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Engaging Individuals in Their Healthcare Through Education and Awareness

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Engaging Individuals in Their Healthcare Through Education and Awareness

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Doctor of Nursing Practice Translational Research and Clinical Project

Engaging Individuals in Their Healthcare through Education and Awareness
Margaret I. Haddock

This project fulfills part of the requirements for graduation in the Doctor of Nursing Practice program at Georgia College & State University and has been approved by the student's Translational Research and Clinical Project Committee.

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Abstract

The purpose of this descriptive pre/post study was to identify if individuals within a church population were engaged participants in their health and healthcare. The project aims were three: (a) to ascertain the knowledge, skills and confidence of the participating parishioners in relation to their health through the use of the Patient Activation Measure™ (PAM™), (b) to provide information and awareness on healthcare topics to all participants (engagement, care transitions, communication with one’s healthcare provider and the importance of asking questions), and (c) to assess the health status and health education needs using a demographic health survey. This project established the groundwork for the creation of a faith-based health ministry at the investigator’s church. The framework used was the Institute of Healthcare Improvement’s Triple Aim. The goals of the Triple Aim are to improve the health of populations, improve the overall experience of care and reduce the per capita cost. The 41 participants were mostly female, 60-69 years old, married, retired and Caucasian. The number of participants in each of the four PAM Levels aligned with a 2007 national survey by Hibbard and Cunningham (2008). Almost 93% (38) of all participants rated their health as excellent or good. Of those, 31 participants (81.6%) scored in Levels 3 and 4, the highest activated. The demographic survey provided topics of interest for future program development. These findings suggest a foundational process for other Faith Community Nurses initiating similar health ministry development.

(Keywords: patient activation, engagement, faith-based nursing, care transitions, Triple Aim)
Chapter I
Introduction and Overview of the Healthcare Environment

In a report published by the Robert Wood Johnson Foundation (RWJF), Medicare data analysts at the Dartmouth Atlas Project, shared the federal government’s concern that one in five elderly patients returns to the hospital within 30 days of discharge (Goodman, Fischer, & Chang, 2013). The cost to Medicare is 17 billion dollars for what the Centers for Medicare and Medicaid Services (CMS) call preventable admissions. These readmissions, while associated with where a person lives and the health system delivering the care, have multiple triggers. Two significant readmission triggers identified in the literature are inadequate patient transitioning from one level of care to another, and lack of patients’ engagement or activation in their own care (Coleman & Berenson, 2004; Mitchell et al., 2013; Naylor, Aiken, Kurtzman, Olds, & Hirschman, 2014). When inadequate care transitions occur, errors become frequent, leading to medication mistakes, and missed information. More than half of discharged Medicare patients have no follow up appointment to see a primary care or a specialist within two weeks of discharge, suggesting poor care coordination between the hospital and the community clinicians. Patients feel confused and ill prepared to take on the task of self-care and readmissions occur. Li, Young and Williams (2014) suggested that miscommunication between providers during a patient handoff accounted for 80% of serious medical errors.

Healthcare continues to get more complex as the Patient Protection and Affordable Care Act (PPACA), referred to as the Affordable Care Act (ACA), drives individuals from a “sick care” system to one of prevention and wellness (DeVille & Novick, 2011, p. 102). Included in the ACA are provisions that increase ownership and accountability for health care providers for total cost of care and quality outcomes. These provisions tie provider health care payments to quality, known as value based care, while moving the payment structure from the traditional fee
for service payment (FFS) (Davis, Guterman, & Bandeali, 2015; Hibbard, Greene, & Overton, 2013). This shift toward improved quality benefits occurs from a more active accountability and participation from the patient and family. Facilities and providers will benefit from identifying which teaching and training interventions will help move their patients further along the health care continuum toward self-advocacy. Clinicians cannot merely overwhelm patients with interventions and education if patients and families are poorly equipped to absorb or act on the information. Clinicians must assess patients to identify if they have the skills, confidence and knowledge to absorb what is being presented.

The ACA has created significant regulations and mandates for hospitals and providers that bonus or fine hospitals based on their readmission rates as well as their quality metrics. The ACA has also provided transparency for patients and families on a facility’s reported quality level to allow patients and families to make healthcare decisions based on that quality level. As one example, individuals can access the CMS’s Hospital Compare to view the ratings of their local hospitals. Hospital Compare is part of the CMS’s Hospital Quality Initiative, rating hospitals on measures agreed upon by the CMS and public sector sponsors such as The Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), the National Quality Forum (NQF) and the Agency for Healthcare Research and Quality (AHRQ) (Centers for Medicare & Medicaid Services, 2013).

There is ongoing research on patient accountability and improving health literacy, or the extent to which individuals have the competence to acquire, manage, and comprehend simple health information and programs needed to make appropriate health decisions (United States Department of Health and Human Services, n.d.-b). The momentum for patient involvement has created consumer groups, blogs, and websites dedicated to improving the patient experience and patient awareness (Engaged Patients, 2015).
Hospitals and providers alone cannot prevent the revolving door of readmissions. Individuals, families, and communities together need to become educated and enlightened through community awareness and education programs in order to impact readmission statistics. Hospitals and providers will need the attention and partnership of individuals in their own care to improve outcomes and satisfaction while reducing per capita cost, as required by the CMS.

This translational project focused on measuring healthcare engagement in a specified population and demonstrated the impact educational interventions and discussions have on participants’ knowledge and actions related to their health. It was essential to first evaluate what drives the need to become empowered and activated in one’s healthcare. Prior to creating solutions around engagement and readmissions, one must have a thorough understanding of the current regulatory environment and all related issues of cost, care transitions, patient safety, and satisfaction.

**Readmissions and Cost**

Goodman et al. (2013) showed there had been little improvement in the readmission rate since 2004, the earliest year readmissions had been studied. For the period of 2007 through 2011, the national 30 day all cause hospital readmission rate showed an average of 19 %, falling to 18.4 % in 2012 (Gerhardt et al., 2013). Reducing readmissions has been a significant priority for those in policy positions and in the CMS. The CMS has led multiple national initiatives to address readmissions from regulatory to community partnerships and from change in payment policies to shared savings for providers (Gerhardt et al., 2013). Being able to determine what the United States spends on healthcare from decade to decade is of great interest to all including the general public (Fuchs, 2013). Policymakers and analysts evaluate trends and sustainability by closely following economic indicators such as the Gross Domestic Product (GDP) (Hockenberry & Thorpe, 2014).
A 2012 Henry J. Kaiser Family Foundation report revealed that the portion of the economy devoted to health care has risen steadily for at least 50 years going from 5.2% of GDP in 1960 to 17.9% of GDP in 2010. The growth of a country’s economy is measured by growth in GDP which is viewed as the “value of all final goods and services produced in an economy” (Hockenberry & Thorpe, 2014, p.1). The same report indicated that health care costs per capita have grown an average of 2.4 percentage points faster than the GDP since 1970. Many ask how a health care cost higher than economic growth (GDP) is sustainable. Hockenberry and Thorpe (2014) suggested while the three decades growth of GDP has remained in the forefront as an issue with policymakers and economists, the proportion of GDP assigned to health care expenditures has also been a major concern. While the U.S. healthcare system measures of health lag behind other developed nations, the proportion of GDP spent on healthcare continues to escalate faster than other developed nations (Hockenberry & Thorpe, 2014). In 2015, authors of a CMS report anticipated that when fully totaled, 2014 U.S. health spending would have reached $3.1 trillion, or $9,695 per person, and would have increased by 5.5% from the previous year. This resulted from millions gaining new health insurance coverage and new expensive specialty drugs hitting the market (Centers for Medicare & Medicaid Services, 2015a). The CMS actuary’s most recent projections predicted that health spending will almost double to $5.2 trillion in 2023 when it will account for 19.3% of the economy (Millman, 2014). Fuchs (2013) suggested that the slow growth of national health care expenditures in 2010 and 2011 resulted, in part, from the move from brand-name drugs to generics and the push to reduce hospital readmissions.

Berwick and Hackbarth (2012) suggested that more than 20% of total health care expenditures are a result of waste, including overtreatment, inadequate care coordination, errors
and failure of care delivery, complexity of administration, pricing failures and illegal activities or fraud and abuse. The opportunities, according to Berwick and Hackbarth (2012) for improvement and reduction in expenditures are huge.

Medicare defines a readmission as an admission to a general, acute, short-term hospital within 30 days of a discharge from the same or another general, acute or short term hospital (Centers for Medicare & Medicaid Services, n.d.-a). While some readmissions can be scheduled (such as rehabilitation services or surgery), the CMS remain concerned about preventable readmissions (James, Hall, Joynt, & Lott, 2013). The Medicare Payment Advisory Committee (Med PAC), an independent federal body that advises the U.S. Congress, cited in their March 2007 payment analysis that up to 76% of those 30 day readmissions were potentially avoidable (Rutherford, Nielsen, Taylor, Bradke, & Coleman, 2013) even though a Health Affairs policy brief suggested that there is no real consensus on how many readmissions are preventable (James et al., 2013). Excessive cost for CMS was one driver that set policy makers and researchers on the path to look deeper into healthcare data and the reasons for the increase in readmissions.

**Readmissions, Patient Safety, and Engagement**

Readmissions are impacted by patients’ diagnoses and illness severity, their geographic area, behavior and adherence in understanding of discharge instructions, engagement in their own health including treatment plan and even the quality of post discharge care (James et al., 2013). Hospital discharge can be a dangerous time for patients and their families if they are unaware of the steps they should follow to prevent errors, reduce readmission and to avoid unsafe practices. Discharged patients are vulnerable populations, defined by Shi and Stevens (2005) as persons at a greater risk of developing health problems. In 2003, Coleman stated that a patient’s discharge can lead to hazardous medication errors as there is generally a breakdown in communication. Ten years later, research by King suggested little improvement in handoffs, with
nurses noting multiple deficiencies in transfer from hospitals to skilled nursing facilities (King et al., 2013). These nurses cited inadequate communication at discharge as the major obstacle to safe and successful transitions. Discharge time is usually hectic with patients and their families anxious to go home, and nurses rushing to provide them with adequate education and information. Patients and caregivers are afraid to ask questions or they don’t know what to ask. Even with years of research on discharge and transitions, and the problems identified, individuals and health systems have only seen intermittent improvement in the discharge and transition process.

The CMS sees a direct link between readmissions, patient safety and patient engagement. Since the release of the Institute of Medicine’s (IOM) landmark report on patient safety, *To Err Is Human*, health care organizations are aware of their need to focus on patient safety and quality (Institute of Medicine, 2000). Poor communication at discharge and no follow through, sometimes by patients, other times by the healthcare team, leave patients and their families confused and vulnerable (Coleman, 2003; Coleman & Berenson, 2004).

The Centers for Medicare and Medicaid Services quality strategy mission statement is to “optimize health outcomes by leading clinical quality improvement & health system transformation” (2014b, p.1). As part of that continuing strategy, in 2009, the CMS expanded publicly reporting hospital outcome measures to include 30 day readmission rates for acute myocardial infarction (AMI), congestive heart failure (CHF) and pneumonia and has since added complications and readmission data for hip/knee replacements as well as in-hospital adverse events and mortality (Centers for Medicare & Medicaid Services, n.d.-b). Individuals can go to Hospital Compare to view quality success rates for these conditions comparing them to other regional and national data to determine if their facility is better than or worse than the national average (Centers for Medicare and Medicaid Services, 2013).
Coleman and Berenson (2004) stated healthcare facilities operated alone as there was no understanding of which practitioner owned the responsibility of the sending and receiving teams at the time of a patient’s transition. They suggested this is a time where important and necessary to-know information gets dropped. The same study suggested that incomplete knowledge transfer to the patient and family at discharge, coupled with the patient and family general lack of engagement in their care, contributed to a poor transition.

According to Robinson, Howie-Esquivel, and Vlahov (2012), medication errors after discharge or adverse drug events (ADE) were a common and contributing factor to readmissions. The risk of an ADE is directly related to the number of medications a person is prescribed, with a serious risk increase if patients receive more than 11 medications (Robinson et al., 2012). Each of these quality and safety issues can lead to adverse events and readmissions.

There is a growing agreement nationally and around the globe that patients’ management of their own health and health care can have a profound impact on cost, outcomes, and satisfaction (Hibbard & Cunningham, 2008). It is thought if patients were more engaged, more knowledgeable, more confident, and had some prior knowledge or education on what to expect and understand what their role should be in the transition, care and quality could be improved and costs could be decreased (Dotseth, 2014; Wasson & Coleman, 2014). The evidence suggested that less engaged and activated patients are twice as likely to have a 30 day readmission (Fellows, 2015). Time, or the lack of time, plays into engaging patients. Both the time spent with patients to get them engaged as well as the time needed by patients to understand what is required of them are critical to having them engaged (Fellows, 2015).

Patients’ attitudes and culture may stand in the way of becoming engaged in their care. Patients’ may believe that doctors know everything and they, as the patient, cannot add anything valuable to their care. Patients’ attitudes may be nonchalant, not wanting to accept more
responsibility and accountability for their own care (Sherman & Hilton, 2014). Kish (2012) described patient engagement as the blockbuster drug of the century suggesting if more patients were engaged, outcomes would be improved.

While engaging individuals in their health and health care is not a new concept, the enactment of the Affordable Care Act (ACA) has made patient engagement both urgent and imperative. As a result of ACA, CMS is reimbursing providers and delivery systems based on outcomes. Hospitals are no longer paid just on services delivered; they are evaluated for their success and their outcomes. Providers of care are either being penalized or rewarded financially based on the care outcomes (Sherman & Hilton, 2014).

**Readmissions and the Regulatory Landscape**

Elements such as high cost, readmissions, poor care transitions, and the need to improve patient safety have been a concern of leaders for a long time. More than a decade ago, the Institute of Medicine Report, *To Err is Human*, identified patient safety issues needing to be addressed (Institute of Medicine, 2000). Jewell and McGiffert (2009) in a follow up consumer report suggested that 10 years later, patients were still being injured from safety issues and millions of dollars had been wasted looking for solutions to the same safety issues. With runaway healthcare costs and a focus on increasing quality and decreasing readmissions, policymakers began a series of initiatives in 2009. These initiatives began with the voluntary reporting to the CMS of hospital readmission rates for public viewing on Hospital Compare, a CMS website (American Hospital Association, 2011; Centers for Medicare & Medicaid Services, 2013). This further initiated a series of progressive and important healthcare regulations that began to change healthcare significantly.

**Patient protection and affordable care act.** On March 23, 2010, a comprehensive health care reform bill was signed into law by President Obama entitled the Patient Protection
and Affordable Care Act (PPACA), better known as ACA (Stone & Hoffman, 2010). Majette (2011) suggested that Congress, in the ACA, designed a well thought out and inclusive legislation focusing on public health issues including health care reform activities related to prevention and wellness. These types of wellness and prevention initiatives can enable the start of an individual’s engagement in their own care.

Medicare had several provisional changes as a result of this legislation. With the goal of reducing preventable hospital readmissions, the CMS began by (a) reducing Medicare payments to hospitals identified with high preventable readmission rates (effective October 2012), (b) creating the ability to provide demonstration and pilot projects that test reforms to the Medicare payment system for hospitals and other providers, (c) creating processes to test care transition program improvements for patients with chronic illnesses as they transition from the initial hospital stay to home, community, and other post-acute and long term settings and (d) reducing Medicare payments to certain hospitals for hospital-acquired conditions (HAC) (effective 2015) ("Summary of the Affordable Care Act, The Henry J. Kaiser Family Foundation," 2013).

**Hospital readmission reduction program.** In addition to the clinical needs and the need to provide the best overall care for patients in transition, the ACA created provisions to improve the quality of care and reduce spending in the Medicare program (James et al., 2013). The Hospital Readmissions Reduction Program (HRRP) encourages hospitals to lower readmission rates by providing a financial incentive (James et al., 2013). This new program looks for hospitals to decrease readmissions by coordinating transitions of care and increasing the quality of care provided to Medicare beneficiaries. The program is part of the CMS’s goal to transition from a fee for service payment to value-based payment or paying for care based on quality and not just quantity. Hospitals are compared with a national average readmission ratio that generally applies to a hospital’s patient population and the applicable condition. For hospitals that
exceeded the average readmission ratio, a penalty was determined and is now being applied to Medicare payments. The hospital payment penalty was implemented in October 2012, deducting 1% of every Medicare payment for a hospital that was determined to have excessive readmissions for the three measures AMI, CHF, and pneumonia. Each October, 2013 and 2014, the penalty increased an additional 1% to the total 3% of today. In 2015 additional conditions/measures for the initial inpatient admission were added to the current three measures and included readmissions following an acute exacerbation of chronic obstructive pulmonary disease (COPD), and following an elective total hip arthroplasty (THA) or total knee arthroplasty (TKA) (Rice, 2014).

While a penalty of 3% could negatively impact a hospital’s profit margin, there is agreement that some readmissions may be out of the hospital’s control. Using 2014 readmission data, the CMS levied fines on 400 more hospitals than had been impacted in the beginning of the program (Rice, 2014). While evidence exists that the HRRP has lowered readmissions, there remains concern that small rural hospitals with high poverty rates, treating many of the chronically ill are bearing the biggest burden of penalties and cost (James et al., 2013) (Rice, 2014). It also raised concern that hospitals alone cannot remedy this problem and that perhaps there are deeper issues, like patient cognition, literacy or education that impact readmissions.

Some organizations and policy makers have begun to question if the program is flawed (Punke, 2015). As the National Quality Forum (NQF) researches to determine if patient socioeconomic factors should be a component of the readmission measurement, hospitals are lobbying CMS and Congress to include socioeconomic factors (Punke, 2015).

**Partnership for patients and the community based care transitions program.** The Partnership for Patients initiative, section 3026 of the ACA, is a collaboration among private and public organizations focused on advancing quality care while promoting safety and affordability
(Centers for Medicare & Medicaid Services, 2015c). This collaboration has two goals of making care safer and allowing patients to heal without complications by improving care transitions. The expectation is that transitions and quality can be improved through hospital engagement networks (HENs), Community-based Care Transition Programs (CCTP), and patient and family engagement in care. The intent of the five year, 500 million dollar funded CCTP program is that partnerships between hospitals and community based organizations (CBOs) will develop care transition programs to improve quality of care by increasing patient and family awareness and engagement in their care (Kocher & Adashi, 2011).

Finally, at the juncture of a patient’s transition, where the patient is transferring to and from, Coleman (2003) suggested that transfer of knowledge to patients and families is lacking, misunderstood, or misinterpreted. The same study suggested that an individual’s needs are sometimes overlooked, medication directions are confused, changed, or omitted and the patient’s need for continuity of care is abandoned or forgotten. Patients and their families become confused about what to do and which instructions to follow. Coordinating care between these multiple providers, in different settings, amplified with socioeconomic factors, poor communication, lack of community support, and ineffective patient and caregiver education is a pathway for failure (Li et al., 2014).

**Meaningful use and patient engagement.** According to the Health Resources and Services Administration (HRSA), providers need to show they are using certified Electronic Health Records (EHR) technology in a meaningful way to help improve the quality, efficiency and safety of America’s health care system (Health Resources and Services Administration, 2016).

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1 According to the Centers for Medicare and Medicaid Services in January 2016, Acting Administrator Andy Slavitt, spoke before the J.P Morgan Healthcare Conference in San Francisco and announced that the Meaningful Use program as it has existed, will come to an end later in 2016 and will be replaced with something more user friendly for physicians and consumers (Powderly, 2016). This project was completed during the time that meaningful use was still an active program.
n.d.). The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act (ARRA) of 2009, to promote the adoption and meaningful use of health information technology (United States Department of Health and Human Services, n.d.-a).

The HITECH Act provided assistance and incentives to providers to assure that the following five goals would be met: (a) reducing health disparities while showing improvement in quality, efficiency and safety of patient care, (b) engaging patients and families in their care, (c) promoting public and population health, (d) improving care coordination, and (e) promoting the privacy and security of patient information (Health Resources and Services Administration, n.d.)

Simply put, meaningful use requires that providers must demonstrate to the CMS that they are using electronic health records (EHRs) in a way that positively affects patient care. Stage 1 meaningful use is related to data capture and sharing. Stage 2 focuses on advanced clinical procedures, including: (a) measures focused on more rigorous health information exchange (HIE); (b) adding requirements for e-prescribing and incorporating lab results; (c) electronic transmission of patient care summaries across multiple settings; and (d) increasing the engagement of patients and their families (Centers for Medicare & Medicaid Services, 2014a).

Stage 2 core objectives are complex, requiring providers to communicate with a certain percentage of patients seen during the reporting period, and requiring that patients have the ability to view online, download and transmit their health information within specific timeframes. In addition, all providers must choose three of six health care policy domains to report on as recommended by the Department of Health and Human Services’ National Quality Strategy: (a) patient and family engagement, (b) patient safety, (c) care coordination, (d) population and public health, (e) efficient use of health care resources, and (f) clinical processes
and effectiveness (Centers for Medicare & Medicaid Services, 2012). The CMS believes that providers and hospitals are best positioned to encourage patients in their use of technology to be engaged in their own healthcare and that getting patients engaged is a proven strategy to reducing cost (Tagalicod, 2013).

