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Investigating the Implementation of a Rural Wellness Center

Cynthia Reed

Oregon Health & Science University

School of Nursing

OREGON HEALTH & SCIENCE UNIVERSITY

SCHOOL OF NURSING

DNP Clinical Inquiry Project Report & DNP Portfolio Approval

Student Name: Cynthia Reed, MSN. FNP-C

Degree: Doctor of Nursing Practice

Title of Clinical Inquiry Project:

Investigating the Implementation of a Rural Wellness Center

APPROVED:

Committee Chair: Gary Laustsen, PhD, APRN, FNP (name and credentials) Signature:

Committee Member: Joanne Noone, PhD, RN, CNE (name and credentials) Signature:

Committee Member: (name and credentials) Signature:

Christine A. Tanner, R.N., Ph.D, FAAN, Interim Dean, School of Nursing Signature:

Date: 06/01/12

Submit completed original form to the Graduate Program office.

Section I: The Clinical Problem

Description and Significance of the Clinical Problem

In March of 2010, President Obama signed the Patient Protection and Affordable Care Act, hereafter addressed as the Affordable Care Act (United States Congress, 2010). This legislation places emphasis on the health of all Americans including the prevention of diseases that have become chronic and endemic in the United States (US). In the community setting, health care providers are facing an inevitable change in the delivery of healthcare due to this legislation. Nurse practitioners (NPs) and other health care providers who take a proactive approach and employ disease prevention strategies have the possibility of improving the health of community members. Planning and developing a wellness center in a community with a focus on prevention is one such strategy.

Wellness centers exist across the US and provide a variety of services in the communities where they are located. A wellness center is a facility that has developed programs dedicated to the promotion and maintenance of physical well-being for optimal health and performance (MedConditions, 2011). The programs offered to promote physical well being may include educational services targeting both prevention and care of chronic illnesses, athletic and balance, relaxation, and stress reduction. These centers may be located within a clinic or hospital, but may also be a stand-alone facility. Wellness centers can be under the direction of NPs or Medical Doctors (MDs) as well as a variety of other health providers including but not limited to chiropractors, naturopathic providers, and homeopathic providers.

The National Nursing Centers Consortium (NNCC) is an organization established in

1996 to provide a forum for community-based nurse-managed clinics and wellness centers to share best practices and address common challenges. The NNCC has 200 clinics and wellness centers that collectively provide health promotion, disease prevention, and primary care to the underserved population across the US (Hansen-Turton, 2009). This organization recognizes the need for additional wellness centers specifically in rural communities. The focus of this project will be investigating the implementation of a wellness center that provides disease specific screening, assessment, and education as well as overall health promotion in rural counties.

Located in southwestern Idaho (ID) and eastern Oregon (OR), are Payette County, ID and Malheur County, OR. The US Census Bureau (2010) reported close to 54,000 residents living in these counties. In 2009 there were only 0.5 providers per 1,000 residents in Payette County and only 1.2 providers per 1,000 in Malheur County as compared to 2.4 providers per 1,000 residents in the US as a whole (Indicators Northwest, 2009). The shortage of providers represents a barrier in access to health care and prevention services for the residents of Payette and Malheur Counties. The development of a community wellness center may offer the residents improved access to disease prevention programs, including screening and educational services.

Population

The population of interest for this project resides in Payette County ID and Malheur County OR with a combined population of approximately 54,000 according to the US Census Bureau (2010). Table 1 provides a breakdown by age, gender, and race;

Table 1:

Population Demographics of Malheur and Payette Counties (US Census Bureau, 2010).

People Quick Facts	Malheur	Payette
County Population	33,313	22,623
Under age 5 years old	7.3%	7.7%

Under age 18 years of age	25.6%	28.1%
65 years old and over	15.2%	14.3%
Female	46.8%	50.2%
White	77.5%	88.60%
Black	1.2%	0.2%
American Indian	1.2%	1.1%
Asian	1.7%	0.8%
Native Hawaiian/Other Pacific Islanders	0.1%	0.0%
Hispanic	31.5%	14.9%

Epidemiology

The epidemiology of the project population has known chronic illnesses in both the pediatric and adult members. The incidence of some diseases in Idaho and Oregon are higher than across the US while others are lower than the US statistics. These data have significance when investigating the implementation of a wellness center in order to understand the study population's health risk in comparison to others living across the US. The Kaiser Family Foundation (2010) reports data on the incidences of disease from the Centers of Disease Control and Prevention (CDC). In Table 2 the data shows the comparison of chronic illness statistics of those living in Idaho, Oregon and those living across the US.

Table 2

Disease Incidence in Idaho, Oregon, and the US (Kaiser Family Foundation, 2010).

Health Indicator	Idaho	Oregon	US
Children Who Had Both a Dental and Medical Preventative Visit in Last 12 Months (2007)	60.2%	62.3%	72%
Pediatric Obesity ages 10-17 (2007)	27.5%	24.3%	31.6%
Pediatric Immunization Rates (2010)	61%	69%	75%
Diabetes in Adults per 1000 (2005-2007)	9.8	6.7	9.1
Adult Death due to Diabetes per 100,000 (2007)	22.7	27	22.5

Deaths per 100,000 Related to Heart Disease (2007)	164.1	156.9	190.9
Cancer per 100,000 (2007)	463.1	457.8	465.1
Deaths per 100,000 Related to Cancer (2007)	165.6	179.3	178.4
Health Indicator	**Idaho**	**Oregon**	**US**
Deaths per 100,000 Related to Cerebrovascular Diseases (2007)	43.2	43.6	42.2
Adults Who Smoke (2010)	15.7%	15.1%	17.2%
Smokers Who Attempted to Quit (2010)	62.5%	53.8%	59%
Adult Reported Asthma (2009)	8.4%	11.1%	8.4%

In addition to the diseases presented in Table 2, children in Idaho (ID) and Oregon (OR) face a high incidence of asthma. In Idaho, 8-9% of children have asthma, in Oregon, $\geq$ 9% have asthma, and 9.6% of children living across the US in 2009 had asthma (CDC, 2011). Asthma nationwide and across all ages has had a 1% increase since 2001(CDC, 2011).

Wellness centers may be an option to target disease through prevention and education in rural communities. Currently in Malheur County OR and Payette County ID, there are no established wellness centers.

Background knowledge

While there is information available on the development of wellness centers and information on individual wellness centers across the United States, the literature did not provide resources on planning a rural wellness center specifically from the organizational leadership, provider, and patient perspectives. The literature does provide information regarding the planning and implementation processes suggested for wellness centers and nurse managed centers (Leonardo, Resick, Torrisi, Hansen-Turton, & Deinhardt, 2009). Research and literature have abundant information on diseases as well as beneficial screening and education tools.

