected.
Responsibility and capacity	The advertised response and service can be provided by named people with appropriate coverage.
Professional boundaries	Relevant clinical, operational, privacy, and other reviewers approve the parts within their responsibility.
Production and reuse	Permissions, quotations, images, fictional labels, version, owner, and withdrawal route are recorded.
Evaluation	Usefulness, effort, errors, access, and follow-through are examined—not only opens or completion.
Creative fit and reuse	Check whether story, metaphor, humor, poetry, music, or imagery fits the person, purpose, culture, and access needs. Preserve essential instructions, easy stopping, source/fiction labels, and required rights or permissions.

Record the decision as **approved for a specified use, revise, hold, or retire**, with reviewer and date. This is an editorial release decision, not certification of clinical effectiveness.

H3. Organization Knowledge and Configuration Brief

Record the mission, audience, approved sources, current services, contacts, formats, and conflict-resolution authority. Define authorized AI tasks and personal-information boundaries, reviewers and coverage, maintenance dates, and local testing.

For each entry, keep its question, relevant principle, source and limits, approved application, owner, permitted use, and review date. Link research detail to Appendix A and assistant responsibilities to C instead of creating competing copies.

Keep a record of which articles, videos, messages, and assistant resources depend on an entry. When a material fact changes, identify affected versions, withdraw or correct them, and check that the revised guidance is actually being used.

H4. A reviewed family-update structure

Appendix J's dated Day Center example offers four headings: To talk about tonight; Ideas for home; Caring for yourself; For your next visit. They organize a reviewed update; they do not establish completed learning.

Use the headings where they fit, with reviewed information—not invented moments. Home ideas are optional and follow approved guidance. The caregiver section should support rather than add duties; a question about the next visit needs a responder.

A shared "Caring for yourself" section may offer generally appropriate, reviewed resources. It must not reveal a confidential caregiver answer, score, or individual-session detail, directly or by inference. Keep private assessment sources outside the family-summary assistant's permitted input; verify the actual controls using Appendix C.

Decision this tool supports: Does this item offer understandable value, and can the organization stand behind what it invites?

Appendix I — AI Safety and Learning Log

Respond to problems and preserve useful improvements

Use with: Chapters 9, 10, 13, and 14.

This log follows the source specification for questionable output, consequences, correction, and resulting change. It does not replace the organization's immediate care, safety, or incident-response procedures. Attend to the person first; record and review the learning through the appropriate route.

I1. One issue or learning entry

Field	What to record
Event and version	Date, task, workflow/model configuration, source set, and output version.
How it was noticed	The question or observation raised by a patient, participant, caregiver, volunteer, staff member, reviewer, or other source.
What happened	The exact problem or useful observation, with relevant material stored only in its approved location.
Exposure and consequence	Was it reviewed, shared, or acted on? Who may be affected? Distinguish observed consequences from possible ones.
Immediate response	Correction, appropriate contact, containment, or a decision to pause—by whom and when.
Cause and uncertainty	What is established, what is suspected, and what still needs investigation.
Decision and change	The named person's decision and the actual revision to sources, instructions, workflow, training, or access.
Verification	How the change was tested, what remains unresolved, and the next review date.

Field	What to record
Credit and permitted learning	How contributors wish to be acknowledged and what lesson can be shared without exposing private information.

Record problems that were caught before publication as well as those reaching users. Do not reward only positive reports or treat a person raising a concern as the problem.

I2. Optional live and post-encounter assistance

Agree to live assistance before use: what may be captured, who receives it, how to pause, and the human-led alternative. The facilitator checks prompts about unresolved questions; the assistant does not infer emotions or decide who is right.

Afterward, organize only permitted feedback, preserve different accounts, and record the change people actually made—not a claim that the AI learned.

Record the decision, actual change, and remeasurement, including difficult results. Keep this log outside the software when needed; Appendix J records the dated capability limits.

Decision this tool supports: Has the risk been addressed, has the correction worked, and what should the organization learn or share?

Appendix J — Genus Capability and Evidence Matrix

Make the claim no larger than the verified record

Use with: Chapters 8, 9, and 13–15.

This appendix separates capability and deployment from evidence of benefit. The matrix below is a verification tool, not a live product inventory. Current entries require the relevant product and partner owners to confirm them.

Genus supplies technology; partners retain their services, staff, programs, and professional responsibilities. Another organization can apply the same matrix to its own suppliers.

J1. Record one experience or claim

Field	What must be established
Claim and intended audience	The exact proposed statement and where it will appear.
Capability and source	What the tool does, the supporting record, its date, and what was actually inspected.
Availability status	The documented label: generally available, configurable, pilot, proposed, or future concept. Record scope rather than forcing overlapping conditions into one label.
Implementation and use	What is built, tested, and actually deployed; exact version, setting, and date where verified.
Local conditions	Configuration, integration, permissions, equipment, training, and staffing needed.
Human and partner responsibility	Who reviews, approves, responds, delivers care, and maintains the arrangement.
Evaluation evidence	What was tested, with whom, against what comparison, on which outcome, and with which limitations. Link Appendix A.

Field	What must be established
Not established	Missing current verification, unavailable functions, untested outcomes, and any claim requiring narrower wording.
Approval and review	Product owner, relevant partner approval, permitted wording, next review date, and reason to withdraw the claim.

“Implemented,” “tested,” and “deployed” answer different questions. “Configurable” does not establish that the particular organization has enabled and tested the required configuration. Nor does deployment establish better health or lower workload.