In 2015 the CMS released the final rules for Stage 3 of the meaningful use incentive program, set to be optional for physicians and hospitals in 2017 and required in 2018 (Centers for Medicare & Medicaid Services, 2015b). Stage 3 is intended to bring improvements in care delivery by requiring more innovative EHR functionality and standards for structuring data, as well as requiring more coordinated care and patient engagement. All providers will be required to meet the Stage 3 objectives in 2018 for the entire calendar year. Today, less than 1 in 5 providers meets the requirements for Stage 2 and as a result the industry has called for a delay for Stage 3 (Scheidlinger, 2015).

The Problem: Lack of Patient Engagement and Empowerment

The World Health Organization (WHO) (2011, p. 9) states that among the most costly and prevalent of all global health problems or the “major epidemiologic trend of the current century” is the rise of chronic illnesses such as cardiovascular disease, cancer and diabetes. In the United States, these chronic illnesses, according to the Centers for Disease Control and Prevention (CDC) (2016b), are the major cause of death and disability among adults and the primary reason they seek health care. The CDC asserts that chronic diseases cause 7 out of every 10 deaths per year accounting for 86% of the nation’s health care cost overall. Many times, those individuals who live with chronic illness, lack the strategies to self-manage their illness, to remain positive, and to face everyday challenges. Time, cultural beliefs, language and literacy, can, over time, cause patients to lose their focus, their confidence and their desire to do the right thing related to their health (Lawn, Delany, Sweet, Battersby, & Skinner, 2014). Strategies
focused on increasing patient engagement translate into better delivery of care, improved outcomes, better recovery and improved satisfaction for both the patient and the provider (Guglielmi et al., 2014).

Personal healthcare must be built on a foundation of collaborative interactions such as care coordination, shared knowledge, and technology when available. Evidence supports improved outcomes when patient involvement is partnered with technology as reported by Kish (2012). Patient engagement involves listening, motivating, understanding perceived barriers and helping to establish a safe environment to allow patients and families to understand their fears, gain confidence and share control (Lawn et al., 2014)

Persons with complex disease, multiple medications and little to no engagement in their health care are at risk for poor care transitions resulting in readmissions within 30 days of discharge. These poor transitions are costly, creating safety and quality of care issues for patients and families. Policyholders, recognizing the impact of readmissions on care, quality and cost have created landmark legislation in ACA. Through this legislation, numerous multi-year initiatives are focused on improvements. Each of these initiatives raises the need of increasing patient engagement and improving care transitions to improve the overall patient experience, improve safety and potentially decrease cost.

**Purpose of the Translational Project**

The purpose of this translational project was to identify if individuals within Our Lady Star of the Sea (OLSS) Catholic Church who were 18 and over and who chose to participate in this project, were engaged participants in their health and healthcare.

**Aims of the Translational Project**

Three aims were proposed to address the purpose of the translational project.
Aim I. The first aim of this project was to ascertain the current knowledge, skills and confidence of the participating parishioners in relation to their health and healthcare. This aim was completed by administering the Patient Activation Measure™ (PAM™) (see Appendix A for a copy of the PAM™) face to face during the educational intervention and repeating it telephonically post intervention 10 to 12 weeks later. In addition, after the repeated PAM™, the investigator asked the following question, "What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be willing to share that with the investigator?" The PAM™ is a self-assessment tool developed by Dr. Judith Hibbard and Dr. Bill Mahoney, colleagues at the University of Oregon and managed by Insignia (Insignia Health, 2016). The PAM™ scores established a baseline of engagement for participating parish members of OLSS and will help determine future interventions.

Aim II. The second aim of the project was to provide information and awareness on healthcare topics of general importance to all consumers as noted in the literature (engagement, care transitions, communication with one’s healthcare provider, and the importance of asking questions).

Aim III. The third aim was to assess the overall health status and health education needs of the participating parishioners of OLSS using a hard copy demographic/health survey form created for this project. This information, along with health teaching interventions, established the groundwork for the creation of a faith-based health ministry at OLSS. The problem identified both in the literature and in practice is that individuals and families need to be better informed, engaged and prepared to accept some of the responsibility for their individual health and health care. Evidence suggested that engaged individuals have better outcomes, reduced costs, and higher activation (Hibbard, Greene, & Overton, 2013). It was also noted that increased use of
preventive screenings resulted in lower costs two years later (Greene, Hibbard, Sacks, Overton & Parrotta (2015).

The Institute of Medicine’s report, *Crossing the Quality Chasm*, (2001) spoke of engaging patients and families as allies of care and suggested it was one of the fundamental tactics to improve the U.S. health care system (Barry & Edgman-Levitan, 2012). Therefore, improving patient outcomes and reducing readmissions will only be successful if patients and families become more engaged and accountable in their own care.

In conclusion, hospital readmissions have been elevated to the national stage. Policymakers are looking to define new initiatives that will positively impact the health of populations, the quality of the care delivered and the overall cost of care. Patient centered accountable care is being seen potentially as the nirvana of healthcare. Engaged and collaborative patients willing to partner with their health care team will contribute to new and exciting opportunities.
Chapter II
Framework and Review of the Literature

Framework

The framework for this project was the Triple Aim, first conceived and communicated by Berwick, Nolan, and Whittington (2008) through the Institute for Healthcare Improvement (IHI). The IHI, founded in 1991, is a leading innovator, partner, and driver of results in health and health care improvement worldwide. It came out of the work of the 1980’s National Demonstration Project on Quality Improvement in Health Care, led by Dr. Donald Berwick looking to redesign healthcare (Institute for Healthcare Improvement, 2016a).

The key focus of the Triple Aim is to provide a framework to improve population health, improve the patient experience of care, and reduce per capita cost (Stiefel & Nolan, 2012). The IHI fostered the Triple Aim as a “statement of purpose for new health systems” as they set about their work of improving the health of populations while decreasing costs (Stiefel & Nolan, 2012, p. 1). Recognizing that the obstacles were many, the IHI persevered to create a framework to move from what they viewed as barriers: physician centric care, supply driven demand, new and growing technologies missing outcome data, and limited system awareness and appreciation as viewed by clinicians and healthcare organizations (Institute for Healthcare Improvement, 2009).

The Triple Aim has since been embraced by the U.S. National Quality Strategy as the organizing framework for public and private health organizations both nationally and internationally. The Triple Aim and the IHI define three interlinking goals in the pursuit of improved health care for individuals and populations while reducing costs (Berwick et al., 2008). The IHI defines the goals as (a) improving the health of the defined population, (b) supplementing the patient experience to include improved quality, care access and consistency and (c) managing and or reducing the cost of care (Institute for Healthcare Improvement, 2009).
Nationally, using the IHI goals of innovations and out of the box thinking, the status quo is being challenged with minute clinics and the medical home, both aligned well to use the Triple Aim framework.

**Triple Aim framework.** The role of nurses within certain segments of health care has changed over the years from care delivery to coach, from doing for patients to teaching them to do for themselves. This role of self-advocate increases patient knowledge as skills and confidence are transferred from the clinician to the patient (Lawn et al., 2014). Building partnerships with patients, families and interdisciplinary teams creates the foundation to take care, and the coordination of care, to the next level. In *Pursuing the Triple Aim* Bisognano and Kenney believe that a major focus driving healthcare organizations is actually pursuing the IHI Triple Aim. Each step toward the Triple Aim, while having individual defining goals includes varying components. Improving the actual experience of care, step one asks for new and innovative ways to improve patient and provider satisfaction through safe, effective, reliable and consistent care for all patients at every encounter. The second step, actually improving the health of a specific population, asks for partnerships in and around communities and organizations, looking to create sustainable programs focused on prevention and wellness, but with the inclusion of chronic conditions. The final suggested step is to find new and innovative ways to decrease the cost of care (Bisognano & Kenney, 2012).

**Triple Aim framework (original and adapted for research).** The IHI’s graphic (Figure 1) depicting the Triple Aim suggests that there is a need to optimize the health system by encompassing three components: the experience of the individual; the health of a defined population; and the per capita cost for the population (Institute for Healthcare Improvement, 2016b). The IHI believes that it is necessary to define quality from the view of an individual member of a defined population (Institute for Healthcare Improvement, 2016c). Using the 2001
Chasm Report of the IOM, the Triple Aim concept suggests that patients should have all the needed information, knowledge, and control to make decisions that are related to them. This shared decision making should include information about provider and facility performance, safety, use of evidence based practice and the degree of patient satisfaction.

The graphic for the Triple Aim, while simplistic in nature, continues to evolve. With a vision to assure that everyone has the best care and health possible, and a mission to improve health and health care worldwide, the IHI has lofty goals (Institute for Healthcare Improvement, 2016c). They do believe that through collaboration and education toward person-centered care, the health of populations can show improvement which will ultimately improve the patient experience of care and cost less.

The IHI Triple Aim

![The IHI Triple Aim Graphic](image)

*Figure 1. Institute for Healthcare Improvement Triple Aim Graphic*

The IHI Triple Aim Initiative (2016d). IHI policy on using states that content posted on IHI.org is free and open to all, as often as possible, as long as credited (Institute for Healthcare Improvement, 2016e).
The researcher broadened the simplistic graphic and included key messages that if included in the Triple Aim as a framework (see Figure 2), would have more direction for the user. For example, Per Capita Cost was transformed into Better Value and included the concept that while clinicians work with individuals in healthcare, over time, the similarities that define single patients, in aggregate can define populations. As individual patients make better choices, the lessons learned can be transferred to groups of patients, and ultimately populations, which over time may decrease costs.

Experience of Care is then transformed into Best Care, and illustrates the key points being made. Patients should be collaborative partners in their care to make best care happen. Their care should be safe and effective. If those two key events occur, patients, families and providers will show increased satisfaction and likely have better results. Population health is then transformed into Better Health to show that the use of evidence based care, care transitions and strong partnerships will equip patients to be partners in their care which in turn will complete the link.

Within this project, using evidence based programs, the participants became educated on how and why to be collaborative partners with their healthcare team. Having the knowledge of past successful evidence based programs can both increase participants’ confidence and reinforce their current health practices to be stronger advocates for their own health and for the health of family members. Continuous innovation, shared partnership and collaboration, and unconditional teamwork delivers what the IHI refers to as “all teach, all learn” (Institute for Healthcare Improvement, 2016d, p.1). With patients always at the center of the effort, they become fully equipped, educated, and enabled full partners of the healthcare team and their community. Patient care and outcomes are enhanced. When persons are more aware, they ask more questions
and search for more solutions. They communicate their needs, desires and goals and in the end, their choices may decrease unnecessary or redundant care.

Figure 2. The Researcher’s Amended Triple Aim Graphic
This translational project fit well within this framework as it investigated if a specific population could show improved outcomes, improved satisfaction and ultimately lower cost. Once patients are engaged and in a collaborative partnership with their healthcare team they will ask more questions and look for answers and information.

*Pursuing the Triple Aim* discussed the assets shared by certain healthcare organizations in their pursuit of the Triple Aim (Bisognano & Kenney, 2012). These assets were shared vision, connection of teamwork, obsession for improvement, patient centeredness, and a desire to break down silos by integration and coordination of care. The authors highlighted the organizations as they navigated from “looking inward to looking outward” (p. x), focusing first within their organizations and ultimately extending into communities to improve the health of populations and towns.

While it is believed that pursuit of the Triple Aim requires commitment from the top down in organizations with defined boundaries and construct, it is also believed to be a goal, a fresh ideal whose time has come. It is a new way to focus on improvements in healthcare and has been embraced by stakeholders across the globe. In 2011, the IHI was working with 60 organizations throughout the world on Triple Aim initiatives. It has pushed health plans and health care organizations to reach beyond their inner boundaries to partner with public health and collaborate with communities in ways not yet identified (Bisognano & Kenney, 2012). The movement toward patient engagement, improved population health and improved satisfaction has also seen an increase in case management and care coordination within health plans hospitals and providers.

Traditionally within payer health plans, the focus of engaging patients and families is done through the practice of case and disease management programs with a secondary focus on the Triple Aim. These programs are delivered by nurses and social workers through the action of
goal setting with patients, using motivational interviewing and the teach-back method. Using these methods of delivery, the case or disease manager works with the individual or family to educate, enlist and empower the individual with information to make informed decisions about their healthcare going forward. Using a teaching method called teach-back, patients confirm that what has been explained to them is understood by them when they are asked to explain it back.

The nursing community or case management staff within health plans and hospitals has historically embraced this concept, allowing the patient to set the direction and the pace. Health plan individuals are identified through claims, hospital data, risk scores, health risk assessments, pharmacy, and lab data and stratified as to their level of need based on established algorithms. Individuals are placed into a care or disease management program and a call is placed to engage the health plan member in the program, (such as diabetes or heart failure). Individuals are followed through any hospitalization as well as their transition of care to ensure they have what is needed after discharge. Case managers collaborate with individuals, families and providers to coordinate care teaching medication and disease/illness knowledge, and helping to establish follow up appointments with their health care team (Case Management Society of America, 2010)

Within the complexity of health care, there are multiple human interactions and experiences occurring every single day. Clinicians come to work to care for the vulnerable, to make a difference in their health and their life. Patients and families join and interact within the health care environment experiencing success in achieving established goals and together identifying and breaking down barriers. The Triple Aim provides the framework or structure on how to come together to achieve the goals.

Health care entities are beginning to discover that the starting point to better care, a component of the Triple Aim, is in knowing what matters most to patients and their families.
Within each of these interactions are individuals who are influenced not only by what they know and how they behave, but by a complex world and issues that surrounds them. The complex issues include the social, economic and political factors that strongly impact health outcomes (MacDonald, Newburn-Cook, Allen, & Reutter, 2013). The patient needs to be a part of the solution and at the table when creating best practices for all interactions including engagement and patient safety.

Berwick et al. (2008) suggest components of the Triple Aim are not independent of each other and changes made to any one component can negatively or positively impact the others. Stiefel and Nolan (2012) believe combining all of the Triple Aim elements: population health, experience of care, and cost of healthcare, begins to show true measurement of overall value. While no organization to date has achieved the full capacity of the Triple Aim, many have begun to create beginning pathways with a serious commitment towards its goal (Bisognano & Kenney, 2012).

The Triple Aim framework, though simplistic in thought, is a detailed foundation to lend support to a translational project where a key aim is to provide proactive health education to a population within a church community. The goal was to provide a meaningful experience that positively impacted the individual’s and ultimately the provider’s, experience of care. Individuals’ care experiences and confidence are enhanced as they become empowered and engaged in their health. Their overall future health outcomes should, over time, show improvement, contributing to lower cost in the end. Providers’ experience can show improvement for those providers who find professional value in collaborating with their patients.

Review of the Literature
The literature around effectively engaging individuals in their healthcare can be grouped within two main headings: (a) patient engagement, empowerment and activation and (b) care transitions and impact on readmissions.

A literature review was completed incorporating databases from MEDLINE/Pub Med, CINAHL, CINAHL Plus, PsycINFO, EBSCO, the Cochrane library, and the CMS. Secondary references from primary articles were conducted to identify studies that critique these identified topics. Keywords searched include care transitions, transitional care models, PPACA, patient engagement, activation, empowerment, and Triple Aim. Years included in search were 2008-2016 however there were key original articles identified as early as 1994-2003 that were included as original research.

**Patient engagement, empowerment and activation.** James (2013, p. 1) defined patient activation as referring to a “patient's knowledge, skills, ability, and willingness to manage his or her own health and care”. Patient engagement is a more inclusive concept that blends patient activation with learned interventions suggested to increase activation while advancing positive and improved patient behavior, such as obtaining preventive care or exercising regularly. James suggested that patient engagement is considered a tactic to attain the Triple Aim (2013).

Patient empowerment is defined as providing patients with the skills and the tools to assist them in having the confidence, skills, ability and willingness to become a member of the healthcare team (Edgman-Levitan & Gandhi, 2014). Patients should be represented on hospital committees that recommend and create policies on health reform, patient safety and other issues. Being involved will provide them with the willingness and confidence needed to speak up when questions or issues arise related to their individual health or that of a family member.

Hibbard et al. (2013) defined patient activation as having an understanding of what is needed in the healthcare process and being able to play the role of self-advocate. They suggested
that patient activation and patient engagement, while similarly used, may prompt different
patient behaviors suggesting that patient engagement is broader, encompassing patient activation.
Patients who are more activated are more likely than lower activated patients to be at a healthier
weight, not smoke, use the emergency room or be hospitalized. They are also more likely than
lower activated patients to have normal blood pressure, seek out health information and seek
preventive care.

All persons are individually in the position to enhance communication with their health
care providers but may not know how or if they should. Patients and families have the key
insights into their medical history; they know their medications, their diagnoses, their past
surgeries, any complications and any special needs. If they have the skills and confidence to
engage in their own care, they begin to feel empowered and activated increasing their confidence
and belief in themselves (Dotseth, 2014). Early in 2001, the IOM laid the groundwork suggesting
that healthcare needed to be patient-centered and that an individual’s patient values needed to
help guide all clinical decisions (Institute of Medicine, 2001).

The literature suggested there is growing evidence to support efforts to encourage
individuals to become better informed and empowered. Health care policy changes such as
consumer-directed health plans assumed that consumers would be able to make appropriate
choices that would improve care quality and decrease costs (Hibbard, Stockard, Mahoney &
Tusler, 2004). In addition, the development of new care models, such as the Chronic Illness Care
Model relied on patient directed care, having patients with skills and knowledge to integrate with
their care teams (Hibbard et al., 2004).

Looking to understand what it would take to measure patient activation, University of
Oregon colleagues began extensive research to create such a tool. Creation of the PAM™ began
with a 22 question tool and was modified over the years to a 13 and a 10 question tool (Hibbard,
Mahoney, Stockard, & Tusler, 2005). The PAM™ has been determined to be a valid, and highly consistent, one dimensional, Guttman-like scale (Hibbard et al., 2004) and was developed using qualitative methods, Rasch analysis, and classical test theory psychometric methods. The Rasch model is the only item response theory (IRT) model in which the total score across items characterizes a person totally ("Rasch Analysis," 2012, p. 1). Hibbard’s research has found the PAM™ to have strong psychometric properties, indicating the PAM™ can predict a range of behaviors (Hibbard et al., 2004). This range of behaviors includes healthy behaviors such as diet and exercise, self-management behaviors related to specific diseases as well as behaviors associated with consumers like reading about new drug risks (Hibbard et al., 2004; Hibbard et al., 2005). The PAM™ gauges the knowledge, skills and confidence needed to manage one’s own health and healthcare. Evidence suggested that engaged individuals have better health outcomes, improved satisfaction and cost less (Hibbard & Greene, 2013).

The PAM™ tool provides scores which divide individuals into one of four progressively higher activation levels. Each level is associated with distinct self-care behaviors and provides a view into the attitudes, values, motivations, and emotional disposition that drive these behaviors. The participant chooses from 1 of 5 answer options: disagree strongly, disagree, agree, agree strongly or not applicable. Scoring is scaled based on how individuals answer questions regarding their beliefs, knowledge and confidence in managing health care responsibilities and tasks (Hibbard et al., 2013).

Level 1 of the PAM™ suggests individuals who are disengaged and overwhelmed managing their healthcare. They show low adherence to treatment or medications, do not set goals and feel that their doctor is in total charge of their health and care. Level 2 suggests individuals who are beginning to realize that they need to step into the role of self-advocate but are struggling with how (Hibbard & Cunningham, 2008). They believe they should be doing
more but lack sufficient knowledge, skills and confidence. Individuals scoring at Level 3 are beginning to take action related to their health and healthcare decisions. They are beginning to set goals, have an increase in confidence as they build their self-management skills and feel as though they are part of the solution. A Level 4 score indicates adoption of self-advocacy behaviors. While these people still may struggle at times of stress or change, they understand the importance of being their own advocate.

In a 2013 study using the 13 item PAM™ on each of 33,163 patients within a large health care delivery system in Minnesota, Hibbard and colleagues studied the relationship between patient activation levels and billed care costs. The results showed that patients with lower activation had predicted average costs 8% higher in the base year and 21% higher in the first half of the following year as compared to the costs of patients with the highest activation levels (Hibbard et al., 2013). The PAM™ assessment produced a 0-100 score based on how participants answered questions related to their beliefs, their confidence and their knowledge evaluating and managing task that are health related. This study was relevant because as health systems moved to increased accountability for patient outcomes and costs for defined populations, knowing which patients had the skills, confidence and willingness to manage their health could impact long term outcomes and costs.