Organizational/local knowledge

Payette County ID and Malheur County OR have no wellness centers established. However, in Ada, County, ID just 50 miles southeast of Payette County ID and Malheur County OR there are several holistic wellness centers that are directed by naturopathic doctors, chiropractic doctors, and herbalists. During informal discussions, the investigator has noted support for this clinical inquiry project (CIP) and the needs assessment process with regional health care providers. They shared that a wellness center aligns with their current business programs that provide wellness services for community businesses and their employees.

The CIP investigator identified the key stakeholders and future driving force for the planning and implementation of a wellness center are the health care administrative and leadership staff of Saint Alphonsus Medical Group (SAMG). During the initial phase of the CIP, there was designated time for investigation of the organization's mission and philosophy regarding wellness and prevention as well as wellness centers directed by the organization both locally and nationally. This research assisted the investigator's development of a formal CIP presentation to the organization.

Importance to advanced practice nursing

To ensure quality care for the US, the Affordable Care Act (United States Congress, 2010) has designated wellness and prevention programs as those programs delivered and maintained by a health care provider, such as MDs and NPs. The designated programs should conduct health risk assessments and interventions for smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease, and diabetes. With current changes in health care and the challenges of health care access, NPs have an opportunity to advance the health promotion and prevention role built by early nursing leaders (Buresh & Gordan, 2000). Advanced practice nurse leaders in their clinical and leadership roles bring a unique skill set

required to identify, plan, implement, and later direct a clinical center that promotes the health and wellness in underserved rural counties.

The recent report from the Institute of Medicine (IOM, 2011) identified that nurse-managed health clinics provide opportunities to expand access for patients in communities across the US. Torrisi and Hansen-Turton (2005) suggest a nurse practitioner directed wellness center may provide this expanded access through evidenced based health promotion, wellness, and prevention programs (p. 3). As a greater number of NP directed clinics and centers become available, collaboration both clinically and professionally among these advanced nursing leaders will promote the role of the advanced practice nurse at the community, state, and national level. This CIP will bring the nurse practitioner into the forefront of planning, implementing, and managing wellness centers in Payette and Malheur Counties with potential application to other rural settings across the US.

Desired outcomes with impact

Both private and state funded health clinics exist in Payette and Malheur Counties and provide prevention and screening programs for the public. However, at the time the project was conducted there were no wellness centers that provide overall health promotion and disease prevention existing, in these counties. The purpose of this CIP was to investigate the perspectives of community members regarding the planning and implementation a wellness center for Payette and Malheur Counties. The initial step in this project was to investigate research data on successful wellness centers that may be present in Idaho, Oregon, and across the United States. The second step was to design a survey tool that when administered would provide valuable data on community member's perspective of a wellness center in Payette and Malheur Counties. This initial data provided direction and focus for the project as provided an indication of potential

barriers NPs might face in the development of a wellness center. The goal for the initial data collection was September 2011 through March 2012.

Early outcomes focused on investigating successful wellness centers across the US. The goal of these findings was to identify and shape a presentation for the key stakeholders to provide examples of options for a local wellness center. Included in the CIP was the administration of surveys that assess the interest and perspectives of organizational leaders, providers, and patients. This investigator believed this information would be valuable for an organization when directing the planning phase of a wellness center.

In addition, a wellness center must be fiscally stable so the project explored billing and revenue sources. The goal of this exploration was to identify revenue sources such as insurance providers, state, and federal funding, and private sources in the community that might have prevention funding available for future planning. Additionally, discussion with organizational leadership included a location for adequate space and collaborative services that might support the operation of a wellness center. Collaborative services include other essential health care providers; such as diabetic nurse educators, physical therapists, and chiropractors. The goal in identifying collaborative services was to highlight the efficacy of an interdisciplinary team working together to meet the components of care essential to improve the wellness of the community members.

Clinical Inquiry Purpose and Question

The purpose of this clinical inquiry project was to investigate the perspectives regarding a wellness center from a sample of people living and working in Payette, ID and Malheur, OR counties. In addition, the project explored key components that could be useful in the future implementation of a wellness center to promote healthy lifestyle choices. The clinical inquiry

project addressed the question: What are the important aspects to consider when planning a wellness center in rural counties such as Payette County, ID and Malheur County, OR?

Synthesis of Evidence

The purpose of the literature review was to identify strategies, concepts, and principles used in the past that might be insightful when considering the implementation of a wellness a center. The investigator conducted a search using the Cumulative Index to Nursing and Allied Health Literature (CINAHL) and MEDLINE. Key words used for this literature search included but not limited to; wellness, centers, nurse directed, needs assessment, accountable care organizations. A web-based exploration of national organizations that provide evidenced based research and data analysis of populations, wellness and prevention, and outcomes was included in the literature review. These databases provided information on new legislation, professional organization's support of nurse directed centers, and for the planning and implementation of nurse managed clinics and wellness centers. However, the literature did not provide perspectives of rural healthcare administrators, providers, and patients regarding the benefit of a wellness programs provided through a community wellness center.

McCann (2010), identified diseases and illnesses that the underserved and rural populations face. The purpose of the McCann's project was to improve health outcomes for an underserved community with known health care needs but with lack of access and available service. The article outlines the steps and processes taken by the project director and the team to create a community-academic partnership with a trusted community organization where interdisciplinary health care services occur. The article provides the steps and processes taken for this project that included the development of problem statement, a market analysis, short-term and long-term objectives, scope of the project, action plan, and summary. The action plan further

divided into subsections including; setting, evaluation, results, unanticipated barriers/consequences, recommendations, and sustainability. The McCann (2010) article provided steps with an actual outcome of care that may be useful for review and utilization for this CIP.

The purpose of Barkauskas,et al's (2006) article was to provide an initial national profile of Academic Nurse Managed Centers (ANMCs). The authors reviewed literature and identified the history of ANMCs in the United States since the 1970's. The compelling information gained from this article was the author's findings of the history and shortcomings of ANMCs that led to closing and discontinuation of services in the communities where they were located. Reviewing this information provided insight on strategies that an organization may employ to improve the sustainability of a wellness center.

Allen, Stanley, Crabtree, Werner, and Swenson, (2005) identified the central focus of improving health status in a population is clinical prevention and health activities. The describe the initiation of the inter-professional Healthy People Curriculum Task Force that developed educational programs for health care professionals to highlight health promotion and disease prevention. This task force initiation supported by the Institute of Medicine (2001), who saw the need to ensure highlighted preventions strategies remain fundamental components of nursing curricula. In consideration for the development of a wellness center, it is important to consider a partnership with area universities and schools of nursing. Understanding the key components that may be included in their education curricula will be beneficial during planning and implementation of a wellness center. A wellness center could be a strong component for the university faculty when looking for sites that will provide clinical experiences that meet the objectives of the curriculum.

