Evaluation Re-Framework

There is an opportunity and a challenge in measuring wellness, especially within the program's timeline. Considering what we know now, this new framework intends to outline the new wellness evaluation.

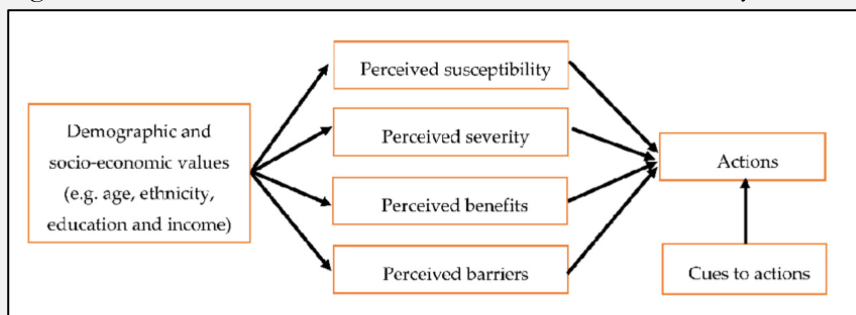
Our program goals, summarized, are the following: (1) renovate 24,000 square feet, (2) establish sustainable lines of business, and (3) evaluate their impact on the healthcare, health, and wellness of our patients and regional populations. This detailed memorandum defines our new approach to our program's evaluation.

Theory Behind Our Evaluation

Our three leading theories in our evaluation re-framework are the Health Belief Model, the Socioecological Model, and the Double Diamond. This section offers context, examples, and the 'why' for this theoretical blend.

The **Health Belief Model (HBM)** describes why one may not adopt a disease prevention action or screening test – when using the Prevention Continuum as an example. In Figure 1, the model suggests that one's belief in (1) the threat of illness and (2) the effectiveness of the health behavior will predict the likelihood that the person will adopt the given health behavior (Alhamad and Donyai, 2021; Boston University School of Public Health [BUSPH], 2022).

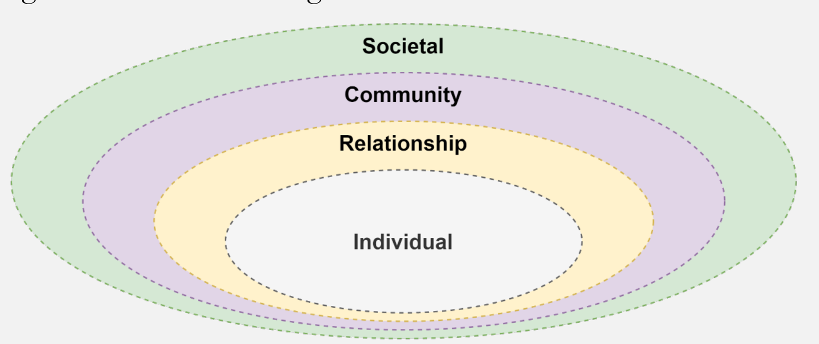
Figure 1. The Health Belief Model from Alhamad and Donyai, 2021



One example of a study utilizing the HBM is evaluating the use of cellphones while driving studies where the perceived susceptibility, severity, benefits, and barriers are quantified and graded by when the respondent chooses to use their phone and when they choose not to (Cox et al., 2023). The study concluded that participants who frequently drove distractedly found interpersonal and urgent communications were a substantial barrier preventing them from stopping their phone use while driving (Cox et al., 2023).

However, external factors, such as environmental, societal, and individual determinants of one's health, are not considered in the HBM (BUSPH, 2022). HBM also "assumes that cues to action are widely prevalent in encouraging people to act on the ['wellness'] action" (BUSPH, 2022).

Figure 2. The Socioecological Model



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The **Socioecological Model (SEM)** demonstrates the influence of relationship (interpersonal), community, and societal factors on individual behaviors and wellness (Figure 2). Our first resemblance of introducing this concept to our evaluation was in Semi-Annual Report 1 in Table 1. In order to develop wellness measures and promotion, it is critical to evaluate each layer of the SEM. The dotted circumferences in Figure 2 signify that factors placed in one dimension may cross into another (Michaels et al., 2022).