In a 2012 study by Greene and Hibbard, researchers followed the PAM™ scores for 25,047 adult patients with 13 outcomes over four areas: prevention, unhealthy behaviors, clinical indicators, and costly utilization. Greater activation was related to better outcomes in 12 of the 13 outcome measures. A pre-requisite of the study was that patients had to have had a primary care visit where the PAM™ was implemented. Results indicated the more activated patient received more preventive care, was less likely to smoke or have a high BMI and was less likely to use the emergency room or have been hospitalized.
Hibbard, Mahoney, Stock, and Tusler (2007) completed a randomized controlled trial of 479 chronic disease patients and concluded that with an increase in activation, a positive change in behavior would follow. As a follow up, Hibbard and colleagues conducted a quasi-experimental study to evaluate the impact of tailoring a person’s care plan to the individual’s activation level instead of the usual disease management approach. Results regularly indicated that creating tailored interventions increased activation scores and also increased positive behaviors which displayed as improved blood pressures, decreased utilization and other clinical measures. Hibbard et al. (2007) study proposed that activation can be changeable and as activation increases, self-management behaviors can also increase.

PAM™ research done by other researchers had similar positive results. In a 2013 PAM™ study by Mitchell et al., increased patient activation was linked to lower overall health care utilization and improved outcomes. In the first study of its kind, linking an individual’s activation score with 30 day or unplanned readmissions, 695 participants at the Boston Medical Center, showed results suggesting that patients with low activation scores had almost twice the risk of 30 day post-discharge utilization of hospital services as compared with patients with higher activation. Evidence also suggested that patient activation is an adaptable trait and that the creation of effective interventions could increase patient activation, improve health outcomes and reduce health service costs. However, Mitchell and colleagues felt that randomized trials should be completed to validate that specific interventions targeting patient activation were effective in reducing avoidable readmissions.

In a 2013 randomized, two group, repeated measures design of 84 participants, Shively et al. stratified participants by activation level and randomly assigned to usual care (n=41) or usual care plus the intervention (n=43). This study repeated the PAM™ post intervention to assess PAM™ results. This work by Shively et al. supported the importance that using targeted
interventions has a positive impact on the PAM™ score and correlates into decreased hospitalizations and improved self-management. The intervention was a 6 month program to increase activation and improve heart failure self-management behaviors such as medication adherence and setting goals. The intervention group showed a significant increase in activation through repeated PAM™ scores from baseline to 6 months compared to the usual care group. There were fewer hospitalizations among the participants in the intervention group. Shively and colleagues’ work supported Hibbard’s et al. (2007) work where interventions directed on increasing patient activation scores can promote success. Positive patient engagement, partnered with knowledge of what to do when they transition from one health care setting to another, can be a powerful weapon in a path toward the Triple Aim.

The evidence is strong to support development of programs and the education of consumers on their need to be engaged, informed, and activated about their health care and the evidence based programs that can lead them to better and safer outcomes. While the identified studies related to patient activation and engagement are diverse, mutually they offer perspective into the use of the PAM™ to help identify those people who are confident in their ability to manage their health and healthcare. Similarly, those people who are less activated and less confident require more hands on and more targeted interventions. The research strongly suggested that there are benefits to measuring a patient’s activation, not only to understand where they are today, but also to measure the results of any educational interventions. Measuring activation can also help understand and trend costs more effectively while understanding how targeted interventions can impact cost (Hibbard et al., 2007; Hibbard et al., 2013).

There was a significant amount of literature regarding the use of the PAM™ to measure patient activation and empowerment, and it included an expanse of international research validated on six continents (Insignia Health, 2016). The ability to do a pre and post educational
intervention to measure the effect of the intervention is also very helpful in creating improved or focused interventions. The PAM™ has been translated into 22 languages and has been shown to be a predictor for future utilization of health care services and costs. Each point increase in a PAM™ score correlates to a 2% decrease in hospitalization and a 2% increase in medication adherence (Insignia Health, 2016).

**Care transitions and impact on readmissions.** Goodman et al., (2013) detailed the long list of issues that may lead to readmissions stemming from a poor transition to the next level of care. It is estimated that poorly executed care transitions may cost $12 to $44 billion per year (Dreyer, 2014). Coleman (2003) suggested that patients are discharged with no knowledge or understanding of their illness, and little knowledge of their treatment plans or the medications required to keep them healthy. Poor communication occurs between what Coleman referred to as the senders and the receivers of the patient; families are not kept informed. Patients leave hospitals without their prescriptions and do not have any follow up with their treating provider. Care is complex, rushed and fragmented and patients may not be aware of what is happening to them and around them in their effort to get home.

In 2007, Coleman and Boult on behalf of the American Geriatrics Society (AGS) wrote the position statement for transitional care using a definition from early research in the field: “a set of actions designed to ensure the coordination and continuity of health care as patients transfer between locations or different levels of care within the same location” (p.1). The same definition was used in early research (Coleman, 2003; Naylor, 2000) and is still closely followed today.

Throughout the literature, care transitions and transitional care are used interchangeably and the definition remains the same. Coleman (2003) suggested that patients and their families should become partners in the transition process as intermediaries, carrying information between
settings to enable them to be proactive participants. He also believed it was necessary to not only identify those patients who had a failed transition, but also to identify the inadequate outcome related to the poor transition. Coleman (2003) suggested in his early research, that patients might benefit from specific, targeted initiatives, like focused trainings or education on those barriers causing the poor outcome.

Much of the early research on care transitions was completed by Dr. Mary Naylor and Dr. Eric Coleman. In 1981, an interdisciplinary model of transitional care was developed at the University of Pennsylvania using advanced practice nurses (Naylor, 2000). The model was originally developed to allow an earlier hospital discharge using advanced practice nurses (APNs) to provide follow up care in the patient’s home. Originally used with very low birthweight infants, it was expanded to multiple vulnerable populations designed to follow quality of care, patient outcomes and cost of care.

In an early 1994 randomized clinical trial conducted by Naylor et al. at the University of Pennsylvania with 276 patients and 125 caregivers, selected patients were 70 years and older and were placed in a selected medical and surgical cardiac diagnosis related group program. Metrics were measured at 2, 6 and 12 weeks post discharge and included length of stay, length of time between initial discharge and readmission, and health services utilized post discharge. Patients in the control group received the hospital’s standard discharge plan. Patients in the intervention group received the standard discharge program as well as a comprehensive geriatric discharge plan individualized for the individual. Soon after admission, the patient and caregiver was visited by the geriatric nurse to develop a comprehensive care plan, complete a caregiver and a patient assessment and developed a structured every 48 hour visit plan while in patient. Prior to discharge, the caregiver and patient received educational information, a copy of the discharge
summary plan and medication reconciliation. In addition to every 48 hour visits, the nurse followed up with several phone calls to the patients over 2 weeks and as needed.

Even this early research program revealed that from the initial hospital discharge to 6 weeks after discharge, patients in the medical intervention group had fewer readmissions, fewer total days re-hospitalized, lower readmission charges, and lower charges for health care services after discharge. This study supported Naylor and colleagues on future research and discharge planning program development designed specifically for the elderly.

In a randomized control trial Coleman, Parry, Chalmers, and Min (2006) showed that patients with complex needs requiring care across multiple health care settings may be exposed to critical quality issues such as lack of follow up care and medication errors. In the 12 months between September 1, 2002 and August 31, 2003, in a large integrated delivery system in Colorado, 750 hospitalized subjects were identified and randomized to receive the intervention or usual care. Patients were 65 years or older and had 1 of 11 diagnoses: stroke, congestive heart failure, coronary artery disease, diabetes, chronic obstructive pulmonary disease, cardiac arrhythmias, spinal stenosis, hip fracture, pulmonary embolism, peripheral vascular disease, and deep vein thrombosis. The rational used for these patients included a possible need for skilled nursing facilities and therefore additional transitions, home health or anticoagulation. The intervention consisted of three elements: (a) cross-site communication tools, (b) encouragement and coaching on why and how to take a more active role in their care and to make known their preferences and (c) continuity across settings delivered from a transition coach. Re-hospitalization rates were measured at 30, 90 and 180 days. The results concluded that at 30 and 90 days intervention, patients in the experimental group had lower re-hospitalizations than those in the control group. They also had lower readmission rates for the same condition that caused the index admission at both 90 and 180 days. Coleman et al. (2006) concluded that development
of a coaching program for patients with chronic illness, as well as their caregivers to confirm needs are met during transitions of care may contribute to the reduction of successive re-hospitalizations.

In a prospective, quasi-experimental care transition study of 172 Medicare Advantage members within a large health plan, Naylor et al. (2013), showed improvement in all health status and quality of life measures post-intervention compared to pre-intervention. The intervention consisted of follow up with the subject prior to discharge and after discharge. The health plan’s traditional telephonic case management program was supplemented with a transitional care management program delivered by a home health and hospice company. For an average of 2 months, an advanced practice nurse met with the patient in the hospital and at home to work on goals, answer questions and educate the patient and family. Researchers compared the enrollees’ health status and quality of life at baseline and at a 2 month post-intervention. Medicare Advantage member and physician satisfaction were also assessed and noted to see improvements in both from pre to post intervention. A significant decrease was noted at 3 months in the number of re-hospitalizations (45 vs. 60, \( P < 0.041 \)) and total hospital days (252 vs. 351, \( P < 0.032 \)). This transition model suggested a decrease of 439 dollars per member per month in total healthcare costs at 3 months. Cumulative per member savings was shown to be 2170 dollars at one year (\( P < 0.037 \)).

Medication reconciliation is a key component within care transition programs. In a 2010 medication study of 101 participants discharged from two Northwest hospitals, it was observed that 94% of the participants had at least one medication discrepancy with a mean of 3.26 per patient (Corbett, Setter, Daratha, Neumiller, & Wood, 2010). Participants taking medications across various classes of drugs were at risk of a medication error. There were more system-level issues identified (69% of participants) than those involving patients directly (40% of
participants). Inaccurate or incomplete discharge instructions or duplicate medications were considered system issues whereas intentional non-adherence by patients or not filling a prescription was considered patient issues. Implications of this study suggested techniques to improve care transitions such as using evidence based strategies to reduce medication mistakes and improving history taking on admission.

Coleman (2003) and Naylor’s (2000) early research was the groundwork for the CMS focus on the importance of care transitions highlighted in the CMS 9th scope of work and carried over to subsequent scopes of work for the CMS (Chen et al., 2011). Thereafter additional research began to create new and innovative care transition programs. As a result of two decades of research on care transitions, several strong, similar and replicated care transition programs have evolved. Table 1 provides the name, owner/researcher, overview and link to those researched, evidence-based care transition models that are in use today throughout the U.S.
Table 1

**Summary of replicated national care transition programs**

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<th>Name</th>
<th>Who</th>
<th>Key Points</th>
<th>Link</th>
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<tr>
<td>Care transitions intervention</td>
<td>Dr. Eric Coleman</td>
<td>Uses Transition Coach (SW or RN) to help empower patients to take a more active role. Follows patient for 30 days. Meets patient in hospital and then at home x1. Weekly calls to patient.</td>
<td><a href="http://caretransitions.org">http://caretransitions.org</a></td>
</tr>
<tr>
<td>Guided care model</td>
<td>Dr. Chad Boult</td>
<td>A care model, with a trained Guided Care RN working closely with patients, MDs and others to provide coordinated care. Focuses on patients with chronic conditions.</td>
<td><a href="http://www.guidedcare.org">http://www.guidedcare.org</a></td>
</tr>
<tr>
<td>Project boost: better outcomes for older adults through safe transitions</td>
<td>National Initiative led by Society of Hospital Medicine</td>
<td>Use &quot;teach back&quot; during discharge teaching. Identify individual patient readmissions risks to tailor communication. For high risk, schedules an outpatient f/u visit and/or conducts 72 hr. call with patient and caregivers. 8 essential elements for improving discharge process.</td>
<td><a href="www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm">www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm</a></td>
</tr>
<tr>
<td>Transitional care model</td>
<td>Dr. Mary Naylor</td>
<td>A Transitional Care nurse completes comprehensive patient and family assessment, coordinates the discharge plan with family and medical team. Implements plan in patient home, assists in management and facilitates interdisciplinary care team.</td>
<td><a href="http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx">http://www.nursing.upenn.edu/media/transitionalcare/Pages/default.aspx</a></td>
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In summary, there is a plethora of evidence over the last 35 years related to care transitions and the incidence of readmissions. All consumers should understand the steps required of them when being discharged from a hospital from understanding why they were there, to knowing what present and future impact it will have on their health and health care. Understanding their medications and what follow up tests are needed is critical. Patients transferring from hospital to home or another level of care can improve outcomes and lower
costs if they receive thorough discharge instructions as they transition (Cibulskis, Giardino, & Moyer, 2011; Naylor & Keating, 2008).

Evidence continues to mount to support care transition programs in the United States and internationally. Patients and families understanding their role on the healthcare team begin to bridge the gaps and can make a difference in the revolving door of hospitals. All patients need to understand they have a critical role to play in the discharge process. Patients and families need to be encouraged to ask questions as they fulfill their role toward the Triple Aim. This may help contribute to lower costs by increasing patient awareness and safety and thereby increasing satisfaction for patients and providers. Positive patient engagement, partnered with knowledge of what to do when they transition from one health care setting to another, can be a powerful weapon in a path toward the Triple Aim.

In conclusion, evidence supports the value of engaged, activated patients who have a solid concept of what is being asked of them and who are an active participant of the discharge process. It is important to empower patients to be active participants in their care. Clinicians should ask for their input, determine their goals and what is important to them related to their health. In addition, clinicians sharing knowledge will help patients to increase their confidence, their skills and their belief in themselves that they are able to take on this task of engaged patient. Patients need to be encouraged, informed and advised that their participation is important, possible, and safe and supported every step of the way (Gruman, 2013).
Chapter III

Methodology and Design

This chapter details the method and design of the study. Data analysis, procedures, and tools used are also discussed. The purpose of the project was to identify if individuals who are members of Our Lady Star of the Sea Catholic Church who were 18 and over and who chose to participate in this project, were engaged participants in their healthcare. This project focused on this specific parish because it is the parish of the investigator who is also creating a health ministry within its domain. It was believed that data gathered through this study will strengthen the foundation for the continued development of a faith-based health ministry at Our Lady Star of the Sea.

Aims of the Translational Project

Aim I. The first aim of this project was to ascertain the current knowledge, skills and confidence of the participating parishioners in relation to their health and healthcare. This aim was measured through participants’ scores on the Patient Activation Measure™ (PAM™) on two occasions: face to face at the intervention and repeating it telephonically post intervention 10 to 12 weeks later. In addition, after the repeated PAM™ the investigator asked the following question telephonically, "What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be willing to share that with the investigator?" The PAM™ is a self-assessment tool developed by Dr. Judith Hibbard and Dr. Bill Mahoney, colleagues at the University of Oregon and managed by Insignia (Insignia Health, 2016). The PAM™ scores established a baseline of engagement for participating parish members of OLSS and will continue to help determine future interventions.

The data from the PAM™ were analyzed using the survey scoring table supplied by Insignia Health and SPSS version 22. The participants’ responses were inserted into the excel
table and generated a total PAM™ score, and placed each participant into 1 of 4 activation levels based on their score. The initial PAM™ data from Our Lady Star of the Sea participants were also evaluated against a Health System Change (HSC) 2007 Health Tracking Household Survey, the first national comparison of the level of activation of the U.S. population using the PAM™ (Hibbard & Cunningham, 2008). The PAM™ was repeated telephonically 10 to 12 weeks after the intervention and scores again were placed in the Insignia Health scoring tool to calculate a second PAM™ score. This scoring tool then calculated a second PAM™ level. The data from this assessment tool were analyzed by the investigator comparing each person’s levels to determine if there had been any change in activation.

**Aim II.** The second aim of the project was to provide information and awareness through an educational session on healthcare topics of general importance to all consumers as noted in the literature (engagement, care transitions, communication with one’s healthcare provider, and the importance of asking questions). The effectiveness of the session was measured using the pre and post intervention survey. The data from these assessment tools were analyzed by the investigator comparing the variance in the scores pre and post intervention.

**Aim III.** The third aim was to assess the overall health status and health education needs of the participating parishioners of OLSS using a hard copy demographic/health survey form created for this project utilizing demographic surveys shared from already established health ministries. The data collected from the survey were analyzed by the investigator using SPSS Version 22, licensed from IBM.

**Design**

This study utilized a descriptive, pre-/post-test design for both healthcare knowledge and patient activation level. Patient activation level was assessed using the PAM™, while knowledge
of the education topics discussed were assessed using an eight question survey tool created by
the investigator.

The PAM™ looked at the knowledge, skills and confidence of the participating
parishioners in relation to their health and healthcare. The PAM™ and pre-intervention
knowledge test (see Appendix B for a copy of the pre-intervention knowledge test) were
administered prior to a single session educational intervention. The education session was
focused on care transitions, communication with one’s health care team, the importance of
asking questions and being engaged in one’s own health and healthcare. The pre-tests (PAM™
and knowledge) were administered in person by the investigator at a meeting of all participants.
The post-intervention knowledge test (see Appendix C for the post-intervention knowledge test)
was administered in person immediately following the intervention, by the investigator at the
same meeting. The post intervention PAM™ was delivered telephonically by the researcher, 10-12
weeks following the intervention.

Protection of Human Subjects

The ethical principles of respect for persons, beneficence and justice were followed as
established by the United States Department of Health and Human Services in the National
Research Act (2015). All parishioners were provided with project information and volunteered
for the study.

The investigator utilized one general informed consent (two copies: one for the
participant and one for the investigator) (see Appendix D for a copy of the informed consent).
The informed consent advised the participant about his or her rights, the purpose of the study, the
procedures to be done, and the potential risks and benefits of participation. The investigator read
the consent line by line to the group of participants. No one had any questions.
Institutional Review Board (IRB) approval (see Appendix E for a copy of the Institutional Review Board approval) was applied for and obtained from Georgia College & State University in Milledgeville, Georgia. A Memorandum of Understanding (MOU) (see Appendix F for a copy of the MOU with OLSS) was also obtained between the Board of Regents of the University System of Georgia on behalf of Georgia College & State University and Our Lady Star of the Sea (OLSS) in St. Marys, Georgia.

All surveys and consents were placed inside a white envelope which was then placed inside a red plastic envelope (see Appendix G for pictures of the red folder and content). The white envelope was to assure confidentiality; the red envelope was for the participant to take home and use to store personal medical records. The red, sturdy, plastic envelope also contained educational information that was reviewed with the participants. Participants were informed that keeping track of their personal medical information is an important step in managing and advocating for their care and suggested that the red folder could serve that purpose. The white envelope was collected by the investigator at the end of the intervention and double locked in a filing cabinet during the study timeframe. While individual identifiers were created for data analysis, only the investigator had access to the identifiers. Data will be destroyed 3 years following project completion, as per Georgia College records retention policy.

There was no monetary compensation for this project. Due to the evening time allotted for the project, participants were provided with dinner, dessert, beverages and healthy snacks prior to the intervention.

**Setting**

The intervention was held in the social hall of Our Lady Star of the Sea adjacent to the church. Cloth covered tables were set up to comfortably accommodate participants. Participants were encouraged to sit anywhere as long as they were able to view the television to see the
videos that were part of the intervention. The social hall was easily accessed, at ground level with comfortable accommodations.

**Recruitment**

Convenience sampling was utilized for this project. This investigator spoke at Mass both Saturday and Sunday, for two consecutive weekends, explaining the project and soliciting volunteers (see Appendix H for the recruitment tool for volunteers used) using the flyer created for the bulletin. During the same time period, a flyer was inserted in the weekly bulletin for 2 consecutive weeks again, explaining the program and soliciting volunteers. In addition, a copy of the flyer was on the Health Ministry tab of the OLSS webpage with an explanation of the project and the request for participants. Finally a basket was placed in the church lobby to collect any sign-up sheets of interested participants. This investigator collected all sign-up sheets at the end of each Mass and remained after Mass to sign participants up, and answer any questions that parishioners may have. One week prior to the initial meeting a group email was sent out as a reminder. Three days prior to the meeting this investigator placed a call to each participant, verifying attendance and determining if there were transportation needs that might need to be resolved. The investigator also reached out to the leads of each of the church ministries to learn if these ministries would participate in this study.

**Inclusion criteria**

1. All parishioners aged 18 and over. While the literature suggested that poor care transitions in older adults can lead to an increase in re-admissions, cost and medication errors, all adults engaged in their healthcare should have a general knowledge of what makes a successful transition.

2. All participants were required to read and speak English.
3. All participants were asked to sign two consents (one for them to take home and one for the researcher to collect), agreed to participate in taking the PAM™ survey, the educational intervention, pre and post intervention knowledge surveys, and the demographic survey (see Appendix I for a copy of the health and demographic survey). In addition, the researcher asked all participants for their permission to contact them telephonically 10-12 weeks after the intervention to retake the PAM™ and to answer the question, “What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be willing to share that with the investigator?”

4. For this study, a parishioner was defined as a person currently registered or planning to register with OLSS or regularly attends Mass at OLSS and available through the project time frame from June 2015 through August 2015.