J2. A dated-source example—not a current capability verdict

The August 31, 2026 export says that family notes require human approval before publication. It also states that updates do not automatically return to a referring practice. Those descriptions can inform what a reviewer checks; they do not establish today’s configuration at a particular partner.

For that entry, record the documented function, then leave **current local verification** and **outcome evidence** unresolved until appropriate records are reviewed. Do not convert “supports a reviewed note” into “reduces caregiver strain” without relevant evaluation.

A financial or funding statement also needs its own current evidence and responsible review. Service counts, clinical outcomes, costs, and payment eligibility are not interchangeable facts.

J3. Dated implementation record: what the example can support

The narrative chapters use these examples to make design choices concrete. Their details are kept here so the principles do not depend on a frozen product version. This record does not establish effectiveness. The source is identified below by its title, schema, and export date; it is an author-held organizational record.

Dated item	What the August 31, 2026 record establishes—and what to verify locally
Record status	Genus Day Centers Inspire, schema genus.dayCenterInspire.aiExport.v2, exported August 31, 2026. This is an organizational content/configuration record, not an independent product audit or current availability guarantee.

Dated item	What the August 31, 2026 record establishes—and what to verify locally
Intake and profile	The record describes communication preferences, updated intake information, and history. Verify actual field access and updating. The recorded intake date is not a separate referral date; source-of-referral free text is not a closed referral record.
Bookings and attendance	Reservations include approval, waitlisting or decline. A booked day is not an attended day. Closeout describes a day or Monday-to-Friday week, with participant detail inside it; arbitrary per-person date-range reporting was not described as available.
Reviewed family notes	Four editable sections are described: To talk about tonight; Ideas for home; Caring for yourself; For your next visit. A person approves publication. Verify this gate and every disclosure route; the caregiver section does not authorize use of private assessment answers.
Draft persistence	The export says some family-report drafts and day narratives remain session-only until publication. Test saving and recovery; do not imply that an unpublished draft has been persistently stored.
Feedback and referring practices	Tile feedback is saved and notifies the center; comments depend on configuration. A human still reads and responds. Automatic return of information to the referring practice is not established.
Education and training	Family guides and educational material can be delivered/exported; reading completion is not captured. Staff training records are per learner; a center-wide completion roll-up is described as planned. Neither delivery nor a course pass establishes competence for every care task.

Dated item	What the August 31, 2026 record establishes—and what to verify locally
Practice and group entry	Paired huddles, branching practice scenarios, and group activity entry with individually correctable records are described. Private huddle commitments are not collected or compared. Check the actual design, burden, and professional requirements locally.
Sensitive caregiver information	The record describes a four-item intake baseline and a caregiver-private lane in development. This does not establish equivalence to C4C instruments or tested separation from family-facing outputs. Use a suitably restricted process until required controls are verified.
Program fit and clinical roles	A dementia diagnosis is described as an eligibility condition in this particular configuration. It is not a universal Day Center rule. A support-planning badge is non-diagnostic; clinical staging and treatment belong to qualified clinicians.
Local measurement	Documentation time is measured locally, not automatically by the software. The incident record has owners and due dates but no completed-at timestamp for closure-duration analysis. Intake lacks demographic fields needed for some proposed comparisons.
Content authoring and shared learning	Some common course/story content requires a code change and redeployment; limited local supplements are separate. Broader authoring, provenance and cross-center contribution are described as planned. The proposed improvement register is maintained outside the product.
Respite and program allowances	The described system does not meter respite allowances. Any allowance is held by the responsible partner program; verify current program rules and local records rather than infer available hours from bookings.

Dated item	What the August 31, 2026 record establishes—and what to verify locally
Continuing verification	Retain the version, owner, evidence, test date, permitted use, and unresolved limits. Test privacy at collection, retrieval, drafts, exports, notifications, print, and publication. A newer version must be checked rather than presumed equivalent.

J4. Verify the caregiver pathway and the 4Ms claim

The August 31, 2026 Day Centers Inspire record described caregiver-only separation as still in development while also stating the intended privacy boundary. That is a dated requirement and capability gap, not proof that today's configuration enforces it. Record and test actual local permissions across intake, AI retrieval, meeting drafts, printing, exports, and family summaries before collecting sensitive answers in that pathway.

A four-item local intake is not established as the full C4C assessment battery. An AI instruction is not a separate clinical record. A reviewed family note is not a private caregiver consultation. Leave each implementation claim unresolved until the relevant records and tests support it.

Use **4Ms-informed** for this book's proposed Day Center mapping. Document which assessments and actions the service can actually deliver, which qualified professionals are responsible, and which require partners. Cite the Hartford Foundation and IHI; do not claim an Age-Friendly designation, affiliation, or endorsement unless the particular site has the required evidence. Public guidance and recognition information are in R1, CG4–CG7 and CG14.

Decision this tool supports: What can we truthfully promise in this setting, and what still needs to be established?

Use the Tools, Then Return to the People

You do not need every appendix for every task. A first conversation may need only selected questions from B. A handoff may need D and G. A team preparing an AI-assisted resource may use A, C, H, and I, with a small measurement plan in F.

Start with one meaningful need. Adapt the relevant tool with the people who will use it. Provide the time, resources, and authority behind the next action. Then ask what happened.

Keep what helps. Revise what creates confusion. Remove duplication. Return to contributors with what changed, and preserve the learning another team can responsibly use.

The final question is not whether the worksheet is complete. It is whether someone is

better able to understand a choice, receive support, share a responsibility, or enjoy an ordinary part of life.

The tools belong behind that experience.

More Room to Be a Family.