Lee and Jones (2004) in their article detailed one neonatal nurse practitioner group's experience using a 4-phase strategic planning process in maintaining a strategic fit between an organization's goals and their resources in the changing health care market. Phase 1 was an assessment of the present situation, the past, and the forecasted future. An internal environment analysis included the identification of organizational strengths and weaknesses to provide forecasting of future performance. An external environmental review recognized external opportunities and threats. Phase 2 focused on the organization's Mission and Objectives. Phase 3 centered on strategies to accomplish each goal's objectives of each goal. Phase 4 addressed action plans that consider the ever-changing needs of the institutional environment. The experience and strategies of this neonatal nurse practitioner group can be useful for the planning and implementation of a wellness center.

In their study De Vries, Fisher, Thomas, and Belanger-Shugart (2008) conducted a study to explore outcomes achieved with nurse practitioner facilitated group medical visits (GMAs) for chronic obstructive pulmonary disease (COPD) patients. This pilot study using a retrospective de-identified chart audit concluded that nurse practitioner GMAs are feasible and can assist in improving health outcomes. This innovative solution for management of chronic diseases such as COPD is reimbursable and practical for implementation in most clinical practice settings. Billing and reimbursement will be a barrier to address when establishing a wellness center. This article provides a reimbursable group structure that could serve as an example to utilize in the planning and implementation of a wellness center.

Hansen-Turton, Bailey, Torres, and Ritter (2010), in their article address the current health care environment due in part to the passing of the Patient Protection and Affordable Care Act. The authors address the affordable care act support for the nurse practitioner leadership and

directorship of community health services such as a wellness center. In their book Torrisi and Hansen-Turton (2005) provide insight into the development of these nurse-managed clinics with the strategies for success and sustainability. The authors present information on initial and ongoing planning, funding, financial operations, policies and procedures, and ongoing continuous quality and performance improvement. Included in the appendices of this book are sample documents that support the body of the text and inform the development of this CIP.

Hansen-Turton, Miller, and Greiner (2009) offer an approach to improve the underserved population's access to important preventative health care. The authors provide a definition of a nurse-managed wellness center, a systematic guide to the development of a wellness center, marketing strategies, and service suggestions for specific populations such as the aging population, the Latino population, and the mental health population. Intertwined in the body of text is valuable information on funding and sustainability of wellness centers.

The Affordable Care Act (United States Congress, 2010), outlines the change in health care legislation that has been instrumental in re-addressing the importance of wellness and prevention programs across the nation. Throughout this document, the focus is improving the health of Americans by providing screening and educational programs that prevent chronic illness for 31 million uninsured Americans by 2014. While this is good news, there are also logistical concerns due to the lack of sufficient primary providers in the United States (US Department of Health and Human Services, 2010). Barriers in access to care due to decreased numbers of primary providers require an innovative approach to meeting the health care needs of communities across the US. This document provides supportive literature for planning awellness center.

The literature addressed thus far provided supportive reference to the strategic steps required to plan and implement a wellness center. Additionally the literature focused on the importance of screening and educational programs. Developing programs that address the interdisciplinary health issues of a community will be a significant part of planning and implementation of a wellness center. The literature provides a rich resource of studies that are disease specific and provide evidence for specific education and screening tools. However, it is beyond the scope of the CIP to provide a thorough review of guidelines related to specific disease education and screening.

In review of the available research there appears to be a gap in the understanding of the perspectives of health care leaders, providers, and the patients regarding a wellness center in their rural communities. Without specific literature, wellness center advocates are without an understanding of the impact a wellness center may or may not have in their community. This gap provided an opportunity for the CIP to present information that would support the planning and implementation of a wellness center in underserved and rural communities across the US.

In a literature review, nurse practitioner-directed wellness centers were located in other states (Integrated Family Wellness Center, 2011). The investigator considered these centers as possible sources of data for a wellness center needs assessment. Prior to implementing a wellness center contact by phone conversations, email communication, or a face-to-face visit could be planned. Through these connections information on the financial aspects of a wellness center, the programs that have been successful and those that have not, the structural components required, and the day-to-day operations may be available.

In surrounding regions of Payette County ID and Malheur County OR there are skilled specialty services who utilized evidenced based guidelines in their treatment of chronic disease

and disabilities. Having an opportunity to interview and work with these specialists provided the CIP investigator a better understanding of health problems county residents have. Through observation of specialty practice, there was an opportunity to gain valuable knowledge on prevention and treatment modalities that may complement wellness center programs.

In Summary

Investigating the planning of a wellness center implementation as a CIP addressed the changing environment of health care. Utilizing a proactive approach by employing strategies that focus on disease prevention and wellness was in alignment with recent legislation. The federal government recognized the need for centers that promote wellness and improved health in 2010 with the Recovery Act funding of $1 billion dollars for prevention and wellness programs across the US. The Recovery Act allocated $650 million specifically to evidenced based clinical strategies and community based prevention strategies. These strategies were and continue to be commissioned to address chronic diseases, support immunization programs, and fight health care associated infections. The programs deliver specific programs with measurable outcomes that demonstrate improved health for recipients (Department of Health and Human Service, 2011).

Improved community health may occur through the implementation of a wellness center. Literature supports better health outcomes through a medical home or primary care provider service (Ferrante, Balasubramanian, Hudson, and Crabtree, 2010). Screening and prevention programs, offered at a wellness center, can increase access to primary care services by; referral to primary provider care, referrals for needed services identified in the screening process, developing patient understanding and awareness of the primary care provider’s role in the prevention of disease.

The nurse practitioner has an opportunity improve the health of the community by investigating the need for wellness and prevention. Employing a strategic plan including the investigation of available literature that documents a clear plan for implementation of a wellness center prepares the nurse practitioner for an effective presentation of the need to community and financial stakeholders. Additionally through the collection of local data regarding the perspectives of residents living and working in Payette and Malheur counties regarding wellness center programs, improves the nurse practitioner's opportunity to meet the counties' health needs (McCann, 2010).

Section II: Methodology

Clinical Inquiry Design

The design of the CIP was a needs assessment described by Polit and Beck (2006) as, "An assessment of the needs of a group, a community, or an organization (p. 504)." This design was appropriate to answer the question: What are the important aspects to consider when planning a wellness center in rural counties such as Payette County, ID and Malheur County, OR? An integral part of this needs assessment design was the collection of valid data via administration of surveys to the chosen population; health care organizational leaders, providers, and patients working and living in Payette and Malheur counties.