**Exclusion criteria**

Exclusion criteria were anyone under the age of 18, unable to speak or read English and visitors to Our Lady Star of the Sea.

**Instruments**

At the start of the educational intervention, baseline data were captured through the use of the knowledge pre-test, the PAM™ and the demographic survey. All completed surveys were placed into a white envelope and assigned an identifier number for the 10-12 week follow up post intervention PAM™. This was done for future data analysis so pre and post data and PAM™ would be able to be linked for statistical comparison. The knowledge post survey assessment was completed at the end of the intervention and placed into the participant white envelope.
Knowledge

Data gathered from the pre-knowledge survey tool created by the investigator, indicated the extent of knowledge the participant had of the topics that were to be discussed. These topics included an understanding of being engaged or activated in one’s healthcare, knowing what care transition means and why they are important, the importance of knowing about one’s medications and communication with one’s healthcare team. There were eight questions on the knowledge survey and the same test was taken pre and post intervention. Each “yes” received one point with the highest score being eight. All communication to be included was exhibited on the program agenda (see Appendix J to view the project agenda) and included active links to each of the videos.

With the intent of getting patients to be more active members of their health care team, the Ask Me 3 campaign was designed by health literacy experts and encourages patients and families to ask three specific questions of their providers to better understand their health conditions and what they need to do to stay healthy. The three questions in the campaign were: (a) what is my main problem? (b) what do I need to do? and, (c) why is it important for me to do this?

Demographics

Demographic data were captured using a form created by the investigator. These data elements were collected to provide a snapshot into some of the needs of OLSS parishioners and to better understand educational opportunities for future programs. These demographic data included age, gender, race/ethnicity, marital status, rating of one’s health, level of education, number of chronic diseases, having a primary care provider (PCP), number of medications, knowing medication side effects, hospitalized in the last 12 months, taking over the counter medications, smoking and alcohol habits, and days available for classes. This survey tool was
created using components of several other health ministry tools shared by health ministry colleagues and faith based internet resources.

**Activation/Engagement**

To measure patient activation and engagement the investigator used the PAM™, a validated tool developed by Dr. Judith Hibbard and Dr. Bill Mahoney, colleagues at the University of Oregon and managed by a company called Insignia Health (Insignia Health, 2016). Permission was requested and obtained from Insignia (see Appendix K for the Insignia licensing approval) to use this tool and final project results will be shared with Insignia. The PAM™ gauges the knowledge, skills and confidence needed to manage one’s own health and healthcare. Evidence suggests that engaged individuals have better health outcomes, improved satisfaction and decreased health care costs (Hibbard & Greene, 2013).

The original PAM™ is a 22-item tool developed using Rasch analysis. It is an interval level, unidimensional, Guttman-like measure with items corresponding to four levels of patient activation. A Guttman scale, considered more accurate than other unidimensional models, is a multi-item measure in which respondents are presented with increasingly difficult measures of approval for an attitude. Rasch person reliability in both those with and without chronic illness was .85. Cronbach’s alpha was .85 for the PAM™13. Generally acceptable values of alpha, range from 0.70 to 0.95. Both the original PAM™ and PAM™-13 have demonstrated predictive validity and sensitivity to change. PAM™13 has continually been validated in both healthy populations and those having a variety of chronic illnesses (Tigges, 2013; Tavakol, 2011).

**Intervention**

All participants in attendance signed in next to their name on a sign-in sheet. They each received a red folder as a “take-away” which included:

- An agenda with links to all videos.
Two identical consents. One for the participant to take home, another was placed back into the white envelope for the investigator to keep.

The Patient Activation Measure™ (PAM™) completed prior to the intervention and collected.

The Health and Demographic Survey completed and collected.

Two copies of the knowledge survey, pre and post intervention, and then collected.

Safe Use of Medicines booklet from the National Institute on Aging (NIA) (see Appendix L for a picture of the NIA electronic pamphlet, “Safe Use of Medicines”).


A copy of “Your Discharge Planning Checklist”, the Centers for Medicare and Medicaid Services document. (See Appendix N for a picture of the electronic tool, “Your Discharge Planning Checklist”).

The intervention included an educational session covering the above topics and took place from 6:30 – 8:30 pm with dinner from 5:45 pm to 6:30 pm.

Curriculum for the intervention was developed through ongoing evaluation of videos and printed material developed by reputable organizations aligned with educating and improving health and healthcare. Videos chosen for this study were the Robert Wood Johnson Foundation’s Care About Your Care video (Robert Wood Johnson Foundation, 2015), the Waiting Room video from the Agency for Healthcare Research and Quality (Agency for Healthcare Research and Quality, 2013) the Ask Me 3 campaign from the National Patient Safety Foundation (National Patient Safety, 2015) and the state of Minnesota’s, You Are Your Own Best Medicine
safety campaign (Minnesota Alliance for Patient Safety, 2014). Participants were encouraged to engage in conversation with each topic.
Chapter IV

Results

This chapter details the findings of the descriptive study. Conveyed findings contain descriptive information defining demographics, pre- and post-test outcomes for baseline and gained knowledge of healthcare topics, and pre- and post-scores on the Patient Activation Measure™ (PAM™). Each of the 41 participants completed the pre- and post-educational surveys. Each of the participants completed the initial PAM™ and the demographic survey. The pre-intervention PAM™ was completed prior to the intervention and in a group setting. The post-intervention PAM™ was completed telephonically 10-12 weeks after the intervention. The PAM™ call back included 38 of the participants (93%). Three participants were called several times but were unavailable for discussion. At the follow up call, descriptive data were gathered from the question, “What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare, and would you be willing to share that with the investigator?”

Data were analyzed using SPSS version 22 to calculate totals and variances. Analysis of the data began with inspection for any missing data. In callback, attempt was made to obtain any missing data elements. PAM™ data were analyzed by the investigator using the PAM™ scoring tool supplied by Insignia Health. The initial PAM™ results were also compared against the national HSC 2007 Health Tracking Household Survey (Hibbard & Cunningham, 2008). The effectiveness of the educational session was measured using the pre and post intervention knowledge survey. The data from these assessment tools were analyzed by the investigator comparing the variance in the scores pre and post intervention. The health and demographic data were analyzed by the investigator looking at the numbers in each category, ages, gender, and comparison of results.
Description of the Participants

A total of 41 participants attended the evening educational session. The majority of the participants were female (61%), in the 60-69 year old age group (39%), married (80.5%), retired (58.5%) and Caucasian (90.2%).

Table 2

Sample characteristics

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of participants</th>
<th>% of participants</th>
</tr>
</thead>
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<tr>
<td><strong>Gender</strong></td>
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<td></td>
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<td>39</td>
</tr>
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<td>61</td>
</tr>
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<td></td>
</tr>
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<td>0</td>
</tr>
<tr>
<td>21-29</td>
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</tr>
<tr>
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<td>3</td>
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</tr>
<tr>
<td>40-49</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>50-59</td>
<td>7</td>
<td>17.1</td>
</tr>
<tr>
<td>60-69</td>
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<td>≥ 80</td>
<td>3</td>
<td>7.3</td>
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<td></td>
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<tr>
<td>Hispanic</td>
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<td>2.4</td>
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<td>4.9</td>
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</tr>
<tr>
<td>Full-time</td>
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<td>19.5</td>
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<td>2.4</td>
</tr>
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<td><strong>Rate your health</strong></td>
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<td></td>
</tr>
<tr>
<td>Excellent</td>
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</tr>
<tr>
<td>Good</td>
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<td>61</td>
</tr>
<tr>
<td>Fair</td>
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</tr>
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<td>0</td>
</tr>
<tr>
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<tr>
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<td>0</td>
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<tr>
<td>Some college</td>
<td>12</td>
<td>29.3</td>
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Table 2 continued

<table>
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<tr>
<th>Characteristic</th>
<th>No. of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of education</strong></td>
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<td></td>
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<tr>
<td>College graduate</td>
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<td>31.7</td>
</tr>
<tr>
<td>Graduate school</td>
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<td>29.3</td>
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<tr>
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<td></td>
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<td>2.4</td>
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<tr>
<td>Separated/divorced</td>
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<td>12.2</td>
</tr>
<tr>
<td><strong>Has primary care provider</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>39</td>
<td>92.7</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td><strong>In hospital in last year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>4</td>
<td>9.8</td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>90.2</td>
</tr>
<tr>
<td><strong>Visited pcp in last year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>36</td>
<td>87.8</td>
</tr>
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<td>4.9</td>
</tr>
<tr>
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<td>7.3</td>
</tr>
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</tr>
<tr>
<td>0</td>
<td>4</td>
<td>12.2</td>
</tr>
<tr>
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<td>11</td>
<td>26.8</td>
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<td>34.1</td>
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</tr>
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<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Take over the counter medications</strong></td>
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<td></td>
</tr>
<tr>
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<td>29</td>
<td>70.7</td>
</tr>
<tr>
<td>No</td>
<td>12</td>
<td>29.3</td>
</tr>
<tr>
<td><strong>Know what meds are for</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>38</td>
<td>92.7</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>NA&lt;sup&gt;1&lt;/sup&gt;</td>
<td>1 (write in)</td>
<td>2.4</td>
</tr>
<tr>
<td><strong>Do you smoke</strong></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>1</td>
<td>2.4</td>
</tr>
<tr>
<td>No/Never</td>
<td>20</td>
<td>48.8</td>
</tr>
<tr>
<td>Quit</td>
<td>20</td>
<td>48.8</td>
</tr>
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</table>
Table 2 Continued

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>No. of participants</th>
<th>% of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcoholic beverages daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None</td>
<td>22</td>
<td>53.7</td>
</tr>
<tr>
<td>1-2</td>
<td>11</td>
<td>26.8</td>
</tr>
<tr>
<td>3-4</td>
<td>2</td>
<td>4.9</td>
</tr>
<tr>
<td>≥5</td>
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<td>0</td>
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<tr>
<td>Blank</td>
<td>3</td>
<td>7.3</td>
</tr>
<tr>
<td>Occasional</td>
<td>3(write in)</td>
<td>7.3</td>
</tr>
</tbody>
</table>

NA\(^1\) was written in by participant who did not take any medications and therefore didn’t need to know what meds were for.

Table 2 displays the characteristics of the participants derived from the demographic health survey. Forty of 41 participants did not smoke or had quit. Greater than 50% did not drink alcohol on a daily basis. Ninety-two percent knew what each of their prescription medications were for and while almost 71% took over the counter medications, 29% did not take any over the counter medications. Thirty-four percent (14) took a total of three to four medications while seven participants took a total of seven or greater. Almost 88% had visited their doctor in the past 12 months and almost 93% indicated their health was excellent or good. Scholastically, 90% stated they had some college, a college or graduate level degree.

**Aim I**

The first aim of this project was to ascertain the current knowledge, skills and confidence of the participating parishioners in relation to their health and healthcare. This aim was completed using the PAM\(^\text{TM}\). Ten to 12 weeks after the educational intervention, the PAM\(^\text{TM}\) was conducted telephonically to learn if the intervention provided had any impact in the participants’ knowledge, skills and confidence for self-management. In addition, the participants were asked the following question by the researcher, “What have you done, or are planning to do,
differently, using the information learned at the intervention, related to your health and healthcare, and would you be willing to share that with the investigator?”

Table 3 compares the results of each PAM™ against the 2007 Health System Tracking Household Survey (Hibbard & Cunningham, 2008), a nationally representative telephone survey of the civilian non-institutionalized U.S. population sponsored by the Robert Wood Johnson Foundation (RWJF). Within this telephone survey, an almost 17,800 sample included 15,500 adults age 18 and over and had a response rate of 43 percent.

Table 3

*Pre-intervention PAM™ results compared to national results*

<table>
<thead>
<tr>
<th>Pre-intervention Level</th>
<th>No. of participants</th>
<th>% of participants</th>
<th>National comparison %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (Least Activated)</td>
<td>3</td>
<td>7.3</td>
<td>6.8</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>14.6</td>
<td>14.6</td>
</tr>
<tr>
<td>3</td>
<td>14</td>
<td>34.1</td>
<td>37.2</td>
</tr>
<tr>
<td>4 (Most Activated)</td>
<td>18</td>
<td>43.9</td>
<td>41.4</td>
</tr>
</tbody>
</table>

Table 3 captures the number of participants and their corresponding PAM™ levels pre-intervention. For this project, the percentage of participants within each level for the initial PAM™, appear to closely align with the Robert Wood Johnson study.

The PAM™ research done by Hibbard and Cunningham (2008) showed participants in four levels of activation. Each level has increasing activation, but may lack the needed confidence or skills to move them to the next level. Level 1, the least activated group, was shown to have a PAM™ score of 0.0 -47.0. This group of low confidence and passive people believed that while an active role in one’s health may be important, their doctor was the one in charge of their overall health. Those who scored in Level 2 (47.1-55.1) were becoming aware, had minimal
knowledge, may lack confidence and basic knowledge in dealing with their health and care and felt they could be doing more. Participants in Level 3 (55.2–72.4), while starting to take some action in building self-management skills may still lack the confidence and the skills needed to carry an intervention through. These people strive to succeed and may be goal oriented.

Individuals in Level 4 (72.5-100.0), while most activated and having skills needed to complete positive actions to manage their health, may still not be able to complete the actions required during stressful times (Greene et al., 2015). They believe that having a focus of a healthy lifestyle will help navigate them to advocacy.
Table 4

*Participant characteristics as related to the pre-intervention PAM™*

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<tr>
<th>Characteristic</th>
<th>No.</th>
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<th>Lev2</th>
<th>Lev3</th>
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Table 4 indicates how participants scored the PAM™ based on certain characteristics. Of all participants 78% (32) scored at a Level 3 or 4. The number of males who scored a Level 3 or 4 was 13 or 81% of all males. Within the female group, 76% scored a Level 3 or 4. Thirty seven
participants (90.2%) were Caucasian with 30 of them (81%) presenting in Levels 3 and 4, the highest levels of activation. Two (50%) of four non-Caucasians, (9.8% of all participants), were equally distributed into Levels 1 and 2. The remaining two non-Caucasians (50%) were both in Level 3. There were no non-Caucasians in level 4.

Thirty-eight people (92.7% of all participants; see Table 2) rated their health as excellent or good. Those participants rating their health as excellent or good, (n=31 or 81.6%) had PAM™ scores of Level 3 and 4. The academic education for this sample revealed that 37 of 38 had achieved some college to graduate school. For that same college educated group, 78.3% (29) scored in Level 3 and 4. However of the four participants who indicated they had achieved a high school education, 75% scored at Level 3 and 4.
Table 5

Participant characteristics as related to the post intervention PAM™

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Table 5 illustrates the results of the post-intervention PAM™. This PAM™ was administered telephonically 10-12 weeks after the educational session. The table displays the movement of participants into different levels after the administration of the educational
There were fewer participants in Levels 1 and 2 as compared to the pre-intervention PAM™.

Table 6

*Comparison scores and levels of pre intervention and post intervention PAM™ by participant*

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<th>Identifier</th>
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<th>Level</th>
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<th>Score</th>
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<td>52.9</td>
<td>2</td>
<td>52.9</td>
<td>2</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>36</td>
<td>72.1</td>
<td>3</td>
<td>72.1</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>37</td>
<td>59.3</td>
<td>3</td>
<td>NA²</td>
<td>NA²</td>
<td>NA²</td>
<td>NA²</td>
</tr>
<tr>
<td>38</td>
<td>100</td>
<td>4</td>
<td>83.7</td>
<td>4</td>
<td>-16.3</td>
<td>0</td>
</tr>
<tr>
<td>39</td>
<td>75.5</td>
<td>4</td>
<td>65.8</td>
<td>3</td>
<td>-9.7</td>
<td>-1</td>
</tr>
<tr>
<td>40</td>
<td>68.9</td>
<td>3</td>
<td>65.8</td>
<td>3</td>
<td>-3.1</td>
<td>0</td>
</tr>
<tr>
<td>41</td>
<td>65.8</td>
<td>3</td>
<td>75.5</td>
<td>4</td>
<td>+9.7</td>
<td>+1</td>
</tr>
</tbody>
</table>

Note: NA² relates to those participants who were not available for the administration of the second PAM™. A score of 0 indicates that the participants score did not change from the pre-intervention PAM™ to the post intervention PAM™.

The pre-intervention PAM™ was completed by all 41 participants, while only 38 were able to be contacted to complete the post-intervention PAM™. Several attempts were made to reach all participants by phone or email. The pre-intervention PAM™ questions were not read out loud in the group, but directions were completed as instructed by Insignia, with guidelines for the participants to raise their hands if there were any questions. A few questions were noted, such as asking what to do if they knew what they were supposed to do, but didn’t. Participants were advised to answer as accurately and honestly as possible. In the pre-intervention PAM™, 32 people (78%) scored in the highest Levels of 3 and 4. Nine (22%) scored in Levels 1 and 2.

The post-intervention PAM™ was completed telephonically 10-12 weeks after the intervention. The difference in the pre- and post PAM™ is that with the post PAM™, each question was read aloud. In the post-intervention PAM™, 34 individuals (89.5%) scored as a Level 3 or 4, while 4 (10.5%) scored as a Level 1 or 2.
As shown, 15 participants (39.5%) had an increase in their pre-post PAM™ score from a low of 2.9 points to a high of 36.3 points with 10 participants showing an increase of from 1 to 3 levels. Post- PAM™ levels decreased 6.6 points to 27.9 points with four participants (10.5%), each dropping from a Level 4 to a Level 3. Post-PAM™ levels remained the same for 24 participants (63%). Six of the 24 (25%) had no change in their PAM™ scores or levels. Thirteen exhibited a drop in their total scores but no drop in levels and five showed increases in their scores, but no change in levels. According to the Insignia team that markets the PAM™, point changes are significant since each point increase in PAM™ scores correlate to a 2% decrease in hospitalization and 2% increase in medication adherence (Insignia Health, 2016). Points and levels can move up and down with increases in a person’s learning or environment.

**Descriptive information.** Within 10-12 weeks after the educational intervention, the researcher placed a call to each of the participants to complete the post intervention PAM™ and to ask the question, “What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be willing to share that with the investigator?” Three participants were unable to be contacted. The 38 participants were content to speak to the question and provided insight about the interventions and about their recent and past experiences in healthcare.
Table 7

Table 7 shows the actions that were identified from the participants when asked the question, “What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be willing to share that with the investigator? Each participant (38) provided some comment to the question, but several comments were not considered actionable. Examples of non-actionable comments were “mother was a nurse, so I always knew I needed to do” or “I listen to all in the medical family, but if I don’t agree I go north as I have lost all faith in southern doctors” or “as a retired nurse I have always been confident in asking doctors questions”.

Eleven participants stated they are asking more questions and doing things that make them feel more in charge of their health and health care. An additional 11 participants stated they were more forthright about asking questions, creating and writing questions down and also writing down their medication list.

Aim II

The second Aim of the project provided information and awareness on healthcare topics of general importance to all consumers as noted in the literature (engagement, care transitions,
communication with one’s healthcare provider, importance of asking questions), using tools created for this intervention and others from various reputable organizations. Participants were provided with a red plastic folder containing literature to read after the intervention. This literature included two publications provided by the National Institute on Aging. The first booklet, (No. 10-7348- September 2010) was entitled *Safe Use of Medicines*. The second booklet, (No. 05-3452- June 2014), entitled *A Guide for Older Adults: Talking With Your Doctor* provided general information on many topics of interest to all consumers. Finally, included in the red folder was a copy of a CMS publication entitled *Your Discharge Planning Checklist: For Patients and Their Caregivers Preparing to Leave a Hospital, Nursing Home or Other Care Setting* (CMS Product No.11376-revised June 2015).

The educational intervention took place in late July. Tables were set with white cloth tablecloths, and the room was pleasant with flowers as décor. Participants were greeted at the door, signed in and allowed to sit randomly. Dinner began as soon as the participants began to arrive, which was 5:45pm. Dinner consisted of submarine sandwiches, with a choice of a green salad or macaroni salad with green onion and tomato. Dessert was a small piece of pound cake topped with strawberries and a small dollop of whipped crème. There was a choice of several beverages to include coffee, water, and iced tea.

Housekeeping issues were addressed and the intervention began after dinner with a conversation on the importance of being engaged in one’s health and healthcare. The investigator shared a reflection on why the topic was personally important and a robust discussion began. The planned intervention contained four videos; the initial video was from the Agency for Healthcare Research and Quality (AHRQ), entitled *The Waiting Room: Questions are the Answer* (Agency for Healthcare Research and Quality, May 2013). This 7-minute video features real patients and real clinicians discussing the importance of asking questions and sharing
information. This video was viewed with great enthusiasm and sparked a great deal of personal stories and examples of good versus bad healthcare experiences.