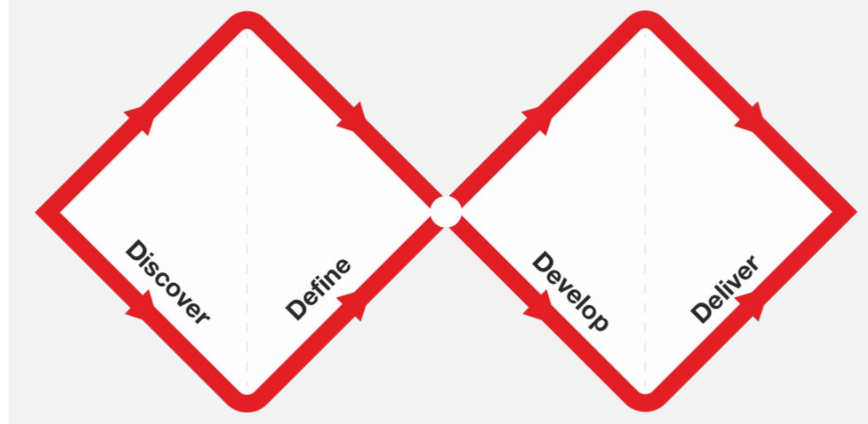
Table 1. Community versus Patient Level Evaluation from USDA Semi-Annual Report 1 (as submitted)

Community Level Evaluation vs. Patient Level Evaluation	
Community-Level	Patient-Level
Baseline data available in Florida CHARTS.	Some baseline data is available if already collected in the EHR.
FL CHARTS data can show the need for the intervention.	New screening tools can aid in collecting greater patient-level data.
E.g., the percentage of residents living in a different house in the prior year as it relates to the Environmental Wellness dimension.	E.g., Ferrans and Powers Quality of Life Index as it relates to Spiritual and Mental Wellness dimensions.

Table 1 shows that data may be available for community and patient levels. Community-level data refers to our six-county region: Jefferson, Madison, Taylor, Lafayette, Hamilton, and Suwannee counties. Patient-level data relates to the data collected from individual patients or clients in the electronic health record (EHR) or another software. In a later section, a revised Table 1 – named Table 3 – considers the newly described SEM approach to our evaluation.

The current reputable research on wellness seldom applies to our clinical and programmatic efforts. This unique opportunity requires a problem-solving approach that yields meaningful insights and solutions to our respective healthcare and wellness coaching management. The **Double Diamond** model is based on divergent and convergent thinking, forming four phases in our innovative program: discover, define, develop, and deliver (Design Council, 2015; Figure 3).

Figure 3. Double Diamond Model from the Design Council, 2015.



One core presumption must be accepted to adopt a problem-solving approach: Our community is not well.

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With our goals in mind, the standard HBM, SEM, and the Double Diamond need to be modified to meet our goals on time. Using standardized screenings and accepted clinical protocols helps strengthen evaluation validity as we modify these models. The following sections outline the steps we will take to (1) '**discover**' more about our population's wellness and (2) '**define**' our findings within our wellness dimensions. In other words, **our steps in addressing the first diamond** of Figure 3.

Step 1: Wellness Definitions

Our current accepted wellness dimensions are environmental, financial, intellectual, mental, physical, social, and spiritual. Figure 4 is the graphic submitted in the Semi-Annual Report 1, and Table 2 outlines our wellness dimensions' definitions. Figure 4 and Table 2 serve as our initial point of divergence as we initiate the first phase in our Double Diamond – 'discover.' These definitions will change as we discover more about our community's wellness.

Figure 4. Our Wellness Dimensions from USDA Semi-Annual Report 1 (as submitted)

Table 2 (next page) outlines each of the seven wellness dimensions in Figure 4. Three validated screening tools – the Ferrans and Powers Quality of Life Index (F&P QLI), Protocol for Assessing Community Excellence in Environmental Health (PACE-EH), and Perceived Wellness Survey (PWS) – will be used in our evaluation to preserve the evaluation integrity. It is crucial to note that environmental wellness is not originally a part of F&P QLI or the PWS screening tools. One possible alternative was to adopt a subset of environmental wellness questions from the University of Princeton, Lifestyle Assessment Questionnaire (LAQ), or Optimal Living Profile (OLP); however, these options are either not validated or reportedly unreliable (Bart et al., 2018; see also Princeton University, n.d.; University of California, Davis, n.d.; University of Maryland, n.d.). The current recommendation is to utilize the PACE-EH to measure environmental wellness, at least in the interim.

Step 2: Collect Clinical and Wellness Data

We have clinically accepted screenings and wellness evaluation plans in Table 2. Both clinical and wellness scores offer some directionality; for example, a higher score may indicate a more severe condition, i.e., PHQ-9. The inverse is also present in the Nestle MNA for Wound Care, where the

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Table 2. Wellness Definitions

Environmental Wellness*	Recognizing and respecting your daily (natural and built) environment impacts your health and wellness.[1,2]
Financial Wellness§	Income and the source(s) of income meet current financial obligations and goals.[3]
Intellectual Wellness†	Interest in acquiring knowledge, learning new skills, and engaging in simulating activities.[4]
Mental Wellness†§	Understanding your own feelings and having the ability to constructively manage stress and cope with life's challenges.[4]
Physical Wellness†§	Avoiding harmful habits and practicing behaviors that support our body and needs.[4]
Social Wellness†§	Building supportive relationships to avoid social isolation and deal with conflict effectively.[4]
Spiritual Wellness†§	Engages in activities to support a sense of self-care, purpose, and value.[4]

* Measured in PACE-EH

† Measured in the PWS

§ Measured in F&P QLI

[1] (University of Maryland, n.d.)