The survey, written at an appropriate reading level for the participants obtained the perspectives of the chosen population regarding the value of a rural community wellness center. The surveys was able to obtain this perspective, while maintaining the privacy of each participant as the design included general demographic information without requesting individual identifiers. Patient demographic information (see Appendix A) included social information and years the participant lived in the Payette or Malheur counties. Four questions

specifically designed for the patient participant, provided information on the individual's current health status. Provider's demographic information (see Appendix B) addressed practice specialty, practice group type, and number of years practicing in Payette or Malheur counties. Health care organizational leader's demographic information (see Appendix C) included the community organization where employed and the years affiliated with the organization.

Additional survey questions targeted all participants' views of certain health programs that may be beneficial to the individual or to the community members, and each participant ranked the importance of each program. The identified programs included: nutritional, diabetic education, high blood pressure education, heart disease education, weight management, smoking cessation, relaxation techniques, stress reduction strategies, and exercise strategies.

Setting

The setting was a health care organization serving the rural communities surrounding Payette County, ID and Malheur County OR. St. Alphonsus Dominican Health Services (DHS) is located in Fruitland, ID and is part of the larger organization of St. Alphonsus Medical Group (SAMG). DHS provides care for both an underserved and adequately served patient population. At the time of the CIP, SAMG in Fruitland, ID conducted all wellness and prevention services during individual patient visits and these services were limited by the time allotted for the visits. The investigation into the implementation of a wellness center evaluated the need of expanding health promotion services in a rural community. Providers working at DHS and other local clinics have identified that additional education on chronic illness such as obesity, hypertension and cardiac disease, diabetes, and overall prevention and wellness is required to assist the patient population to make better lifestyle choices.

Promotion of the CIP occurred through a close working relationship between the project investigator, DHS, SAMG, and the St. Alphonus Medical Center located in Ontario, OR. The Saint Alphonsus Regional Medical Center's institutional review board approved the CIP survey distribution to patients within the SAMG clinic in Fruitland, ID. The administrative leadership in these organizations provided valuable insight to the feasibility and the value of a wellness center in the Payette and Malheur Counties. In an informal meeting, (July 2011) the SAMG leadership expressed interest in this CIP and the information the investigation would provide. During informal discussions, colleagues also employed by SAMG expressed interest in the benefits of a wellness center for their patients. Not only did organizational leaders and health care colleagues offer interest but the investigator had patients who expressed interest in further health promotion information available at a wellness center.

Meetings held with coding staff at SAMG provided valuable information on prevention and wellness billing practices. Discussion in these meetings also included strategies for marketing prevention and wellness to local businesses that currently utilize the SAMG for employee health care and services. Plans for future dissemination of the CIP findings to the organizational leadership and stakeholders are planned for the summer of 2012.

Sample

The population sample included health care organizational leadership, health care providers, and patients. The SAMG and Saint Alphonsus Medical Center in Ontario, OR organizational leadership sample were chosen due to these organizations' role in the possible implementation of a wellness center. Additional organizational leadership within Payette and Malheur counties included leaders from St. Luke's Idaho Health Systems, Hospital Corporation of America, and independent health care services. The health care providers selected serve in the

communities where the implementation of a wellness center was under investigation. The patients involved were residents living and working in Payette and Malheur counties, with the potential for utilization of a wellness center in the community. The proposed minimum number of participants to survey was 50 patients, 20 providers, and 10 organizational leaders.

Survey participants were selected using convenience sampling methods and collection of data from people who utilized service at the SAMG clinic or provide specialty services in the community. A judgment sample of organizational leaders and providers from the setting previously mentioned were selected. Polit and Beck (2006) identify that the use of a convenience and judgment sample allows the investigator to obtain the data with ease and improves the feasibility of a needs assessment project.

Measures

The previously mentioned survey questionnaires (Appendices A, B, and C) were designed to obtain valid data, in a quantitative form, and measure the perspective of the chosen population. Anonymous data were generated from participant's comments, using self-developed surveys. The investigator sought comments made by participants on the needs assessment that might provide useful qualitative information. These data were documented and analyzed for trends and commonalities.

Data Collection Procedures

A face-to-face contact or a verbal contact with, subsequent mailings to organizational leaders and health care providers, allowed distribution of surveys to these participants. A cover letter (Appendix D) provided the participants informed consent and by their completion of the survey, assumed consent to participate in the CIP. The survey data and questions were structured so all information obtained from individuals was unidentifiable and maintained the anonymity of

each participant. When face-to-face presentation occurred with SAMG leaders or providers, the project investigator presented the purpose of the CIP project, description of a wellness center, data collection methods, timeline for completion of the project, and invited the leadership and providers to participate in the survey. A question and answer period was also available during the presentations.

The selected patient sample for this needs assessment was from the population of those obtaining health care services at the Fruitland, Idaho SAMG clinic. A convenience sample chosen from patients who were cared for by the project investigator received survey packets in the following manner: 1) Registration of the adult patient was completed. 2) The patient visit proceeded as per normal process. 3) Upon completion of the visit, the patient received the survey packet with a cover letter of explanation and informed consent, the survey, and the preaddressed envelop for returning the survey. 4) If the patient had questions, the CIP investigator clarified the information and answered any questions the patient had. 5) The completion of the survey provided an assumption of consent to participate in the CIP. Instructions were included in the survey packet for mailing the completed survey in the pre addressed and stamped envelope to a post office box purchased by the CIP investigator.

Minitab® and Microsoft Excel ® were the data analysis tools used. Upon the return of the surveys, the investigator entered the data into an excel spreadsheet and transferred select data to the Minitab program for descriptive statistical analysis of variance (ANOVA), and chi square comparison. The remainder of data which included demographic information on the sample, were examined in Microsoft excel. Using these data analyses the final needs assessment presentation for the CIP key stakeholders was developed and presented.

Analytic Methods

As the surveys were returned they were separated into the patient, provider, and leadership categories and assigned a unique identifying number. Each survey was numbered within each category.

Using Minitab® and Microsoft Excel ® for data entry allowed the investigator to summarize the data distribution. The spreadsheet allowed the results to be grouped into interval frequencies that can be displayed in graph or histogram for visualization of results. The spreadsheet reports the summarized distribution with the use of statistical indices allowing for comparisons of certain variables surveyed and the analysis of variances of ranked data. Using these methods allowed a report, which provided the stakeholders a better understanding of the sample's perspective of a wellness center in their community. By utilizing different methods of analysis, the investigator was able to validate the significance of the data. Identification of the common diagnoses of those surveyed will also be isolated and reported to enhance the ability to develop preventative and wellness services that will best treat the surveyed population.

Qualitative data, generated in the comment fields of the survey were recorded, tabulated for similarities and trends, and categorized if similar responses were found. If categories were evident, the use of frequency distribution would report the number of occurrences of each category (Green & Salkind, 2008).