The second video, Care About Your Care, from the Robert Wood Johnson Foundation addressed care transitions and their importance in one’s health and healthcare (Robert Wood Johnson Foundation, 2015). Halfway through the video, the internet connection was lost. After several attempts by the investigator as well as others in the room to reestablish a network connection, the consensus was to continue without the videos and to talk through the remaining topics of Ask Me 3 and You Are Your Own Best Medicine. Educational information was provided about both topics with encouragement to view the videos at home when able. Engaging conversation continued for 90 minutes with participants declaring that they learned a great deal and were pleased they attended the intervention.
Table 8

Pre and post intervention and evidence of knowledge/awareness gained

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I have heard about patient engagement/activation in healthcare.</td>
<td>21 yes, 20 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>2. I understand why patient engagement is important for my healthcare.</td>
<td>34 yes, 7 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>3. I know what Care Transition in healthcare is.</td>
<td>12 yes, 29 no</td>
<td>40 yes, 1 no</td>
</tr>
<tr>
<td>4. I understand why it is important to know about care transitions.</td>
<td>20 yes, 21 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>5. I understand the importance of knowing about my medications.</td>
<td>41 yes, 0 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>6. I understand the importance of open communication with my healthcare team.</td>
<td>38 yes, 3 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>7. I understand the importance of ASK ME 3 questions.</td>
<td>12 yes, 29 no</td>
<td>41 yes, 0 no</td>
</tr>
<tr>
<td>8. I understand what it means that “I am my own best medicine”.</td>
<td>35 yes, 6 no</td>
<td>41 yes, 0 no</td>
</tr>
</tbody>
</table>

Table 8 illustrates the pre and post education scores as they relate to the questions asked.

Most knowledge seemed to be gained related to the concepts of engagement, care transitions and the Ask Me 3 Campaign.
Table 9

*Pre and post intervention knowledge scores*

<table>
<thead>
<tr>
<th>Identifier of participant</th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>8</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>9</td>
<td>7</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>10</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>11</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>14</td>
<td>5</td>
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</tr>
<tr>
<td>15</td>
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<td>8</td>
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<tr>
<td>16</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>17</td>
<td>8</td>
<td>8</td>
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</tr>
<tr>
<td>18</td>
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<td>8</td>
<td>0</td>
</tr>
<tr>
<td>19</td>
<td>4</td>
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<td>4</td>
</tr>
<tr>
<td>20</td>
<td>2</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>21</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>22</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>23</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>24</td>
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<td>25</td>
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</tr>
<tr>
<td>26</td>
<td>4</td>
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<td>4</td>
</tr>
<tr>
<td>27</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>28</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>29</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>30</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>31</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>32</td>
<td>2</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>33</td>
<td>8</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>34</td>
<td>2</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>35</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>36</td>
<td>3</td>
<td>7</td>
<td>4</td>
</tr>
<tr>
<td>37</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>38</td>
<td>7</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>39</td>
<td>6</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>40</td>
<td>5</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>41</td>
<td>4</td>
<td>8</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 9 illustrates pre intervention knowledge score and post score improvement in knowledge/awareness gained. The questions were yes/no questions related to the topics being discussed, and the time between the pre and post test was about 90 minutes. The data showed that 11 individuals (26.8%) scored high on the pre-test with a score of 7 or greater. Post-test, 24 individuals, (59%), had a 3 to 6 point increase in their scores.

Aim III

The third Aim assessed the overall health status and health education needs of the participating parishioners of OLSS using a hard copy demographic/health survey form created for this project. These data will be used for the newly created health ministry as a guide in creating programs and educational sessions.

Table 10

Additional health data: chronic conditions

<table>
<thead>
<tr>
<th>Which chronic conditions</th>
<th>No. of participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arthritis</td>
<td>10</td>
</tr>
<tr>
<td>Diabetes</td>
<td>4</td>
</tr>
<tr>
<td>Asthma</td>
<td>3</td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>3</td>
</tr>
<tr>
<td>Cancer</td>
<td>2</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>1</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>1</td>
</tr>
<tr>
<td>Coronary Artery Disease</td>
<td>0</td>
</tr>
<tr>
<td>Write ins</td>
<td></td>
</tr>
<tr>
<td>Anemia</td>
<td>1</td>
</tr>
<tr>
<td>Spina bifida</td>
<td>1</td>
</tr>
<tr>
<td>Gout</td>
<td>1</td>
</tr>
<tr>
<td>Migraines</td>
<td>1</td>
</tr>
<tr>
<td>Gastro-esophageal reflux disease</td>
<td>1</td>
</tr>
<tr>
<td>Lupus</td>
<td>1</td>
</tr>
<tr>
<td>Atrial fibrillation</td>
<td>1</td>
</tr>
<tr>
<td>Spinal stenosis</td>
<td>1</td>
</tr>
<tr>
<td>Trigeminal neuralgia</td>
<td>1</td>
</tr>
</tbody>
</table>
While the question “Have you been diagnosed with a chronic condition?” revealed that 24 participants had been diagnosed with a chronic condition and 16 had not (one blank), there were additional write in diagnoses besides the eight diagnoses listed in the survey. Thirteen participants stated they had one chronic disease, five indicated they had two chronic diseases and seven indicated they had three or more chronic conditions.

Table 11

*Future health promotion/support groups of interest*

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of participants interested in topic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Disease management</strong></td>
<td></td>
</tr>
<tr>
<td>Exercise</td>
<td>35</td>
</tr>
<tr>
<td>Nutrition/healthy eating</td>
<td>32</td>
</tr>
<tr>
<td>Stress management</td>
<td>16</td>
</tr>
<tr>
<td>CPR (cardio-pulmonary resuscitation)</td>
<td>16</td>
</tr>
<tr>
<td>Time management</td>
<td>11</td>
</tr>
<tr>
<td>Safety/fall prevention</td>
<td>8</td>
</tr>
<tr>
<td>Individual counseling (assistance for lifestyle change)</td>
<td>7</td>
</tr>
<tr>
<td>Smoking cessation</td>
<td>2</td>
</tr>
<tr>
<td>Memory loss</td>
<td>1</td>
</tr>
<tr>
<td><strong>Physical health programs</strong></td>
<td></td>
</tr>
<tr>
<td>Womens health issues</td>
<td>14</td>
</tr>
<tr>
<td>Aging process</td>
<td>12</td>
</tr>
<tr>
<td>Stroke</td>
<td>11</td>
</tr>
<tr>
<td>High blood pressure</td>
<td>9</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7</td>
</tr>
<tr>
<td>Heart</td>
<td>5</td>
</tr>
<tr>
<td>Lung disease/asthma</td>
<td>5</td>
</tr>
<tr>
<td>Men’s health issues</td>
<td>5</td>
</tr>
<tr>
<td>Cancer</td>
<td>3</td>
</tr>
<tr>
<td>HIV/aids</td>
<td>0</td>
</tr>
<tr>
<td><strong>Family health programs</strong></td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td>6</td>
</tr>
<tr>
<td>Interpersonal relationships</td>
<td>6</td>
</tr>
<tr>
<td>Living with teenagers</td>
<td>5</td>
</tr>
<tr>
<td>Dealing with parents</td>
<td>4</td>
</tr>
<tr>
<td>Child abuse prevention</td>
<td>3</td>
</tr>
<tr>
<td>Single parenthood</td>
<td>1</td>
</tr>
<tr>
<td>Pregnancy/mid-life crisis</td>
<td>0</td>
</tr>
</tbody>
</table>
Table 11 Continued

<table>
<thead>
<tr>
<th>Category</th>
<th>No. of participants interested in topic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emotional Health</strong></td>
<td></td>
</tr>
<tr>
<td>Self-Esteem (feeling good about me)</td>
<td>13</td>
</tr>
<tr>
<td>Depression</td>
<td>9</td>
</tr>
<tr>
<td>Death and Dying</td>
<td>9</td>
</tr>
<tr>
<td>Anger</td>
<td>5</td>
</tr>
<tr>
<td>Shame (feeling bad about me)</td>
<td>4</td>
</tr>
<tr>
<td>Divorce</td>
<td>1</td>
</tr>
<tr>
<td>Drugs and Alcohol</td>
<td>1</td>
</tr>
<tr>
<td>Violence</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other programs (write in)</strong></td>
<td></td>
</tr>
<tr>
<td>Autism</td>
<td>1</td>
</tr>
<tr>
<td>Spirituality</td>
<td>2</td>
</tr>
<tr>
<td>Wellness</td>
<td>2</td>
</tr>
</tbody>
</table>

Table 11 displays the list of topics that participants would like future educational sessions on. Additional topics (other) not included in the printed demographic survey and written in by participants were autism, spirituality and wellness.

Table 12

*Important concerns for the participants, their family and their community*

<table>
<thead>
<tr>
<th>Concerns</th>
<th>Self</th>
<th>Family</th>
<th>Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blanks</td>
<td>9</td>
<td>20</td>
<td>27</td>
</tr>
<tr>
<td>Alzheimers/ memory loss /aging</td>
<td>7</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Physical activity</td>
<td>11</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Spiritual/emotional health</td>
<td>7</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>Diabetes/ diabetes control</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Obesity/weight control/ nutrition</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Mental health/stress/depression</td>
<td>7</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Keeping current disease in control</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Caring for self/family/spouse/community</td>
<td>2</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Dying with dignity</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>

Results of the final question are displayed in table 12. This question asked participants what their most important health concerns were for themselves, their family and their community and cited general examples such as emotional, physical and spiritual. There were 9 to 27 blanks
across the three categories of self, family and community. Physical activity was the most important concern for self while spiritual and emotional health were the highest for family and community.

The results from the study are a good foundation to help support the ongoing health ministry. The demographic/health survey provided a list of multiple topics for future programs and the PAM™ results are a good foundation for evaluating both the learning potential related to knowledge, skills and confidence for a parish population as well as the effectiveness of the actual interventions.
Chapter V

Conclusions

Chapter V presents the discussion of major findings. Also included in this section are the strengths and limitations of the project, implications for nursing practice and for Our Lady Star of the Sea (OLSS) church and her parishioners as well as recommendations for future research.

Discussion of Major Findings

The purpose of this translational project was to identify if individuals who are members of OLSS Catholic Church, aged 18 and over and who chose to participate in the project, were engaged participants in their health and healthcare. Out of approximately 441 families in the church population, 41 volunteers agreed to participate. Participants in the study were predominantly Caucasian (90.2%), married (80.5%), female (61%) and retired (58.5%). Overall the findings from this study showed an engaged, older, well-educated population eager to learn more. Higher engagement in general suggests people who seek out and synthesize relevant health information and who appear to be successful navigating the complex and often times confusing health system (Hibbard & Cunningham, 2008). People were interested, attentive and sharing of their experiences, their feelings and their concerns about their own individual healthcare and of healthcare in general. Some shared frustrations, others asked “why” and one or two shared a general distrust of providers in general.

The literature suggested that people who are activated or have the knowledge, skills, ability, and willingness to oversee their health and care have better health outcomes (James, 2013). James further indicated that patients who actively engage in interventions to promote healthy behaviors like preventive care or regular exercise, are patients who positively contribute to the Triple Aim. The Triple Aim, a model developed by the IHI, encourages the concurrent pursuit of three elements: improved health outcomes, improved patient care and a lowering of
overall costs (Berwick et al., 2008). Attendance and participation in a summertime, middle of the week, health related learning session, such as this project, may suggest that those who volunteered for this project recognized that managing one’s health is important.

In general, this project may have contributed to the overall experience of better care, a major goal of the Triple Aim. Participants stated verbally both a gain in knowledge and awareness that it was acceptable, in fact encouraged, to ask questions and to get clarity when things were not explained well or when questions remained. If they were already asking questions and participating as their own healthcare advocate, they stated the intervention and discussions validated that what they had been doing was correct and meaningful. Longer term, this project may begin to improve the health of populations and decrease costs. As people become more aware and ask more questions they become better self-advocates choosing the right care for the right reasons.

**Aim I.** The first aim of this project was to ascertain the current knowledge, skills and confidence, or activation of the participating parishioners in relation to their health and healthcare. The Patient Activation Measure (PAM™) was administered twice in this study to assess patient activation and engagement of the project participants. In the pre-intervention PAM™, the 41 project participants score groupings indicating Levels 1-4, were closely aligned with a 2007 national telephone survey completed by Hibbard and Cunningham and sponsored by the Robert Wood Johnson Foundation. The Hibbard and Cunningham (2008) study found that the majority of the participants scored at levels 3 and 4 (37.2% and 41.4% respectively). The remaining participants scored at levels 1 and 2 (6.8% and 14.6% respectively). This research project displayed similar findings at Levels 3 and 4 (34.1% and 41.4% respectively) and Levels 1 and 2 (7.3% and 14.6% respectively).
The number of project participants scoring in each level, indicated, like the national survey, that less than half of all project participants were at the highest level of activation (Level 4). Additional data from the Hibbard and Cunningham (2008) study found that 76% of their participants scoring within Levels 3 and 4 indicated that their overall health was excellent or good. For this research project, data showed that 81.6% of the participants scoring within Levels 3 and 4 indicated their overall health was excellent or good. According to Hibbard and Cunningham (2008), those in Levels 3 and 4, while beginning to take some action toward self-advocacy may still not have all the skills and confidence needed to support healthy behaviors especially in stressful times.

The project participants’ indication that their overall health was excellent or good may be a reflection of their high levels of activation and sense of control over their own personal health. Studies do suggest however, that even when patients have multiple chronic illnesses, or are elderly, they can continue to improve their activation and exercise some control over their personal health (Hibbard et al., 2013).

The second administration of the PAM™ occurred after the educational session. The scores on the post intervention PAM™ showed less participants in Levels 1 and 2 and had more participants move into the highest Level 4. Levels 1 and 2 decreased by five participants and while Level 3 remained constant with 14 people, Level 4 increased by two. Studies do indicate that over time, activation is changeable and that health related behaviors can improve (Hibbard & Cunningham, 2008). This may suggest that several participants, post intervention, gained some knowledge necessary to empower them and move them into a more activated state.

Previous research indicated that patients who are more activated are engaged in more preventive behaviors, healthier behaviors, disease specific self-management behaviors and more health information-seeking behaviors (Hibbard & Greene, 2013). Making the decision to
participate in this project intervention focused on health and engagement in one’s health care is considered health information-seeking behavior. Another possible reason for improved overall PAM™ scores may be that the post intervention PAM™ was delivered telephonically and generated additional clarification and conversation. In some instances, this may have prompted the participant to score themselves differently.

The data from the demographic health survey indicated that 31 participants in Levels 3 and 4 rated their health as excellent or good. The number of participants who visited their PCP in the last 12 months revealed 36 people (87.8%). Additionally less than 10% had been hospitalized in the last year. These data suggest as the research does that people who are involved in their health and healthcare are more confident, report better health and had significantly lower utilization in regards to visits with their doctor (Greene & Hibbard, 2012; Hibbard & Greene, 2013; Hibbard & Cunningham, 2008; Hibbard, Greene & Overton, 2013).

The scores on the PAM™ administered after the educational intervention, for those rating their health as excellent or good, revealed an increase of those scoring in Level 4. This may suggest that patients who see themselves as activated and engaged felt validated that what they are doing is the right thing. In addition, only one participant smoked, expressing the desire to quit in the near future. Those who had quit or never smoked were equal at 20 each and over 50% reported no daily consumption of alcohol. These types of healthy behaviors suggest that these participants were aware of what was needed to maintain better health.

The education level within this group of participants was high with 37 of the 41 participants (90.2%) having attended some college, or obtained a college or a graduate degree. While this study was focused on parishioners of OLSS Catholic Church, Georgia data shows that for 2010, in St. Marys, 45% of the 25 and over population had achieved either a bachelor’s degree or had attended graduate school (Coastal Health District, 2010). This could indicate that
the population for this study was more educated than the general population of St. Marys and may therefore be more engaged and activated in their health. Research validates that activation levels are high for people with more education and people with good self-reported health (Hibbard & Cunningham, 2008).

Of all project participants 78% (32) scored a PAM™ Level 3 or 4 pre-intervention. The number of males who scored a Level 3 or 4 was 13 or 81% of all males. The number of females who scored a Level 3 or 4 was 76%. There were 34 participants (80.5%) who were married. The research showed conflicting associations between PAM™ scores and age, gender or marital status (Mukoro, 2012; Fowles et al., 2009). Fowles et al. (2009) indicated in their study of personal characteristics and the PAM™, that gender did matter, indicating that men had lower scores. Hibbard and Cunningham (2008) indicated that younger patients were more activated and had higher PAM™ scores than older patients. The data for this project exhibited 19 females (76%) and 13 males (81%) in Levels 3 and 4 whereas 6 females (25%) and 3 males (18%) were in Levels 1 and 2.

Thirty seven participants (90.2%) were Caucasian with 30 of them (81%) presenting in Levels 3 and 4, the highest levels of activation. Two (50%) of four non-Caucasians, (9.8% of all participants), were equally distributed into Levels 1 and 2. The remaining two non-Caucasians (50%) were both in Level 3. There were no non-Caucasians in Level 4. Hibbard et al. (2008) observed racial differences in a national and Medicaid sample. They discovered that PAM™ scores were four points higher in whites than African Americans with four points on the PAM™ suggesting a meaningful difference.

While the greater number of project participants (92.7%) rated their health as excellent or good, almost 82% of them exhibited through PAM results to be able to self-manage their health (Level 3 and 4). The level of education for this sample revealed that 37 had achieved some
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college to graduate level. For those same college level people, 75.7% (28) scored in Level 3 and 4. However of the four participants who indicated they had achieved a high school education 75% also found themselves in Level 3 and 4. Fowles et al. (2009) study of personal characteristics and the PAM™ found that educational level, age and race were non-significant.

The difference in the pre-post PAM™ scores indicated that almost 40% increased their scores from 2.9 points to 36.3 points. Ten participants actually exhibited an increase from one to three levels. This may be a result of the difference in the way the two PAMs™ were administered. The telephonic delivery of the second PAM™ prompting occasional conversation may have impacted the scores. Participants occasionally asked for clarifications on the questions.

Higher activation is suggestive of persons who will have positive health behavior changes and look for ways to be engaged in their health. Even those with chronic disease can show improvement in their scores. Hibbard et al. (2007) followed patients with chronic disease during a 6 month period. Increases in their PAM™ scores saw improvements in 11 of 18 health related actions. Similarly, Harvey, Fowles, Xi and Terry (2012) described comparable outcomes for their study population of 320 employees (with and without chronic disease) from two U.S. companies. The change in PAM™ was associated with improvement in health behaviors at every Level (1–4), particularly at Level 4. The researchers also indicated that Level 4 is not an endpoint; patients can continue making improvements. Regardless of the person’s activation level at baseline, when the PAM™ score increased, improvement was seen in multiple behaviors.

**Descriptive information.** Ten to 12 weeks after the project intervention, the researcher placed a call to each participant and was able to reach 38 of the 41. In addition to repeating the PAM™, the question, “What have you done, or are planning to do, differently, using the information learned at the intervention, related to your health and healthcare and would you be
willing to share that with the investigator?” Responses to the question were noted to be actions taken by the participants in managing their health and care. Eleven participants stated they ask questions and take charge of their health. Another 11 participants responded stating they are more forthright in writing the questions down, asking them and preparing a list of questions and medication list for their doctor. Because each of the video interventions included key pointers on asking questions, especially the Ask Me 3 video, and it was a large part of the intervention conversation, it is likely to have played a part in educating many of the participants.

Wasson and Coleman (2014) suggested that the term health confidence, an alternative for engagement, is a preferred way to measure engagement or activation. Using the question “How confident are you that you can control and manage most of your health problems?” (p. 9), they believe prompts individual reflection and conversation between patient and doctor. Patient engagement is essential in any situation that requires patients to play a role such as self-advocate. If they do not understand their role, they will not look for information and if they lack confidence, they will not take a pro-active role (Hibbard & Greene, 2013).

Aim II. The second aim of the project was fulfilled by providing information and awareness on healthcare topics of general importance to all consumers as noted in the literature (engagement, care transitions, communication with one’s healthcare provider, and the importance of asking questions). The internet failure midway through the intervention actually allowed for much more collaborative conversation. The topics were presented and the participants were encouraged to view the videos at home when they could, to reinforce the topics being discussed.

The participants were eager to ask questions and to share experiences, both good and bad. Participants sharing a bad experience stated the experience made them better advocates for themselves and their families. Generally, the conversations were related to a poor experience
with a healthcare provider or office personal, and the participant needing to take control of the situation. Several participants spoke of situations where they were the caregiver, requiring them to advocate for the person they were caring for.

The general feedback on the program both immediately after and days later was very positive. Five to seven months post educational session, participants have met the researcher in OLSS and commented on the usefulness of the red folder, the videos and the knowledge gained. The health ministry, since the project ended, has become operational and has provided an opportunity for the parishioners, the pastor, and the participants to gain more trust and confidence in the researcher and the entire health care ministry team.