[2] (University of California, Davis, n.d.)

[3] (Consumer Financial Protection Bureau, 2015)

[4] (Princeton University, n.d.)

higher score indicates improved nutrition. One question may be evaluated from this concept: "To what extent does our wellness improve as our health improves?"

A combination of tools is used depending on the specific line of business (LOB) and what the respective standards of care dictate. There is a form applicable to all LOBs called the Pre-Screening form. The Pre-Screening form contains (1) the Standard Approach for Screening from the SBIRT protocol, (2) PHQ-2, and (3) PRAPARE – a standardized social determinant of health (SDOH) tool. The Pre-Screening is amendable, but one primary consideration when implementing any changes is the increased demand on our clinical staff and patients across all LOBs.

Step 2 represents our 'Individual' and 'Relationship' levels of the Socioecological Model.

Step 3: Health and Demographic Profiles

Health

In the first USDA Semi-Annual Report, Table 1 used two broad data sources from establishing community (or regional) and patient (population) baselines. Table 3 expands this idea from Table 1

into the socioecological model (SEM). Data availability for this step is limited to mostly healthcare and health; however, it may serve to develop our target personas to measure their wellness.

Table 3. Socioecological Model (SEM) Evaluation (proposed revision)

Adapting the Socioecological Model to Evaluation		
Level	Factors[1]	Potential Sources
Individual	Biological and personal factors, e.g., age, education, income, race, recovery, and biomarkers.	PRAPARE, Alcohol/Substance Use Screening (from SBIRT), PHQ-2, EHR(s), PACE-EH. F&P QLI, PWS
Relationship	Family, home, social, and emotional factors, e.g., housing status, partner safety, and number of family members living in the household.	PRAPARE, PACE-EH, F&P QLI, PWS
Community	Factors impacted by school, work, church, and volunteering sites, e.g., transportation.	PRAPARE, PACE-EH, F&P QLI, Florida CHARTS
Societal	Policy and regional[2]-level factors, e.g., Florida CHARTS and Robert Wood Johnson Foundation data.	Florida CHARTS, Robert Wood Johnson Foundation data

[1] Krug et al., 2002
[2] *Note.* Regional refers to Jefferson, Madison, Taylor, Lafayette, Hamilton, and Suwannee counties

Per the structure of our programmatic reporting, the goals (broad) and objectives (specific) will proportionately shape our focuses for the profiles below. The community-level data should primarily focus on the current goals: Chronic Disease and Behavioral Health for youth and adults. Also, for example, geriatric considerations are needed to align and support the development of the geriatric (Aging Well) LOB objective. The objectives will added to our profile(s) as we develop or address each. Note: The community-level data is limited to the intervals set by the local health departments and made available via FL CHARTS. Data presentation and interpretation should begin from 2014 in at least three-year intervals, e.g., 2014-2016, 2017-2019, and 2020-2022.

Demographics

The available community-level demographics will be general, while the patient-level demographics will be from the hospital intake and PRAPARE. The overlap between community and patient levels could indicate the populations the hospital serves and does not serve. The level of detail of this profile should meet or exceed the required amount in the Community Health Assessments (CHAs) and Community Health Implementation Plans (CHIPs).

Step 3 represents our 'Community' and 'Societal' levels of the Socioecological Model.

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Step 4: Explore Correlations to Wellness and its Dimensions

As we approach the later steps, the re-framework becomes intentionally general. The generalization aims to allow the data to guide our thinking and programmatic direction. Maintaining a divergent thinking approach in our Double-Diamond's 'Discover' phase is critical to begin these next steps with the highest fidelity. Presumptions and heuristics will impact how we attempt redefining (or the 'Define' phase) our Wellness Dimensions in this stage – Step 4.

Sample correlations like "To what extent does our wellness improve as our health improves?," were introduced. Statistical and comparative analysis aims to extract information from our data collection to form new correlations.

Step 5: Define the Coaching Topics for Being Well

While wellness coaching is co-occurring under the guidance of wellness curriculums and prior experiences, the correlations may indicate ways to target wellness rather than health concerns. We will also approach an understanding of what social factors impact our wellness and objectively prioritize developing specific external referral partners and inter-departmental relationships.

Steps 4 and 5 represent the conclusion of our first diamond in the Double-Diamond Model.

Conclusion

As we progress through these first five steps, we learn more about our patients, their families, communities, and society. We will identify clear steps in our second diamond's (3) '**develop**' and (4) '**deliver**' phases. Another co-occurring event is clinically developing and delivering services and lines of business; however, this re-framework focuses on evaluating wellness and how it juxtaposes with the clinical service provision of Madison County Memorial Hospital.

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