To maintain the privacy and confidentiality of the data the CIP investigator stored all data in a computer that required password access. This computer, was maintained in a secured non-public environment, and ensured the anonymity of those involved. Analysis of the data was generated for reporting only and when reported had no identifying participant information.

Protection of Human Subjects/ethics

The participants had the right to make a fully informed decision prior to participation in the survey process. To inform the participant the survey packet described the nature and purpose of the needs assessment and survey tool. The project investigator was available for clarification of questions regarding the surveys.

The participant had the right to be respected and their privacy maintained. An anonymous survey tool was designed to gather data without divulging information that could make the identity of the participant known (see Appendices A through C).

Plan for Dissemination of Key Stakeholders

Initially the CIP investigator met with the administrative staff of SAMG to provide details on the CIP project goals and timelines. Included in this presentation was information on the planned administration of surveys and any need for support from the SAMG staff.
As part of the presentation the CIP investigator clarified that all costs accrued, would be absorbed by the investigator and not the organization. When the need arose for clarification or discussion on programs status, the CIP investigator met with SAMG administrative staff.

After the compilation of data was completed, the CIP investigator developed a presentation for the SAMG administrative and clinic staff. This presentation is planned for the summer of 2012. During this presentation, the administration and clinic staff will have opportunity to ask questions and provide valuable input to the CIP investigator regarding the development of wellness center programs.

A final presentation was held on the Oregon Health and Science University (OHSU) campus and included the CIP committee members and OHSU faculty and community. Once again in this presentation the attendees were allowed and encouraged to ask questions regarding the process of the CIP and the outcomes noted.

Dissemination of the results of the CIP may include reporting the findings through professional journals and professional conferences. The offer has been made to share the findings with the Nurse Practitioners of Idaho Fall, 2012 symposium in Boise, ID.

Timeline for Project

The project planning began in the summer of 2011 and continued until the defense presentation in May, 2012. Table 3 outlines the project timeline.

Table 3 Project Timeline

Date	Completion Item
June, 2011-August, 2011	CIP Proposal Draft
October, 2011	CIP Defense with Committee
November, 2011	CIP delivery to Institutional Review Board (IRB)
November, 2011- December, 2011	IRB reviews and revisions of CIP
January, 2012-March, 2012	Data collection
April, 2012	Analysis of data
May, 2012	CIP presentation to SAMG and Saint Alphonsus Medical Center key stakeholders
May, 2012	Final defense presentation to committee members, student colleagues, and OHSU community

Section III: Results

Sample

Surveys were administered to 124 participants with 52 completed for a return rate of, 42 %. Of those administered, 72 were distributed to patients with 36 % return rate (n=26), 42 were administered to providers with a 48 % return rate (n=20), and 10 were administered to health care leaders with a 50 % return rate (n=5).

Findings

The clinical inquiry question: “What are the important aspects to consider when planning a wellness center in rural counties such as Payette County, ID and Malheur County, OR?”, was

the focal point of the investigation. To partly address this question the investigator reviewed the respondent's demographic data. Patient participants (n=26) were asked how long they had resided in Malheur County, OR or Payette County, ID. The twenty-two patients residing in these counties (4 reported living outside the counties) had a mean residency of 26 years. Residency years ranged from 1 year to 74 years.

The patients were asked to identify their primary, secondary, and additional medical diagnoses. *Figure 1* presents the findings with a large percentage of patients reporting no medical history.

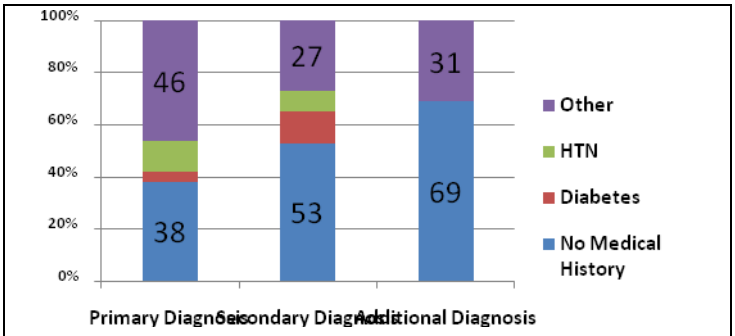


***Figure 1*: Patient Diagnoses**

Additional demographic data included patient height and weight. Using these data, *Figure 2* presents the Body Mass Index (BMI) categories, with the larges number of participants in the overweight category. The mean BMI of the patient sample (n=26) was 28.4. Twenty-seven % of participants reported a normal weight (n=7), forty-six % reported being overweight (n=12), twelve % reported obesity (n=3), and eight % reported severly obese (n=2).

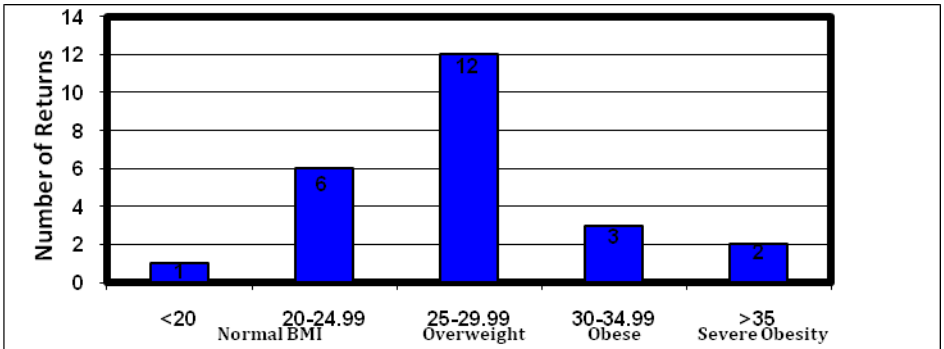
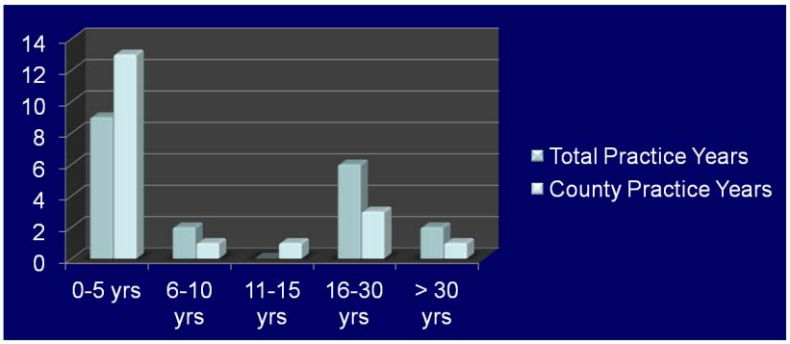


***Figure 2*: Patient Body Mass Index.** Mean BMI: 28.4

Demographic information requested from the provider participants included provider type and provider practice specialty. Provider type (n=20) included physicians (n=8), NPs (n=4), Physician Assistants (n=4), and other types (n=4). Specialty areas of these providers were family practice (n=8), orthopedic (n=3), internal medicine (n=2), general surgery (n=1), and other (n=6).