**Aim III.** The third Aim of the project was to assess the overall health status and health education needs of the participating parishioners of OLSS using a hard copy demographic/health survey form created for this project. The survey provided much data to support the ongoing program development of the health ministry at Our Lady Star of the Sea Catholic Church. It provided a snapshot of the current health of the participants, as well as requests for additional topics. Convenience sampling was used to identify participants for this study. It is possible that the health and demographic data do provide a prototype of the remaining parish members. Responding to a request for volunteers to participate in a health project as the participants did, may suggest they were more interested, and overall more engaged in their health. Research shows that those who seek out health improvement and preventive behaviors are more engaged in their health (Harvey et al, 2012; Hibbard & Greene, 2013; Hibbard et al., 2007).

Twenty-five percent of the participants stated they had arthritis as a chronic condition. Almost 59% stated they had been diagnosed with a chronic condition. Neither statistic is surprising as 37 (90%) of the participants are 50 and over. The CDC states that increasing age increases the risk for most types of arthritis and that 60% of the people with arthritis are women
Ninety three percent stated their health was excellent or good possibly suggesting they have their chronic conditions under control. While some research shows that higher educational attainment and being married both contribute to being more interested and actively engaged in practicing healthy behaviors (James, 2013; Hibbard et al., 2008), other research finds no correlation (Mukoro, 2012; Fowles et al., 2009).

There was significant interest expressed in developing future programs based on the responses to the demographic and health survey. Exercise, nutrition/healthy eating, stress management and CPR training were highest on the disease management list. Having a nutritionist on the new health ministry team will allow the team to give focused presentations on nutrition and exercise as it relates to ones’ health. Physical health programs of interest included womens health issues, the aging process and stroke. With 61% of the participants as female, it was not surprising to see women’s health issues as a high priority. Under emotional health, 31 participants showed an interest in hearing more about self-esteem issues, depression and death and dying. Thirteen participants were concerned about obesity, weight control and nutrition for themselves, their family and their community. Nineteen people expressed concern about physical issues, immobility or lack of exercise for themselves, their families and their community. While there was only one smoker among the project participants, tobacco use in Camden county is elevated with 24% of the residents still smoking. Camden county consists of the cities of St. Marys (largest), Kingsland, and Woodbine. According to the 2010 County Health Rankings, obesity occurs in 29% of Camden citizens. A Camden survey showed that 47% of residents report that they are overweight, 52% say that they do not eat a healthy diet, and 29% say that they seldom exercise (Coastal Health District, 2010). Observation suggests it is also an issue at OLSS. Exercise and nutrition/healthy eating are national needs to combat obesity. OLSS is no exception.
As previously noted, many of the project participants were older so aging issues and spiritual health were in line with expectations. The project took place in a parish community with the majority of participants aged 60-69. The physical health needs were expected but the emotional and mental health were surprising for this project population since almost 93% rated their health as excellent or good. St. Marys does have a somewhat depressed economy as the Naval base is the major employer followed by an Express Script call center. There are no other major employers. Jobs are with small businesses that are shutting down continuously. While there is a revitalization campaign and project in the downtown St. Marys city government, planning for these types of projects can take years.

**Strengths of the Project**

The use of the PAM™, an international activation engagement tool translated into 22 languages, provided a strong foundation to measure patient activation and engagement in the participants’ health and health care. The tool was easy to administer both face to face and telephonically with instruction from Insignia prompting few questions from the participants. The pre and post knowledge/awareness test indicated that knowledge and awareness of the project topics (communication, care transitions and the importance of asking questions) were increased post intervention as were PAM™ scores. Scores may have increased also from the amount of conversation that took place at each table. Insignia states on their website that “each point increase in a PAM™ score correlates to a 2% decrease in hospitalization and 2% increase in medication adherence” (Insignia Health, 2016). The participants were very collaborative and interested in the topics presented with lengthy conversations and questions.

Another strength of the project was the opportunity for the researcher to gain trust with the participants/parishioners. The researcher, also a member of OLSS was somewhat new to OLSS; the priest was also new having come to OLSS less than 12 months before the project
start. However combined with the health ministry team and the new administrative assistant to the priest, all were focused and dedicated to see new projects and programs brought to the church that would be beneficial for the parishioners.

A final strength of the project was both the framework of the Triple Aim, a focused goal toward achievement in healthcare of things that really matter, and recognition by the researcher that for this project, the Triple Aim needed to be adapted. The adaptation was needed to allow for a more complete picture of components and tasks that one would require to actually achieve the goals of the Triple Aim.

**Limitations of the Project**

A limitation for this project was a sample size of 41 participants. The 41 participants were recruited thorough convenience sampling. Convenience sampling can be considered biased and not representative of the population (Sousa, Zauszniewski & Musil, 2004). Their study used a cross-sectional design and a convenience sample of 141 subjects to illustrate ways to assess the possible bias. The results of their study suggested that the sample characterized the investigated population. They suggested that more research was necessary to strengthen results of studies using convenience sampling.

Another limitation was a lack of thorough understanding of the church’s membership. At the time of this project, the church was transitioning from a paper membership data collection process to an electronic membership data structure. Much of the church data were old or missing. A new administrative assistant to the pastor was hired to aid in this transition requiring systems training and re-registration of the entire parish membership. While an estimated 441 families are parishioners of OLSS, the population in each age group and the number in each family were unknown.
A third limitation was having a new young priest at OLSS with no knowledge of health ministries or research being completed in a parish. The priest asked his superiors, legal counsel and others for guidance, and venturing into the unknown, eventually provided permission for this project to unfold. The project was presented to the parish council. While some in the council appeared to have some doubt and uncertainty, the pastor and others embraced the possibilities.

An unknown limitation was the 10-item PAM™. All of the research speaks to the use of the 22 and the 13-item PAM™. The investigator found no research specifically on the use of the 10-item PAM™, and inquired to those at Insignia on the validity and reliability of the 10-item tool. Insignia stated that the PAM™ 10 is now the standard used by almost all of their clients (commercial and research) over the last two to four years. Insignia shared that while the differences between measures in terms of predictive reliability was limited, consumer’s time and survey fatigue was not and therefore almost all use of the PAM™ is currently the PAM™ 10. A document not intended for external use was shared by Insignia that showed no significant variation between standard deviation and mean scores. The document also showed a strong Cronbach Alpha reliability with both the PAM™ 10 and 13.

The last limitation for this project was the time of year it was implemented. Summertime is generally filled with people out of town, family vacations, and children home from school. The end of July, evening meeting was a week or two before the start of school. Parents were gathering school clothes and supplies and going on last minute vacations.

**Implications for Nursing Practice**

This doctoral project has been used as an entry and a foundation for a newly formed health ministry at OLSS Catholic Church. The evening intervention allowed the researcher to get to know some of the parishioners/participants better. The participants were given the opportunity to begin to learn about how a church health ministry worked and what it could do for them.
With the impact of the Affordable Care Act, there is much interest and focus on how communities can contribute to this health care maze. The law continuously refers to patient centered care, satisfaction, care experience, and patient engagement, components that can all contribute to the Triple Aim through collaborative practice. Providers, both physician practices and hospitals, will need to reach out to create working partnerships with those in the community to carry on the care that was initiated in clinics and hospitals. Churches, which generally see their congregation more frequently than doctors see their patients, can be a place where health and wellness messages are consistently renewed and the caring component of healthcare can be delivered by those who are close to the persons needing care.

Our country has been moving from a culture of illness to a culture of health and wellness. Even public health is changing how they do things looking for ways to creatively support health and wellness. Recognizing that health and wellness are impacted by other dimensions such as social, physical, spiritual, intellectual, emotional, and the environment, collaborative partnerships can begin to create community partnerships that can all do their part on the path to the Triple Aim.

Faith community nursing (FCN) is a service that is rapidly increasing both nationally and internationally (Yeaworth & Sailors, 2014). Through churches FCNs are filling a void within communities providing free care, services, education and support. They are assisting hospitals with readmission programs, partnering with other FCNs and other nurse networks. FCNs are functioning as transition coaches as patients move from the hospital to home. They may sponsor and lead care teams, supply meals, do house cleaning, or take patients to appointments. They provide education, foot care, and a caring and spiritual connection.

This project can be an impetus for other churches and other clinicians to collaborate with their entire community including providers and facilities, to close the gap for those in need. The
needs may be education, follow up, transitional care, meals or just a caring friend who will listen and “be with” them.

A concern for practice is the cost of the PAM™. The document can currently be used by researchers at no cost but has limitations on volume. There is a cost for commercial use which may limit hospitals, providers, and health plans, but the cost is supposed to be minimal. However, if the use of the PAM™ can reduce healthcare costs over time, it may pay for itself.

**Implications for Our Lady Star of the Sea and her Parishioners**

The health ministry at OLSS is on its way to becoming one of OLSS’s established ministries. A link on the OLSS home page brings one to the health ministry tab (see Appendix O for a snapshot of OLSS webpage health ministry tab) where healthy recipes, aging information, disease information and other requested information can be found. What started as a doctoral project, has evolved into a group of people thinking outside the box with a mission to improve the health and the healthcare experience of its parishioners.

**Research Recommendations**

Follow up research around activation using the PAM™ both at OLSS and other churches would provide more information on the use of the PAM™ in church communities. If the health ministry expands to other churches in the St. Marys downtown area, a comparison of samples could be completed between each church. There is also a satellite parish to OLSS where a similar project could be completed.

As educational programs are developed and executed, the use of the PAM™ would help discover if people are benefiting from these programs related to their level of activation. Programs created for specific populations like diabetes or mental health could improve the health of individuals, while over time, populations could be impacted.
Parishes working with healthcare facilities like hospitals and provider offices could improve care for consumers and clinicians, improve the overall experience of care and ultimately decrease the cost of care, a pathway to the Triple Aim. This future research opportunity could contribute to the evidence that the RWJF is looking for as it leads all in healthcare to build a culture of health.

**Conclusions**

Modern healthcare is complex, ever changing and moving rapidly. Patients may lack health literacy as they struggle to process, communicate and understand their health information, yet the current healthcare environment is advocating them to be engaged and take the lead regarding their healthcare needs. They are discharged from the hospital unable to care for themselves, lacking information on next steps, and deficient in education on their medications. Many are discharged to empty homes with no network to check and assure they are getting what they need.

Patient activation and engagement is a new role for many people. They need to understand it and they need to have the appropriate skills, knowledge and confidence to be successful in it. It is the job of clinicians to prepare, coach and encourage consumers as they take on this new role of self-advocacy. Patients and families should be the lead on their healthcare team. Patients and families should be given the tools needed to not only survive these situations, but also to be a part of a community network that watches, waits, listens and responds to the needs and goals of its community members.

Patient engagement is considered a recommended strategy to achieve the Triple Aim (James, 2013). Utilizing the amended Triple Aim graphic (Figure 2) clinicians can seek to discover ways to collaborate with others in the community who know and work with their patients. These collaborations with patients as partners in their care can create safer and more
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effective outcomes creating the best care experience. When doctors, patients, families and communities work together, the experience is more satisfying for all. As more and more individuals collaborate with clinicians leading with evidence based standards of care, improvement is noticed in the health of populations and communities thereby creating better health. This in turn creates better value as patients begin to make improved and informed choices reducing the cost of care. When each component of the Triple Aim functions in tandem, health care achieves patient centered care through patients who are equipped, engaged, empowered, and enabled to make the very best healthcare decision possible.

The RWJF is seeking to learn about all attempts at community partnerships in their ongoing efforts to build a culture of health (Lavizzo-Mourey, 2014). They ask all in healthcare to think outside the box and imagine life within a society whose goal it is to inspire all to live the most healthy life possible even if dealing with chronic disease and social barriers. They ask all in healthcare to imagine a system of health care where treatment and personal caring embrace all who enter, and upon exiting, follows them home. This continuous caring can be done through church groups, home health, transition teams, neighborhood volunteers. Collaborative partnerships and the sharing of information help to create the realization that all in society are in this together.

The use of tools like the Patient Activation Measure™ to measure engagement and activation levels, can inform clinicians of a person’s readiness and ability to take on the role of self advocate. Patients need to learn individually, with the creation of individual care plans and local communities and providers that are aware of their needs. Health ministries and faith community nurses nationally have begun to move the needle through community partnerships that can improve the health of their parish populations. Working together with patients who want more information and who want to become more engaged is one step. Improving care will not
happen without the partnership of physicians. Nurses and physicians should be setting patients up for success, finding out what is important to them, and helping them attain it.

**Post Project Actions and Next Steps**

The initial project meeting with the participants began in July, 2015 with telephonic follow up in mid-September 2015. The health ministry team began regular monthly meetings after the project completion to discuss possible projects as noted from their long history of attendance at OLSS or from conversations with parishioners. Evaluation of the data retrieved from the surveys was incomplete at this point. Three initial programs were discussed and meetings were initiated: cardio-pulmonary resusitation (CPR) certification, foot care and the automated external defibrillator (AED).

Knowing there was an AED within the church, the health ministry inquired about the process for ongoing maintenance. The pastor stated there was no policy for AED maintenance and asked if the health ministry would create one and take on ownership of the AED. The health ministry then inquired about the number of parishioners with current CPR and AED training. This too was unknown. The health ministry then set up a CPR and AED training where 11 parishioners and health ministry members received training and certification.

Foot care was started in June 2015, but was slow to get established. The investigator had previous experience with this in a Senior Center setting. It was announced to the church congregation at Mass and placed in the bulletin. Today, 9 months later it is established as a monthly program and sees from 3-7 parishioners monthly. (See Appendix P for the monthly bulletin announcement for foot care and the health ministry meeting).

In early December 2015, the health ministry began thinking of a Lenten program that could relate faith to the dimensions of health and created a program entitled, “Learning to Live Well through Lent and Beyond” (see Appendix Q, the announcement and sign up for the Lenten
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Lent begins on Ash Wednesday and is usually 46 days before Easter. It is a very busy time in the Catholic faith, and early preparation for any program during Lent is required. Permission was requested of the pastor, and after much discussion about the program, it was approved. Planning meetings to discuss menus, Mass, and prayers, were held. The first program was held the Wednesday after Ash Wednesday from 9am-12:30pm and discussed three dimensions of health, followed by Mass and a light lunch of homemade minestrone soup, salad, drinks and fruit. A second meeting 2 weeks later was held on a Saturday (for those unable to come during the week) from 2pm-4:45pm followed by a regularly scheduled Mass (Appendix R displays the agenda for the 2nd meeting of the Lenten program). The Saturday meeting discussed the remaining three dimensions of health and provided a healthy snack of fruit, cheese and crackers and drinks. In addition to health ministry members leading discussions on the social, emotional, physical, and intellectual dimensions of health, guest speakers were brought in to discuss spirituality and health as well as occupational health and wellness. After each presentation, table discussions were held with table leads discussing the results.

A total of 30 participants attended the two programs, many attending both days. Program handouts were provided that included a synopsis of the material, a Lenten booklet, a calendar from Health and Human Services, an exercise book from the National Institute of Aging as well as a video demonstrating the exercises. Program evaluations and emails received by the health ministry team were very positive. The pastor was pleased at the conversations that took place and the involvement of all the attendees.

Continuous discussions and planning are ongoing with the health ministry team using the aggregate results of the demographic and health survey tool. Self esteem, depression and feeling good about oneself were topics that participants requested to learn more about. A program led by a licensed professional counselor on each of the topics as well as faith and spirituality is in the
planning stages. Permission was requested of the pastor and was immediately given. Ongoing planning is also including a fashion show with the participants as the models and a seminar on the proper way to apply makeup. Discussion is also underway to invite others in the community of St. Marys to this program, perhaps extending the invite to the other churches in the area.

The final program under discussion is Walk with a Priest. This would be a replica of a national program called “Walk with a Doc” that was begun in Columbus, Ohio in April of 2005 by Dr. David Sabgir a cardiologist, and has now expanded throughout the country (Walk with a Doc, 2016). Walk with a Doc currently has 165 chapters and is in 38 states. Discussion within the health ministry has been to get parishioners and priests out walking to improve overall health, and perhaps spiritual self as well. The health ministry’s goal will be to extend the invitation to the local physicians and nurse practitioners to create a Walk with a Doc chapter in St. Marys to improve the health of individuals and ultimately the population. Walk with a Doc and Walk with a Priest could be alternate weekly or monthly programs with the ultimate goal of improving overall health.

A new ministry report has been requested by the OLSS pastor to share each ministry’s events and progress. This report will be submitted to the Parish Council on a monthly basis (see Appendix S for a copy of the health ministry update to parish council).

There is no end to what can be accomplished if communities, churches and organizations collaborate internally and externally, think outside the box, use available resources or create new ones, look for evidence based programs that work, and create partnerships that can result in improved outcomes for all. The RWJF reminds us all that diversity helps define an individual’s uniqueness (Lavizzo-Mourey, 2014). Different economics, topographies and social conditions may impact each person differently as Americans, but living the best and healthiest lives is the goal of all.
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Appendix A

Patient Activation Measure

Below are some statements that people sometimes make when they talk about their health. Please indicate how much you agree or disagree with each statement as it applies to you personally by circling your answer. Your answers should be what is true for you and not just what you think the doctor wants you to say.

If the statement does not apply to you, circle N/A.

<table>
<thead>
<tr>
<th></th>
<th>When all is said and done, I am the person who is responsible for taking care of my health</th>
<th>Disagree</th>
<th>Disagree Strongly</th>
<th>Agree</th>
<th>Agree Strongly</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Taking an active role in my own health care is the most important thing that affects my health</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>3</td>
<td>I know what each of my prescribed medications do</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>4</td>
<td>I am confident that I can tell whether I need to go to the doctor or whether I can take care of a health problem myself</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>5</td>
<td>I am confident that I can tell a doctor concerns I have even when he or she does not ask</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>6</td>
<td>I am confident that I can follow through on medical treatments I may need to do at home</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>7</td>
<td>I have been able to maintain (keep up with) lifestyle changes, like eating right or exercising</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>8</td>
<td>I know how to prevent problems with my health</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>9</td>
<td>I am confident I can figure out solutions when new problems arise with my health</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
<tr>
<td>10</td>
<td>I am confident that I can maintain lifestyle changes, like eating right and exercising, even during times of stress</td>
<td>Disagree</td>
<td>Disagree Strongly</td>
<td>Agree</td>
<td>Agree Strongly</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Name: ________________________________ TEST 1: Pre-Intervention Knowledge Test

1. I have heard about patient engagement/ activation in healthcare.
   - Yes ____
   - No ____

2. I understand why patient engagement is important for my health care.
   - Yes ____
   - No ____

3. I know what care transition in healthcare is.
   - Yes ____
   - No ____

4. I understand why it is important to know about care transitions.
   - Yes ____
   - No ____

5. I understand the importance of knowing about my medications.
   - Yes ____
   - No ____

6. I understand the importance of open communication with my healthcare team.
   - Yes ____
   - No ____

7. I understand the importance of the ASKME 3 questions?
   - Yes ____
   - No ____

8. I understand what it means that “I am my own best medicine”.
   - Yes ____
   - No ____
Appendix C

Post- Intervention Knowledge Test

Name: ____________________________ TEST 1: Post- Intervention Knowledge Test

1. I have heard about patient engagement/ activation in healthcare.
   □ Yes ____
   □ No ____

2. I understand why patient engagement is important for my health care.
   □ Yes ____
   □ No ____

3. I know what care transition in healthcare is.
   □ Yes ____
   □ No ____

4. I understand why it is important to know about care transitions.
   □ Yes ____
   □ No ____

5. I understand the importance of knowing about my medications.
   □ Yes ____
   □ No ____

6. I understand the importance of open communication with my healthcare team.
   □ Yes ____
   □ No ____

7. I understand the importance of the ASKME 3 questions?
   □ Yes ____
   □ No ____

8. I understand what it means that “I am my own best medicine”.
   □ Yes ____
   □ No ____
Appendix D: Informed Consent

CONSENT FORM

I, {Name of Participant}, agree to participate in the research (Engaging Individuals in their Healthcare by Increasing Activation through Education), which is being conducted by {Margaret (Peg) Hudock}, who can be reached at {678-642-2893 cell or 912-439-3636 home}. I understand that my participation is voluntary; I can withdraw my consent at any time. If I withdraw my consent, my data will not be used as part of the study and will be destroyed.

The following points have been explained to me:

1. The purpose of this study is {to identify if individuals within Our Lady Star of the Sea Catholic Church, in St. Marys, Georgia, who are 18 and over and who choose to participate in this project, are engaged participants in their healthcare}.

2. The procedures are as follows: You will be asked to attend a session on what it is to be "ENGAGED IN ONES' HEALTHCARE". At the session, you will be required to complete a Patient Activation Measure (PAM), a Demographic/Health survey, and a pre-education survey on the material to be used for the intervention. You will be required to view four short videos on important healthcare topics and participate in the same number of conversations讨论 on the same topics. At the end of the session, you will be required to complete a post-intervention survey on knowledge gained. Eight to ten weeks after this intervention, the investigator will call each of the participants. The investigator will request to repeat the PAM telephonically with the participant and will ask the question, "What have you done differently, or are you planning to do differently, using the information learned at the education session, regarding your health and healthcare and would you be willing to share that with the investigator?" The investigator will transcribe the participant's answer and read it back to assure accuracy.