Providers were also surveyed regarding the number of total years they had practiced and the number of years they had practiced in Malheur County, OR and/or Payette County, ID. These data are presented in *Figure 3*.



An ANOVA analysis was done using the variable of patient BMI and the reported benefit of weight management programs by patients (see table 4). The findings were not significant (p=0.090).

Table 4 BMI vs Wgt Management

Source	DF	SS	MS	F	P
BMI-Wgt Mgt	1	128.7	128.7	3.13	0.090
Error	24	986.5	41.1		

Total	25	1115.2			

Results of the ranking for patients and providers of the importance of wellness programs are found in Table 5.

Table 5 Response of Importance by %

Variable / = 0%	Sample	Total	Very Important %	Important %	Neither Important or Not Important %	Not Important %
Nutrition	Patient	N= 26	58	42	/	/
	Provider	N=20	70	30	/	/
Diabetic Education	Patient	N=26	46	15	31	8
	Provider	N=20	90	10	/	/
High Blood Pressure	Patient	N=26	42	35	19	4
	Provider	N=20	85	15	/	/
Heart Disease	Patient	N=25	68	16	12	4
	Provider	N=20	85	15	/	/
Weight Management	Patient	N=26	77	15	8	/
	Provider	N=20	85	15	/	/
Smoking Cessation	Patient	N=26	31	15	24	30
	Provider	N=20	95	5	/	/
Relaxation Techniques	Patient	N=26	42	42	12	4
	Provider	N=20	35	60	5	/
Stress Reduction Strategies	Patient	N=26	58	30	8	4
	Provider	N=20	40	50	10	/
Exercise Strategies	Patient	N=26	69	23	8	/
	Provider	N=20	70	25	5	/

A Pearson's Chi-Squared analysis was used to evaluate the difference between the patient's responses regarding the benefit of an individual wellness program and the provider's responses regarding whether patients would utilize the wellness programs. While there was a difference in the word use of "utilization" versus "benefit" the investigator assumed that if a patient felt there was benefit from a wellness program then they were more likely to utilize the program.

In two of nine wellness programs, there was a noted difference between the patient group and provider group responses. In one analyses, the patient group did not feel they would benefit

from a diabetic program but the provider group felt their patients would utilize a diabetic program (*df = 1, p = 0.001)* (Table 6).

Table 6 Perspectives of Diabetic Programs

Patient	No	Yes	Missing	All
	12	14	0	26
	46.15	53.85	*	100.00
	100.00	42.42	*	57.78
	6.93	19.07	*	26

Provider	No	Yes	Missing	All
	0	19	1	19
	0.00	100.00	*	100.00
	0.00	57.58	*	42.22
	5.07	13.93	*	19

Pearson Chi-Square = 11.958, DF = 1, P-Value = 0.001

As presented in Table 7 a difference is found between the patient benefit of a smoking program versus the provider view of the utilization of a smoking program by their patients (*df = 1, p = 0.001*).

Table 7 Perspectives of Smoking Programs

Patient	No	Yes	Missing	All
	16	10	0	26
	61.54	38.46	*	100.00
	88.89	38.46	*	59.09
	10.64	15.36		26

Provider	No	Yes	Missing	All
	2	16	2	18
	11.11	88.89	*	100.00
	11.11	61.54	*	40.91
	7.36	10.64	*	18.00

Pearson Chi-Square = 11.958, DF = 1, P-Value = 0.001

The returned surveys of the leadership group were not analyzed, due to the small sample (n=5). One qualitative comment offered by a health care leader, was related to the cost of services and suggested that classes be “free of charge.” No further comment was included.

Comments from all sample groups were recorded and analyzed for trends and similarities. Participants provided six comments on the importance of providing a wellness center and classes in the community, other comments were of a personal nature and did not offer relevance to the study. Three comments were made regarding cost of services, but no specific

suggestions were given. Two providers offered their willingness to assist if wellness programs were established.

Section IV: Discussion

Interpretation

Important aspects to consider regarding wellness in rural communities include the perspective of those who may benefit from or support a wellness programs. A literature search did not provide insight on the perspectives of rural patients, providers, and health care leaders on wellness centers. The investigator's focus was to obtain an understanding of the need for a wellness center from those living and working in Malheur County, OR and Payette County, ID. Using the data collected in this descriptive study the investigator had the opportunity to evaluate the perspectives of a small sample (n=52) and provide outcomes as they relate to participant's responses regarding the benefit, utilization, and importance of wellness programs.

To decrease time and coordination the investigator was the sole survey administrator and data collector. Difficulties arose with administration of the surveys to the provider participants due to the nature of their workload and schedules. The coordination of a face-to-face meeting with the providers was limited, which led the investigator to leave the survey packets with the office staff who then distributed the packets via their established mail system. Though there was this noted difficulty, the survey returns from providers demonstrated a adequate (48%) return rate.

The demographic data indicates the patient participants had longevity in the communities with an average residency of 26 years. The leadership participants had an average number of years working in Malheur County, OR and Payette County, ID of 19 years and provider participants had an average number of 7 years working in these counties. Taking these data into

consideration inferences may be drawn that if wellness programs are initiated the community stakeholders and supporters may be available long term. When future research is considered, longitudinal studies may benefit from the stakeholders longevity in the rural counties. These future studies may provide valuable data and outcomes that promote improved health in rural populations and an understanding of the unique aspects of rural wellness centers.

The patient demographics also address BMI. The findings determined the patient respondent's average BMI was 28.4, which is overweight. This led the investigator to conclude that the sample was at risk for chronic diseases including diabetes, hypertension, and cardiovascular disease (CDC, 2011). Though the ANOVA analysis did not find significance ($p = 0.090$) between the patient BMI and the variable of utilization of wellness programs, the data obtained supports the investigator's plans for development of wellness programs that address obesity and it's relationship to chronic diseases.

The participants were asked to rank the importance of wellness programs. These data demonstrate that there were differences in the patient and provider responses. All of the providers (100%) ranked the importance of diabetes, high blood pressure, heart disease, weight management, and smoking cessation programs as being very important or important. The patient's responses ranged 46% to 92% on their ranking of the same programs as being important or very important. From these responses, it is inferred, that patient responses had more variability between the four categories. This was further supported with the Pearson's Chi Square analysis (see Tables 6 & 7) which noted a difference between the provider and patient responses to smoking cessation (*df=1, p=0.001*).

When reviewing these findings, the investigator speculates that the variance in the responses could be related to a difference in the understanding of the lifetime risk of developing

chronic diseases. Patients may have viewed their risk as low related due to not having a current diagnosis of chronic disease such as diabetes, hypertension, or cardiovascular disease. Whereas, the providers recognize the lifetime risks all patients have of developing chronic disease states. Future marketing strategies could highlight these findings to providers in Malheur County, OR and Payette County, ID, to increase their awareness and increase referrals to wellness programs.

A limitation of achieving validity in this descriptive study was due to the small sample size and the imbalance of the small samples. The investigator realized that future studies may provide more valid findings by having larger samples sizes with more balance between the variables. This could be attained with a longer and broader study.

An interesting finding in the study was the low number of patients who reported a primary and a secondary diagnoses of diabetes and high blood pressure. There were no patients who reported cardiovascular disease as a primary or secondary diagnoses. A large percentage of patients reported no health history (38%) or other diagnosis (46%) in their primary diagnoses. These data are interesting considering the same patient population had an average BMI of 28.4 (overweight). A limitation could be the patients did not understand the diagnostic terms or do not understand their own diagnoses. In future studies, clearer explanation of the questions, or using a qualitative method may result in obtaining, more valid information. A retrospective chart review of the patient respondents could provide more accurate data regarding existing medical diagnoses.

The qualitative data obtained in this study was limited, however, there were several positive comments regarding wellness programs. Consideration should be given to a qualitative study that could gather more in-depth responses of the community member’s thoughts and support for a wellness center. In future studies consideration could be given to including the

leadership results combined with the provider's results as both roles are involved with providing health care services to community populations.

During the study, the investigator had an opportunity to meet with organizational leaders and discuss billing and financial issues of a wellness program. Plans have been made to evaluate the risk versus benefit of having wellness classes in a new health plaza being built in the community. This meeting will cover financial and logistic issues and is planned for the summer of 2012.

In conclusion, although the project's sample size was small (n=52), this descriptive study did provide information and insights that can assist relevant stakeholders when considering the implementation of a wellness center in their rural counties. Inferences can be drawn that may be helpful in developing the specific educational and wellness programs by linking obesity to chronic illness and better inform the rural population of the risk they have. After analysis of the data, future research with the possibility of a qualitative study should be considered. The Doctor of Nursing Practice remains an ideal candidate to complete this future research and disseminate the findings to key stakeholders, with clear opportunities to improve the health of the community.

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Section V Appendices

Appendix A
Patient Survey

Instructions: Please write in or circle your answer

Primary Diagnosis: This is the diagnosis or illness that you originally were diagnosed with and treated by your provider	1 No medical history-Healthy 2 High Blood Pressure 3 Diabetes 4 Heart Problems 5 Other
Secondary Diagnosis: This is the diagnosis or illness your primary provider began to treat you for at or after the your primary diagnoses	1 Not Applicable 2 High Blood Pressure 3 Diabetes 4 Heart Problems 5 Other
Additional Diagnosis: Any one additional diagnosis you may have.	1 Not Applicable 2 High Blood Pressure 3 Diabetes 4 Heart Problems 5 Other
Please provide your height and Weight	1 Weight: 2 Height:
Choose the answer that best describes you	1 Employed 2 Homemaker 3 Student 4 Not employed
Choose the answer that best describes you	1 Single 2 Married 3 Divorced
Choose the answer that best describes you	1 Married with no children 2 Married-children in house 3 Married-no children in house 4 Not applicable
Total number of years you have lived in Payette County or Malheur County	Fill in the number of years

A community wellness center would benefit me if prevention programs were offered on topics like:

Nutrition	1 Yes 2 No
Diabetic Education	1 Yes 2 No
High Blood Pressure	1 Yes 2 No
Heart Disease	1 Yes 2 No
Weight Management	1 Yes 2 No
Smoking Cessation	1 Yes 2 No
Relaxation Techniques	1 Yes 2 No
Stress Reduction Strategies	1 Yes 2 No
Exercise Strategies	1 Yes 2 No

Please rate the importance to you of the following programs:

Nutrition	1 Very important 2 Important 3 Neither important or not important 4 Not important
Diabetic Education	1 Very important 2 Important 3 Neither important or not important 4 Not important
High Blood Pressure	1 Very important 2 Important 3 Neither important or not important 4 Not important

Heart Disease	1 Very important 2 Important 3 Neither important or not important 4 Not important
Weight Management	1 Very important 2 Important 3 Neither important or not important 4 Not important
Smoking Cessation	1 Very important 2 Important 3 Neither important or not important 4 Not important
Relaxation Techniques	1 Very important 2 Important 3 Neither important or not important 4 Not important
Stress Reduction Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important
Exercise Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important

Additional comments and suggestions:

Thank you for your participation in this survey. You may place the survey in preaddressed and stamped envelope and drop in the mail.

Appendix B
Provider Survey

Instructions: Please write in or circle your answer

Provider Type	1 Doctor or Chiropractic (D.C.) 2 Doctor of Dental Surgery (D.D.S) 3 Doctor of Nursing Practice (D.N.P.) 4 Doctor of Osteopathy (D.O.) 5 Doctor of Pharmacy (Pharm. D.) 6 Doctor of Physical Therapy (D.P.T.) 7 Doctor of Podiatric (D.P.M.) 8 Medical Doctor (M.D.) 9 Nurse Practitioner 10 Physician's Assistant 11 Other
Practice Specialty (if applicable to your practice)	1 Cardiology 2 Ear/Nose/and Throat 3 Family Practice 4 General Surgery 5 Internal Medicine 6 Neurology 7 Neurosurgery 8 Orthopedic 9 Pediatric 10 Psychiatry/Mental Health 11 Women's Health 12 Other
Practice Owner	1 Independently Owned 2 St. Alphonsus Medical Group 3 St. Lukes Idaho Health Systems 4 Hospital Corporation of America 5 Other
How many years have you practiced in Payette or Malheur Counties	Fill in the number of years:
How long have you practiced in total	Fill in the number of years:

I believe my patients would likely use a community wellness center if prevention programs were offered on topics such as:

Nutrition	1 Yes 2 No
Diabetic Education	1 Yes 2 No
High Blood Pressure	1 Yes 2 No
Heart Disease	1 Yes 2 No
Weight Management	1 Yes 2 No
Smoking Cessation	1 Yes 2 No
Relaxation Techniques	1 Yes 2 No
Stress Reduction Strategies	1 Yes 2 No
Exercise Strategies	1 Yes 2 No

Please rate the importance of the following topics:

Nutrition	1 Very important 2 Important 3 Neither important or not important 4 Not important
Diabetic Education	1 Very important 2 Important 3 Neither important or not important 4 Not important
High Blood Pressure	1 Very important 2 Important 3 Neither important or not important 4 Not important

Heart Disease	1 Very important 2 Important 3 Neither important or not important 4 Not important
Weight Management	1 Very important 2 Important 3 Neither important or not important 4 Not important
Smoking Cessation	1 Very important 2 Important 3 Neither important or not important 4 Not important
Relaxation Techniques	1 Very important 2 Important 3 Neither important or not important 4 Not important
Stress Reduction Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important
Exercise Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important

Additional comments and suggestions:

Thank you for your participation in this survey. You may place the survey in preaddressed and stamped envelope and drop in the mail.