3. The information gathered will be confidential and locked up in a safe/cabinet in investigators’ home until used for analysis. Investigator will be the only person with access. All results are confidential. Georgia College and State University requires that all research data be kept for 3 years. At the end of 3 years, all results will be shredded except the Demographic/Health survey and PAM, which will be kept by the investigator for future OLSS projects.

4. You will be asked to sign two identical consent forms. You must return one form to the investigator before the study begins, and you may keep the other consent form for your records.

5. You may find that some questions are invasive or personal. If you become uncomfortable answering any questions, you may cease participation at that time.

6. You are not likely to experience physical, psychological, social, or legal risks beyond those ordinarily encountered in daily life or during the performance of routine examinations or tests by participating in this project. A benefit is that you may gain knowledge regarding important healthcare topics. You will receive a red folder containing training materials from the session.

7. Your individual responses will be confidential and will not be released in any individually identifiable form without your prior consent unless required by law.

8. The investigator will answer any further questions about the research (see above telephone numbers).

9. In addition to the above, further information, including a full explanation of the purpose of this research, will be provided at the completion of the research project on request.

10. The results of this project will be presented and shared to you at the end of this project.

Signature of Investigator ____________________________ Date ____________

Signature of Participant ____________________________ Date ____________

Research at Georgia College involving human participants is carried out under the oversight of the Institutional Review Board. Address questions or problems regarding these activities to Dr. Huey Ting, Chair, CRB 609, GC, email: dtting@georgiasouthern.edu, phone: (478) 443-3180.
Appendix E

Institutional Review Board Approval

Application #2102 "Engaging Individuals in their Healthcare by Increasing Activation through Education"

Title: "Engaging Individuals in their Healthcare by Increasing Activation through Education"

Status: Approved status set by whitney happen... on 2015-05-24 (previously With Moderator)

Exempt
No

Extension
No

Principal Investigator (PI)

Margaret L Hubbell
margaret.hubbell@emory.edu
College of Health Sciences
null
2110 Isles of St. Mary’s Way St. Mary’s, Georgia 31550
(706) 941-2593 Extension: 952
Email: Margaret.Hubbell@emory.edu

[Image of an application form with fields filled in]

[Image of a renewal application form with fields filled in]
MEMORANDUM OF UNDERSTANDING BETWEEN THE BOARD OF REGENTS OF THE UNIVERSITY SYSTEM OF GEORGIA BY AND ON BEHALF OF GEORGIA COLLEGE AND STATE UNIVERSITY AND OUR LADY STAR OF THE SEA CATHOLIC CHURCH.

This is a Memorandum of Understanding on the part of Our Lady Star of the Sea Catholic Church (hereinafter referred to respectively as "OLSS") and the Board of Regents of the University System of Georgia by and on behalf of Georgia College & State University (hereinafter referred to respectively as the "Institution"). OLSS and Institution shall be hereinafter jointly referred to as the "parties."

A. PURPOSE:
1. The purpose of this Memorandum of Understanding is to guide and direct the parties respecting their affiliation and working relationship, inclusive of anticipated future arrangements and agreements in furtherance thereof, to provide high quality applied learning experiences for the Institution's students.
2. Neither party intends for this Memorandum to alter in any way their respective legal rights or their legal obligations to one another, to the students and faculty assigned to OLSS, or to any third party.

B. GENERAL UNDERSTANDING:
1. The applied learning experience (hereinafter referred to as the "ALE") will be of such content, and cover such periods of time as may from time to time be mutually agreed upon by the Institution and OLSS.

   Effective Date: May 1, 2015
   Expires: May 1, 2016

2. Either the OLSS or the Institution may withdraw any student from an ALE at OLSS based upon a lack of competency on the part of the student, failure to comply with the rules and policies of the Institution or OLSS, if the student poses a direct threat to the health or safety of others, or for documented unethical or unprofessional behavior based on the decision made by the internship field supervisor or the faculty member supervising the student intern. Such party shall provide the other party and the student with immediate notice of the withdrawal and written reasons for the withdrawal.
3. There shall be no discrimination on the basis of race, national origin, religion, creed, sex, age, disability or veteran's status in either the selection of students for participation in the ALE, or as to any aspect of the ALE; provided however, that with respect to disability, the disability must not be such as would, even with reasonable accommodation, in and of itself, preclude the student's effective participation in the ALE.
4. OLSS hereby grants to the Institution the right to publish Institution administrative materials such as catalogs, course syllabi, ALE reports, etc. that identify or use the name of OLSS or its members, staff, directly or indirectly.

C. OLSS RESPONSIBILITIES:
1. OLSS will retain responsibility for supervision of students insofar as their presence and ALE assignments affect the operation of OLSS.
2. OLSS staff shall assist the Institution in the evaluation of the learning and performance of participating students. OLSS will assign a staff representative as liaison between OLSS and the Institution. OLSS staff representative may be designated in the Agreement.
3. OLSS staff representative will work in conjunction with the nursing program faculty supervisor within the guidelines of the course objectives stated in the syllabus.
4. OLSS shall provide for the orientation of participating students as to the philosophies, rules, regulations and policies of OLSS.
5. OLSS hereby grants to the Institution the right to publish Institution administrative materials such as catalogs, course syllabi, ALE reports, etc. that identifies or uses the name of OLSS or its members, staff, directly or indirectly.

D. INSTITUTION RESPONSIBILITIES:
1. The Institution will use its best efforts to see that the ALEs at OLSS are conducted in such a manner as to enhance the resources available to OLSS.
2. The Institution will encourage participating student compliance with OLSS's rules, regulations, and procedures and use its best efforts to keep students and faculty informed as to the same and any changes therein.

3. The Institution shall have the full responsibility for the conduct of any student disciplinary proceedings and shall conduct the same in accordance with all applicable statutes, rules, regulations and case law.

4. The Institution will assign faculty/staff representative(s) as liaison(s) between OLSS and the Institution. The Institution faculty/staff representative(s) will be designated in the Agreement.

5. The Institution will assign the student's grade.

E. MUTUAL RESPONSIBILITIES:

1. The parties will work together to maintain an environment of quality learning experiences for the Institution's student(s), while at the same time enhancing the resources available to OLSS. At the request of either party, a meeting or conference will be held between Institution and OLSS's representatives to resolve any problems or develop any improvements in the operation of the A.L.E.

2. This working relationship and affiliation shall be reviewed annually by the parties. This Memorandum of Understanding may be amended at any time by mutual written agreement of the parties. It may also be canceled at any time by either party upon not less than ninety (90) days written notice to the other party, but any students currently in an A.L.E. may complete the A.L.E.

3. The Institution and OLSS acknowledge and agree that neither party shall be responsible for any loss, injury or other damage to the person or property of any student participating in the A.L.E. unless such loss, injury or damage results from the negligence or willful conduct of that party, its agents, officers or employees.

4. This relationship is intended solely for the mutual benefit of the parties hereto, and there is no intention, express or otherwise, to create any rights or interests for any party or person other than OLSS and the Institution; without limiting the generality of the foregoing, no rights are intended to be created for any patient, student, parent or guardian of any student, spouse, next of kin, employer or prospective employer of any student.

5. Neither party is an agent, employee, or servant of the other. The Regents, Institution, and OLSS acknowledge and agree that student participants in the A.L.E are not employees of the Regents or Institution by reason of such participation, and that they assume no responsibilities as to the student participants that may be imposed upon an employer under any law, regulation or ordinance. Student participants shall in no way hold themselves out as employees of the Regents or Institution. It is the sole responsibility of OLSS to follow all federal, state, and local laws, rules, and regulations governing the participation of students in this program.

6. This Memorandum of Understanding shall be governed by, construed and applied in accordance with the laws of the State of Georgia.

7. This Memorandum of Understanding shall supersede any and all previously executed Memoranda of Understanding between the parties for applied learning experiences.

AGREED TO BY:

GEORGIA COLLEGE AND STATE UNIVERSITY

Signature: 
Name: Sandra K. Campstead, Ph.D.
Title: Dean, College of Health Sciences
Date: 11-30-15

Our Lady Star of the Sea

Signature: 
Name: [Signature]
Title: [Title]
Date: 05-19-2015
Appendix G

Pictures of Red Folder and Content
Appendix G Continued

Pictures of Red Folder and Content
To: Father Mariusz, Deacon Joe and all Parishioners of OLSS
From: Peg Hudock MSN, RN, CCM (678-642-2893(c) or 912-439-3636 (h)
Regarding: Research Project and Call for Volunteers
Date: Wednesday evening July 29, 2015 from 6pm to 8:30pm. Light supper.

REQUEST for VOLUNTEERS AGE 18 and over

I am attending Georgia College and State University pursuing a Doctor in Nursing Practice (DNP) degree. As part of this program, I have a requirement to complete a clinical project. This project provides me an opportunity to look into the evidence or prior research for a healthcare issue or problem, and develop a potential solution.

I am asking if you would each consider volunteering to participate in my project. I would like to have as many volunteers as possible. All information collected will be kept confidential and seen only by me, the investigator.

If you are interested, please fill out a card with your name and contact information. There will be flyers in the bulletin with sign-up sheets to return to me or place in a basket in the lobby of the church.

WHAT IS THE PROJECT ABOUT?

The purpose of this project is to lay the foundation for a faith-based ministry at OLSS. I am interested in how active our church members are in their health and healthcare. Clinical Evidence shows that individuals active in their care have better outcomes and are more satisfied with their healthcare experience.

As a volunteer, you would be required to sign a consent, attend a meeting, and answer survey questions. The first survey would measure your activation or engagement in your health and healthcare. You would then need to complete a demographic survey that asks questions about you, your health and some individual data such as age and medications. Remember, this is all confidential. You would also need to complete a short pre-intervention survey that measures your current knowledge of health topics. Next, we will look at a few short videos and talk about healthcare topics. This information will give you usable knowledge and techniques that will help you and your family navigate the healthcare world more effectively. Once the intervention is completed, you will complete a post-survey to measure knowledge gain. The total time is about two hours.

You will be provided with refreshments, and you will receive a take away of a RED folder that will hold information on the topics discussed at the meeting. It can also be a good place to hold any personal healthcare information in the future so it is kept all in one place.

MY SINCERE THANKS

I am also hoping this will allow me to get to know more of you as we build our health ministry together. Thank you in advance for your voluntary participation.

I am interested in volunteering for your project and learning more about healthcare topics. I am 18 years age or older NAME: __________________________ PHONE: ____________________________ EMAIL: ____________________________

Request to Parish for Volunteers- Read aloud and place in bulletin
From: Peg Hudock MSN, RN, CCM (678-642-2893(c) or 912-439-3636 (h)
The Health Ministry team invites your participation in the attached Health Survey to assist our Parish and Health Ministry in determining our parish priorities and needs related to Health and Health Issues. **Please put your name, email and phone # on the bottom of each page.**

Please tear off and place in basket provided in church lobby....or please call me. Numbers are above. Thank you. Peg
Appendix I: Health and Demographic Survey

Across the country, Faith Community Nurses are working in churches to serve as health educator, a resource and referral for health related services, and to provide a caring outreach of listening to the needs of the congregation in order to improve the health of body, mind and spirit. By completing the survey below you will assist our parish in taking steps toward a community spiritual growth and personal wellness.

Please Place an “X” by the Correct Answer

1. **Your age:** Under 20___|21-29___|30-39___|40-49___|50-59___|60-69___|70-79___| 80+___|

2. **Gender:** Female____| Male ____|

3. **Race/Ethnicity:** White___| Black/African American___| Hispanic___| Asian___| Multi-Race___| Other___|

4. **Status:** Single__| Married__| Widowed__| Separated/Divorced__| Single Parent__|

5. **Employment Status:** Part-Time__| Full-Time__| Unemployed__| Retired__| Student __| Planning to Retire in 3-5 years__| YES__| NO __ |

6. Are you covered by **Health Insurance**? YES___| NO ___ | Name of Health plan: _________ |

   Through your employer? YES__| NO__|

   Through a Health Exchange? YES__| NO__|

   Through Medicare: YES__| NO__| Medicaid: YES__| NO__|

7. Did any of the following keep you from obtaining adequate medical care in the last year? (Please Mark All That Apply)

   ____ Lack of transportation ____ Do not like doctors

   ____ Did not know where to go for medical care ____ Afraid to go

   ____ Cost of care too high ____ No insurance

   ____ Do not have a primary care provider ____ Other ________________

   ____ None

8. Has your inability to pay for out-of-pocket expenses such as Pharmacy charges or Medicare deductible kept you from seeking medical care?  YES____| NO____ | Not Applicable ____|

9. How would you rate your health? Excellent___| Good___| Fair___| Poor ___|

10. **Level of Education:** Less than High School___| High School___| Some College___ | College Graduate ____| Graduate School____ |
11. Health Promotion and Support Groups and/or Classes that enhance physical, emotional and spiritual health (holistic health) may be developed to meet the needs or interests of the greatest number of people. Please indicate if you would participate in any of the following if they were offered. Please mark as many as you would participate in:

DISEASE PREVENTION

___ Exercise
___ Stress Management
___ Nutrition / Healthy Eating
___ Smoking Cessation
___ Safety/Fall Prevention
___ CPR (Cardio-Pulmonary Resuscitation)
___ Individual Counseling (assistance for making lifestyle change)
___ Time Management
___ Other _____________

PHYSICAL HEALTH PROGRAMS

___ Aging Process
___ Heart
___ Stroke
___ High Blood Pressure
___ Lung Disease/Asthma
___ Diabetes
___ Cancer
___ AIDS
___ Women’s Health Issues
___ Men’s Health Issues

FAMILY HEALTH PROGRAMS

___ Pregnancy
___ Parenting
___ Mid-Life Crisis
___ Interpersonal Relationships
___ Dealing with Parents
___ Child Abuse Prevention
___ Single Parenthood
___ Living with Teenagers

EMOTIONAL HEALTH

___ Depression
___ Drug/Alcohol Issues
___ Anger
___ Violence
___ Shame/ (feeling bad about me)
___ Divorce
___ Death and Dying
___ Self-Esteem (feeling good about me)

Other Programs: ___________________________________________________________
________________________________________________________________________

12. Do you have a Primary Care Provider? YES___ | NO___ |
   Have you seen this primary care provider in the last 12 months? YES___ | NO ___ |
   (*A Primary Care Provider can be your family doctor, nurse practitioner, or someone who treats you for most of your healthcare needs).

13. Have you been diagnosed with a Chronic Condition: YES____ | NO ____ |
   Please Mark All that Apply:

___ Diabetes
___ Asthma
___ Congestive Heart Failure (CHF)
___ Osteoporosis
___ CAD
___ Chronic Obstructive Pulmonary Disease
___ Arthritis
___ Cancer
___ Other ____________________________
14. Have you been in the hospital in the past 12 months?  YES ____| NO ____|

15. How many prescription medications do you take?  None____| 1-2____| 3-4____| 5-6____| 7-8____| 9-10____| over10____|

16. Do you take over the counter (OTC) medications?  YES ____| NO ____|

17. Do you know what each of your medications is for?  YES ____| NO ____|
   Do you know of any side-effects or red-flags of your medications?  YES ____| NO ____|

18. Do you currently smoke?  YES____| (# of packs/day)____| NO: NEVER____| QUIT____| (# years ago____)

19. How many alcoholic beverages do you consume daily?  None____| 1-2____| 3-4____| >than 5____|

20. What day(s) of the week and time(s) would be preferred to attend a class or group?
   MON___ TUE___ WED___ THU___ FRI___ SAT___ SUN___
   MORNING____ | AFTERNOON____ | EVENING____

21. What is your most important health concern(s) for: (Includes emotional, physical and spiritual)
   Yourself: ________________________________________________________________
   Your Family: __________________________________________________________________
   Your Community: __________________________________________________________________

22. Do you have experience with any health topic? Yes ____| No____ | Would you be willing to offer assistance, teach or share your knowledge and experience? YES ____ | NO ____ | TOPICS: ________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________

23. Additional Comments, Suggestions or Needs:____________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
   ________________________________________________________________________
AGENDA: Meeting Information:
Subject: Meeting: Educational Meeting on Self-Engagement in Healthcare, Care Transitions, Communication and AskMe3
Organizer: Peg Hudock MSN, RN, CCM
Date: Wed. July 29th, 2015
Time: 6pm to 8:30pm
Location: OLSS Social Hall
Meeting Invitees:
Father Mauricz, Participants for Translational Project
Meeting Agenda:

<table>
<thead>
<tr>
<th>Agenda Items</th>
<th>Time</th>
<th>Description</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>5 min</td>
<td>Thank you all for making the time to attend this meeting. As discussed in previous conversations, this meeting is part of my clinical research that you have agreed to participate in….and I sincerely thank you for your participation.</td>
<td>Peg Hudock</td>
</tr>
<tr>
<td>Introductions</td>
<td>5 min</td>
<td>The purpose of this meeting is threefold: 1. To understand the level of activation or engagement that each of you have in your individual health and healthcare (Use of the PAM) 2. To gather data that I will use to understand the healthcare needs and interests of the population of OLSS 3. To understand what your level of knowledge is on certain healthcare topics that are considered extremely important in today’s healthcare environment. Each of you have a RED FOLDER at your seat. The folder contains health tips on asking questions, and information to ask at a hospital discharge and also has a white envelope containing: 1. A consent; (2 copies—one for me and one for you to keep) 2. The Patient Activation Measure (PAM-says INSIGNIA HEALTH at top) 3. A Demographic/Health Survey 4. A Pre—Education Survey 5. A Post- Education Survey</td>
<td>Peg Hudock + all</td>
</tr>
<tr>
<td>Reminder of Meeting Purpose and Signing the Consent for Research Subject.</td>
<td>5 min</td>
<td>We will read the consent, discuss any questions you might have and then please sign. One of the volunteers will collect. There are two copies. I get one and you keep one. As you complete the questionnaires, please place them back in the envelope to maintain confidentiality. I will collect them as or before you leave. Please put name, phone and email on your folder.</td>
<td>Peg Hudock</td>
</tr>
<tr>
<td>Questions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complete the Patient Activation Measure (PAM)- Says INSIGNIA HEALTH at the top of the page.</td>
<td>15 min</td>
<td>Explanation of the Patient Activation Measure (PAM)- Clinical literature suggests that less than less than 50% of the national population is engaged or participating in their health and healthcare. The literature also shows that persons who are engaged have better health outcomes, are more satisfied with their care and as a result cost</td>
<td>Peg Hudock</td>
</tr>
</tbody>
</table>
The PAM was developed to evaluate an individual’s self-concept as a manager of their own health and to understand how that self-concept influences their health behaviors and any helpful interventions.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
<th>Description</th>
<th>Instructor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete the Demographic Survey</td>
<td>15 min</td>
<td>The Demographic survey will give us at OLSS a look into the type of needs and interests that the parishioners have for future program building.</td>
<td>All</td>
</tr>
<tr>
<td>Complete the Pre-Intervention Questionnaire</td>
<td>10 min</td>
<td>Short 10 question survey on existing knowledge of healthcare topics that will be presented.</td>
<td>All</td>
</tr>
<tr>
<td>Interventions</td>
<td></td>
<td>Peg Hudock</td>
<td></td>
</tr>
<tr>
<td>• Patient Engagement and Commun.</td>
<td>5 min</td>
<td>Discussion- What is meant by patient engagement or good communication?</td>
<td>All</td>
</tr>
<tr>
<td>Questions</td>
<td></td>
<td>Peg Hudock</td>
<td></td>
</tr>
<tr>
<td>• Care Transitions</td>
<td>10 min</td>
<td>What does care transitions mean? Hand-offs? Why do you think they are important?</td>
<td></td>
</tr>
<tr>
<td>• VIDEO- Care Transitions</td>
<td>3 min</td>
<td>Robert Wood Johnson Foundation Video <a href="https://www.youtube.com/watch?v=TJCSBHmyq6s">https://www.youtube.com/watch?v=TJCSBHmyq6s</a></td>
<td></td>
</tr>
<tr>
<td>• Key Points to Learn</td>
<td>5 min</td>
<td>The importance of scheduling a follow up doctor appointment within 7-10 days after discharge from a hospital inpatient stay.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The importance of knowing and taking your medications as well as why you take them and what the red flags are or their side effects.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The importance of a Personal Health Record.</td>
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<tr>
<td></td>
<td></td>
<td>The importance of understanding your illness/disease, what put you in the hospital at the start and how you recognize the red flags if your illness worsens?</td>
<td></td>
</tr>
<tr>
<td>• Ask Me 3</td>
<td>2 min</td>
<td>National Patient Safety Foundation</td>
<td></td>
</tr>
<tr>
<td>• VIDEO- AskMe3</td>
<td>4 min</td>
<td>3 Important Questions: a. What is my main problem? b. What do I need to do? c. Why is it important for me to do this?</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="https://www.youtube.com/watch?v=B3EB-icaNKQ">https://www.youtube.com/watch?v=B3EB-icaNKQ</a></td>
<td></td>
</tr>
<tr>
<td>• CMS-Understanding Patient Discharge</td>
<td>10 min</td>
<td>Understanding what discharge instructions:</td>
<td>Peg Hudock</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review copy of the CMS “Your Discharge Planning Guide”</td>
<td></td>
</tr>
<tr>
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<td>HANDOUT in RED FOLDER</td>
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<td>• Questions</td>
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<td>• Summary and Closure</td>
<td>10 min</td>
<td>“You Are Your Own Best Medicine”- Patient Safety Campaign in MN</td>
<td>Peg Hudock</td>
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</table>
ENGAGING INDIVIDUALS IN THEIR HEALTH

Appendix J: Project AGENDA, Page 3

- **VIDEO -- 4 min**
  
  [https://www.youtube.com/watch?v=ulYZRZ2b1U1](https://www.youtube.com/watch?v=ulYZRZ2b1U1)

- **Complete the POST-Intervention Survey**
  
  **5 min**
  
  DISCUSSION and QUESTIONS

  Peg Hudock

**THANK YOU!!!**

Build your own healthcare questions at Agency for Healthcare Research and Quality: [http://www.ahrq.gov/apps/q](http://www.ahrq.gov/apps/q)

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**The Label on the Patient Safety Packets**

![Image of Patient Safety Packet](image)

**YOU: YOUR OWN BEST MEDICINE**

**BEFORE YOUR APPOINTMENT:**

- ✓ BRING MEDICATION LIST.
  - Bring a complete, accurate list to share.
- ✓ BRING TEST RESULTS.
  - Bring all recent test results to share.

**DURING YOUR APPOINTMENT:**

- ✓ WRITE A WARNING SIGNS LIST.
  - Ask about warning signs. Write them down.
- ✓ WRITE NEXT STEPS LIST.
  - Ask about recommended next steps. Write them down.

**AFTER YOUR APPOINTMENT:**

- ✓ ACT ON NEXT STEP LIST.
  - Schedule appointments and tests. Fill prescriptions.
- ✓ WATCH FOR WARNING SIGNS.
  - Ask doctor if you have warning signs (see your list).

For more information: [www.ownbestmedicine.mn](http://www.ownbestmedicine.mn)

Source: Minnesota Alliance for Patient Safety (MAPS)
NON-EXCLUSIVE COPYRIGHT LICENSE

License Fee. As good and valuable consideration for the license granted herein, you shall pay to Insignia Health, LLC ("Insignia") the payment as shown in your shopping cart above (the "License Fee").

License Terms. Subject to the terms of this Agreement, you have the right to administer the PAM Materials (as defined herein) to up to the number of survey participants selected in your shopping cart and as defined below ("Participants"), beginning on the date of your online license purchase ("Effective Date") and ending twelve (12) months thereafter ("End Date").

DEFINITIONS

"PAM Materials" means the Patient Activation Measure (PAM) survey tool, the PAM survey scoring table; four different levels in which to classify people participating in a PAM survey; guidelines for responding to people in each level, benchmark score and level data and if selected, the Coaching for Activation online nurse/coach guidance, PAM online survey administration tools, and/or online e-learning tools.

A "Participant" is defined as any individual consumer or potential consumer of health care services who is provided access to the PAM Materials, up to the maximum number of participants you selected in your shopping cart.

TERMS AND CONDITIONS

This Agreement is a grant of a non-exclusive, non-transferable copyright license to use the PAM Materials for the purpose of assessing and modifying the level of health engagement of Participants, subject to the terms and restrictions set forth herein (the "Agreement"). Use of the PAM Materials for any purpose other than those described herein is expressly prohibited without the written consent of Insignia. For clarity, the rights granted herein DO NOT include the right to:

- Copy, reproduce, publish, disseminate, or otherwise publicly display the PAM Materials or any part thereof outside of the scope of this Agreement;
- create derivative works or make alterations to the PAM Materials or any part thereof;
- use the PAM Materials or any part thereof, including but not limited to the PAM survey, to develop, validate or optimize a new or existing assessment of consumer health engagement, motivation, activation or similar assessment tool;
- sublicense the PAM Materials; or
- reverse engineer, reverse translate, decompile, disassemble or in any manner decode the PAM Materials or any part thereof, or any of the algorithms contained therein.

1. Rights Granted. Insignia hereby grants to you a non-exclusive, personal and non-transferable right to reproduce, distribute, and display the PAM Materials for the purpose of administering the PAM survey and collecting information related thereto to no more than the number of Participants defined by your on-line Participant range selection. Using PAM with Participants beyond that Participant range is a violation of this Agreement.

2. Your Obligations.

2.1. You agree not to alter, add, change, or remove any identification marks, including copyright or trademark notices, from the PAM Materials. You further agree that if you reference the PAM Materials to Participants in written materials, publish any studies or findings relating to your use of the PAM Materials, or in any other way publicize your use of the PAM Materials, you shall refer to the PAM survey as the "Patient Activation Measure®" or "PAM®." You further agree to obtain any consents from Participants that are necessary to allow the PAM Materials to be provided to them.

2.2. Reporting: Upon End Date.

(i) You shall provide to Insignia a written report in an electronic format approved by Insignia identifying the number of Participants who were given the PAM survey during the term of this Agreement. You further agree to maintain records supporting such report(s) for at least one (1) year following submission; and
(ii) Subject to the confidentiality requirements of Section 3, you agree to share with Insignia non-personally identifiable, individual data ("Data") generated from your use of the PAM Materials. The Data shared shall include individual-level data records containing answers to each of the PAM questions, and, if captured, (i) demographic variables, health status and condition variables, (ii) specific outcome variables including health behaviors, self-management behaviors and whether patients using PAM improved the self-management aspects of their health care, and (iii) the PAM Materials' effect on or relationship to patient health care utilization and costs. Such Data shall be reported to Insignia at least annually in the electronic format agreed upon by the parties to this Agreement. You hereby grant Insignia a royalty-free, perpetual license to use such Data for its product improvement efforts.

3. Confidentiality. Both you and Insignia each acknowledge that either party may receive confidential and proprietary information of the other party including, without limitation, (i) technical information, including functional and technical specifications, analysis, research, processes, computer programs, job control language, communications scripts, methods, ideas, “know how” and the like; (ii) business information, including sales and marketing research, materials, plans, provider and beneficiary demographics, provider-specific information and the like; (iii) electronic media claims data in accordance with the Federal Privacy Act of 1974, as amended; (vi) the PAM Materials and any algorithms utilized by Insignia in the provision of the services set forth in this Agreement, (v) Data, and (vi) other information designated in writing by the owner as confidential at the time of delivery of such information to the recipient (collectively “Confidential Information”).

Except for Protected Health Information (as defined by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (HIPAA)), Confidential Information of a party hereto shall not include information that: (a) becomes generally available to the public other than as the result of unauthorized disclosure by the recipient; (b) is independently derived by the recipient without the aid, application or use of the disclosing party’s Confidential Information; or (c) was received by the recipient on a non-confidential basis prior to receipt from the disclosing party from a third-party lawfully possessing and lawfully entitled to disclose such information.

4. Covenant Not to Disclose. Except as provided in Section 2.2, each party receiving Confidential Information from the other party hereby agrees that it shall not use, commercialize or disclose such Confidential Information to any person or entity, without prior written permission of the non-disclosing party. Each party shall use at least the same degree of care in safeguarding the other party’s Confidential Information as it uses in safeguarding its own Confidential Information.

5. Ownership of the PAM Materials. The State of Oregon, acting by and through the State Board of Higher Education on behalf of the University of Oregon, owns the copyright, title, and other related rights in and to the Patient Activation Measure ("PAM") and related guidance (collectively referred to as the "PAM Guidance") developed by Dr. Judith Hibbard and others. Insignia is the exclusive licensee of certain rights related to the PAM Guidance and is the owner of all trademark rights associated with this technology. All rights not otherwise granted to you in this agreement are reserved by Insignia and/or the University of Oregon.

6. Indemnification and Limitation of Liability

6.1. You agree to indemnify and hold harmless both Insignia and the University of Oregon and their respective members, directors, officers, governing board members, agents, employees, students, volunteers, and assigns against any and all claims, demands, damages, liability, losses, causes of action, costs and expenses arising out of or in any way related to the use, reproduction, distribution or public display of the PAM Materials by you or any of your Participants, or your failure to comply with applicable privacy laws.

6.2. INSIGNIA AND THE UNIVERSITY OF OREGON PROVIDE ACCESS TO THE PAM MATERIALS ON AN "AS IS, WITH ALL DEFECTS" BASIS. NEITHER INSIGNIA NOR THE UNIVERSITY OF OREGON MAKE ANY REPRESENTATIONS OR WARRANTIES, EXPRESS OR IMPLIED. BY WAY OF EXAMPLE, BUT NOT LIMITATION, INSIGNIA AND THE UNIVERSITY OF OREGON MAKE NO REPRESENTATIONS OR WARRANTIES OF MERCHANTABILITY OR FITNESS FOR ANY PARTICULAR PURPOSE (EVEN IF INSIGNIA OR THE UNIVERSITY OF OREGON KNOW OF SUCH PURPOSE), OR THAT THE USE OF THE PAM MATERIALS WILL NOT INFRINGE ANY PATENTS, COPYRIGHTS, TRADEMARKS OR OTHER RIGHTS OF THIRD PARTIES. YOU HEREBY AGREE TO SAVE, HOLD HARMLESS, DISCHARGE AND RELEASE INSIGNIA AND THE UNIVERSITY OF OREGON AND ALL OF THEIR RESPECTIVE AGENTS, SERVANTS, EMPLOYEES AND VOLUNTEERS, FROM ANY AND ALL LIABILITY, CLAIMS, CAUSES OF ACTIONS, DAMAGES OR DEMANDS OF ANY KIND AND NATURE WHATSOEVER WHICH MAY ARISE FROM OR IN CONNECTION WITH YOUR USE OF THE PAM MATERIALS.
7. **Term and Termination.**

7.1. The term of this Agreement shall commence on the **Effective Date** and shall continue until the **End Date** or until terminated in accordance with this Section 7, whichever is earlier ("Term").

7.2. Insignia may terminate this Agreement and the license granted herein for Insignia’s convenience, by providing not less than ten (10) days advance written notice to you by electronic communication or otherwise.

7.3. Upon termination or expiration of this Agreement you shall cease using, reproducing, distributing, or publicly displaying any portion of the PAM Materials.

7.4. You acknowledge and agree that termination of Insignia’s agreement with the State of Oregon for the right to use and sublicense the PAM survey and PAM Guidance shall terminate this Agreement; provided however that you may request continuation of this Agreement by making written request to the State of Oregon within sixty (60) days of your receipt of written notice of such termination. Such written request for license continuation shall include your agreement to assume with respect to the State of Oregon all obligations (including obligations for payment) contained in this Agreement with Insignia. In such case, the State of Oregon may in its sole discretion agree to accept or decline such request for assignment of this Agreement. Such written request shall be made to Director, Office of Technology Transfer, 1238 University of Oregon, Eugene, Oregon, 97403-1238.

8. **Return or Destruction of Information.** Except for the Data provided by you pursuant to Section 2.2, upon the expiration or termination of this Agreement, you and Insignia shall, within twenty (20) days, each return or destroy all Confidential Information of the other party; provided, however, that the receiving party may keep one copy of the Confidential Information for archival purposes so long as such archived Confidential Information is safeguarded against disclosure and use prohibited hereunder. In either case, upon request, the recipient shall provide the disclosing party with written certification that all Confidential Information has been returned or destroyed, as the case may be. Despite such a return or destruction, the parties’ obligations under this Section shall survive indefinitely.

9. Remedies for Breach of Confidentiality. Each party hereby acknowledges that the violation by it or the restrictions imposed hereunder would cause irreparable harm to the owner of such Confidential Information and that remedies at law would be inadequate to redress any actual or threatened violation of this Agreement. Each party agrees that, in addition to other relief that may be available, the foregoing restrictions may be enforced by temporary and permanent injunctive relief. Any award of relief to the owner of such Confidential Information in an action in which the owner substantially prevails shall include recovery of such owner’s costs and expenses of enforcement (including attorneys’ fees, including attorneys’ fees and any costs associated with appeal).

10. **General Provisions.**

10.1. Assignment. The rights granted hereunder and this Agreement may not be assigned, transferred, or sublicensed directly or indirectly, by operation of law, contract or otherwise, by you except with the express written consent of Insignia, which consent may be withheld at Insignia’s sole discretion.

10.2. Entire Agreement, Modification, and Waiver. This Agreement replaces and supersedes any prior agreements between the parties and sets forth the entire agreement between the parties with respect to the subject matter hereof, and may not be modified or amended except by written agreement executed by the parties hereto. No waiver, consent, modification, or change of any terms of this Agreement shall be binding unless the same is in writing and signed by both parties and all necessary approvals have been obtained. Such express waiver, consent modification, or change, if made, shall be effective only in the specific instance and for the specific purpose set forth in such signed writing.

10.3. **Governing Law.** This Agreement shall be construed and enforced in accordance with the laws of the State of Oregon, without giving effect to the conflict of law principles thereof, and applicable federal law. Any action or suit brought by the parties relating to this Agreement shall be brought and conducted solely and exclusively in the state and federal courts in Multnomah County in the State of Oregon in Portland, Oregon. You hereby waive any objection to venue in such courts, and waive any claim that such forum is an inconvenient forum. **BY EXECUTION OF THIS AGREEMENT, YOU HEREBY CONSENT TO THE PERSONAL JURISDICTION OF SUCH COURT.**

10.4. Notice. Any notice under this Agreement shall be in writing and be delivered in person or by public or private courier service (including U.S. Postal Service Express Mail) or by certified mail with return receipt
requested or by electronic mail. Notice to you shall be addressed to the contact information you provided above.
notice to Insignia shall be addressed to the following address or at such other address as Insignia may from time
to time direct in writing.

For Insignia:

Insignia Health, LLC
Attn: License Department
Street: 10900 Wayzata Blvd, Suite 810
City, State Zip: Minnetonka, MN 55305
Email: info@insigniahealth.com

Any notice shall be deemed to have been given on the earlier of: (i) actual delivery or refusal to accept delivery,
(ii) the date of mailing by certified mail, (iii) the day facsimile delivery is verified or (iv) if by email the date sent
unless an out of office-type reply is received in which case the notice shall be deemed given when the notice
indicates the recipient will return to the office. Actual notice, however and from whoever received, shall always
be effective.

10.5. Severability. If any one or more provisions of this Agreement shall be adjudicated to be illegal, invalid, or
unenforceable in any respect, the validity, legality and enforceability of the remaining provisions shall not in any
way be affected or impaired thereby. The parties hereby agree to attempt to substitute for any illegal, invalid, or
unenforceable provision a valid or enforceable one, which achieves the economic, legal and commercial
objectives of the invalid or unenforceable provision to the greatest extent possible.

10.6. No Third Party Beneficiaries. Nothing in this Agreement gives, is intended to give, or shall be construed to
give or provide any benefit or right, whether directly, indirectly, or otherwise, to any other third persons.

10.7. Headings, Drafting, and Counterparts. This Agreement may be executed electronically and in
counterparts, each of which may be an original but all of which, when taken together, shall constitute one and the
same instrument. Headings included herein are for convenience only and shall not be used to construe this
Agreement. The parties agree that they have participated equally in the formation of this Agreement and that the
language herein should not be presumptively construed against either of them.

10.8. Audits. You shall create and maintain records as required by this Agreement and you shall grant Insignia
reasonable access during normal business hours to examine and take copies of, on no less than ten (10)
business days' advance written notice and at Insignia's cost, the records relating to this Agreement, to verify your
compliance with the terms and conditions of this Agreement.

10.9. Survival. All terms of this Agreement with the exception of Section 1 shall survive the expiration or
termination of this Agreement.
Appendix L:

Safe Use of Medicine Booklet

Appendix M:

A Guide for Older People: Talking with your Doctor

Appendix N: Your Discharge Planning Checklist

Your Discharge Planning Checklist: For patients and their caregivers preparing to leave a hospital, nursing home, or other care setting

Retrieved from https://www.medicare.gov/Publications/Pubs/pdf/11376.pdf
Our Lady Star of the Sea Webpage:

http://weareolss.org/

Our Lady Star of the Sea Health Ministry Tab:

http://weareolss.org/65
Appendix P

Monthly Bulletin Announcement for Foot Care

and the Health Ministry Meeting

**Foot Care:** the first Wednesday, 2/3, from 9-12 in the Religious Education Building—POC—Peg Hudock in the RE classroom.

**Health Ministry:** meeting first Thursday, 11/5, from 11-12:30 in the Parish Hall.
Appendix Q

Announcement and Sign Up for Lenten Program

Please Join Us

What: Learning to Live Well Through Lent and Beyond

Date: Wed. February 17th, 2016, 9am-12:30pm; Mass and lite lunch (Discuss Heart and Soul)
Saturday February 27th, 2016: 2-4:30 with healthy snack; (Discuss Mind and Strength); Mass at 5pm

Place: OLSS Religious Ed Building

Who: All members of OLSS Program consists of: [You can attend one or both; while different topics will be discussed, there will be information for you on both];
- enjoying the abundance of God’s creation and taking seriously our responsibility to care for it.
- discussions, sharing and learning how we can improve our health and wellness,
- learning how to make better health related choices
- learning new healthy recipes and better ways to cook
- learning that our bodies and our spirits are intimately connected

Each session will begin with a message from Father Mariusz, followed by interactive discussions, prayers, exercises, support and communion with others to lead us to a healthier path. Please join us.

Blessings and thank you,
Peg Hudock RN, and the Health Ministry Team

*SIGN UP: Please Email/Call: Darlene Logan at (225) 772-2797 OR Rlogan7711@aol.com
Appendix R

Agenda for 2nd Meeting of Lenten Program

**AGENDA**

Lenten Program: Learning to Live Well through Lent and Beyond

2pm Welcome, housekeeping and introductions
2:10 Opening Prayer: Father Mariusz
2:15 Overview/Review of Week One:
   - Physical Dimension and Health and Wellness- Barb
   - Social Dimension and Health and Wellness- Peg

Spirituality and Health and Wellness-Father will repeat first week

3:00 Emotional Dimension and Health and Wellness- Barb
   Yoga-type Exercise X2

3:25 Occupational Dimension and Health and Wellness- Mayor Morrissey

3:45 Intellectual Dimension and Health and Wellness- Peg

4:00 Discussion Groups:
   - Choose a group leader. Each group will choose a dimension to discuss.
   - Write key points on large sticky wall notes to present to class.
     - Discuss, determine and name as many things as possible included in each dimension that we should pay attention to [i.e.-Physical- eating, exercise, sleep]
     - How can an individual make improvements in these dimensions?
     - What is important in dimension? How does faith play into health?
     - What are the barriers and how can we remove them?
     - Each group presents to entire group.

4:20 Commitment Prayer/Pledge
4:30 Closing Prayer/Evaluations

Thank you for attending. Remember to care for the awesome gift you have been given. Find balance….through moderation….love….friendship…..reading a good book….talking to God….walking….finding a way to give back…… and knowing HE loves you. Be the best that you can be.
Health Ministry Update to Parish Council

Health Ministry Team Summary for February

March 1, 2016

The Health Ministry began in summer of 2015, with the first foot care in June 2015.

- Monthly foot care continues on the first Wednesday of each month from 9-1. The number of parishioners seen each month has been from a low of 2 to a high of 7, with an average of about 4. [If you are aware of others who may need this service, please let me know. I do not polish nails; I do however soak feet, cut nails, check pulses, integrity, temperature and sensation of the skin. While this is most critical for diabetics, for the elderly this is also helpful.]

- We completed CPR training in October (as stated last month) with 11 people certified in CPR. We will be looking to have another class perhaps prior to the summer. The goal should be to have as many people certified in CPR and AED as possible, including our youth. We will also be developing a policy and procedure for the upkeep and check of the AED.

- Sat. Feb 27th, the health ministry team concluded a Lenten health and wellness program entitled “Learning to Live Well through Lent and Beyond” that discussed six dimensions of health and wellness (physical, spiritual, social, emotional, intellectual, and occupational). Health ministry team members presented some of the dimensions and Father presented the spiritual dimension at each meeting. In addition parishioner and Mayor, John Morrissey presented the Occupational discussion. The two sessions (Wed. Feb 17th and Sat. Feb 27th) were both well attended. A total of about 30 people attended the sessions, (male and female), some coming to both and others attending one. Feedback received from emails and a written program evaluation was very positive.

- We are discussing additional programs based on some of the topics, concerns and health needs raised at my school research project and educational session in July 2015.

- The Health Ministry hosted the February Donut Sunday adding fresh fruit and milk to the items for consumption.

Respectfully submitted,

Peg Hudock, RN Health Ministry