Appendix C
Organizational Leadership Survey

Instructions: Please write in or circle your answer

Workplace	1 Independently Owned 2 St. Alphonsus Medical Group 3 St. Lukes Idaho Health Systems 4 Other
Optional Questions:	What is your role within the organization?
Community where you work	1 Fruitland, Idaho 2 New Plymouth 3 Nyssa 4 Payette 5 Ontario 6 Vale 7 Weiser 8 Other
Practice Owner	1 Independently Owned 2 St. Alphonsus Medical Group 3 St. Lukes Idaho Health Systems 4 Other
How many years have you worked in Payette or Malheur Counties	Fill in the number of years:

Community members would likely use a community wellness center if prevention programs were offered on topics such as:

Nutrition	1 Yes 2 No
Diabetic Education	1 Yes 2 No
High Blood Pressure	1 Yes 2 No
Heart Disease	1 Yes 2 No
Weight Management	1 Yes 2 No
Smoking Cessation	1 Yes

	2 No

Relaxation Techniques	1 Yes 2 No
Stress Reduction Strategies	1 Yes 2 No
Exercise Strategies	1 Yes 2 No

Please rate the importance of the following topics to the having a wellness center in your community:

Nutrition	1 Very important 2 Important 3 Neither important or not important 4 Not important
Diabetic Education	1 Very important 2 Important 3 Neither important or not important 4 Not important
High Blood Pressure	1 Very important 2 Important 3 Neither important or not important 4 Not important
Heart Disease	1 Very important 2 Important 3 Neither important or not important 4 Not important
Weight Management	1 Very important 2 Important 3 Neither important or not important 4 Not important
Smoking Cessation	1 Very important 2 Important 3 Neither important or not important 4 Not important
Relaxation Techniques	1 Very important 2 Important 3 Neither important or not important 4 Not important

Stress Reduction Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important
Exercise Strategies	1 Very important 2 Important 3 Neither important or not important 4 Not important

Please add any comments or suggestion you may have about community wellness centers:

Thank you for your participation in this survey. You may place the survey in preaddressed and stamped envelope and drop it in the mail.

Appendix D

eIRB #00008037
Protocol Approval Date: 12/05/2011

OREGON HEALTH & SCIENCE UNIVERSITY
Information Sheet

TITLE: Investigating the Implementation of a Rural Wellness Center

PRINCIPAL INVESTIGATOR: Gary Laustsen, PhD, FNP, RN, Associate Professor, OHSU-School of Nursing, One University Blvd., La Grande, OR 97850. Phone: 541-962-3132.

CO-INVESTIGATORS: Cynthia (Cindy) Reed, MSN, FNP-C, RN, Family Nurse Practitioner, OHSU DNP student. #176, 100 N. Whitley Ave. Fruitland, ID 83619

PURPOSE:

You have been invited to be in this research study because you are either a patient, health care administrator, or health care provider living or working in Payette County, ID and Malheur County, OR. The purpose of this study is to ask you some questions about yourself and your thoughts about developing a wellness center in your area. A wellness center is a center that offers educational programs, which promote spiritual, mental, and physical well-being in an effort to maintain a person's optimal health and performance.

We plan to enroll about 80 participants. Thank you for your interest and willingness to participate in our clinical project "Investigating the Implementation of a Rural Wellness Center." We look forward to in hearing from you as a way to evaluate interest in a rural wellness center.

PROCEDURES:
You will complete a survey questionnaire and mail the completed survey in a pre-addressed envelope to the researchers. There are questions regarding your general personal or work demographics and questions regarding what wellness programs you feel would be beneficial for community members.

RISKS AND DISCOMFORTS:

Before you agree to participate, it is important that you understand the following: (a) taking part in this study is entirely voluntary; (b) there are no risks anticipated for those who participate in this study and there is no cost to participants; (c) your participation is anonymous-so you will not be asked to provide any information that can identify you. Although we have made every effort

to protect your identity, there is a minimal risk of loss of confidentiality; (d) no responses obtained in this study will be reported as coming from an individual. The responses will be reported as a part of groups of people, so no individual can or will be identified; (e) we may present the results of this study at local, state, or national conferences or we may publish the results.
If you are a patient, completing or not completing the survey will not affect the regular care you receive.

BENEFITS:

There will be no direct benefit to you for participating in this study. However, by participating, you may help us to gain information that may benefit others.

ALTERNATIVES:

You may choose not to be part of this study; your decision will be anonymous.

CONFIDENTIALITY:

Research records may be reviewed and copied by the OHSU Institutional Review Board and the Office for Human Research Protections.

COSTS:

There is no cost to you for being in this study; you are offered no payment for your participation.

PARTICIPATION:

By completing and returning the survey, you are agreeing to participate in this study.

If you have any questions regarding your rights as a research subject, you may contact the OHSU Research Integrity Office at (503) 494-7887.

You do not have to join this or any research study. If you do join, and later change your mind, you may quit at any time. If you refuse to join or withdraw early from the study, there will be no penalty or loss of any benefits to which you are otherwise entitled.

The participation of OHSU residents or employees in OHSU research is completely voluntary and you are free to choose not to serve as a research subject in this protocol for any reason. If you do elect to participate in this study, you may withdraw from the study at any time without affecting your relationship with OHSU, the investigator, the investigator's department, or your grade in any course.

This Information Sheet is yours to keep.

VI. CIP Executive Summary

The Patient Protection and Affordable Care Act, (United States Congress, 2010) places emphasis on the health of all Americans including the prevention of diseases that have become chronic and endemic in the United States. Nurse practitioners (NPs) who take a proactive approach and employ disease prevention strategies which can be offered in wellness centers, have the possibility of improving the health of community members.

In this descriptive study, the doctor of nursing practice student surveyed patients, providers, and health care leaders living and working in rural Malheur and Payette counties. The participant demographic provides insight on the respondent's current health status and longevity in the rural communities where they live and work. Although the project sample size is small (n=52), this study provides information and insights on the participant's perspectives on the benefits, importance, and possible utilization of wellness programs. The patient participants have an average Body Mass Index (BMI) of 28.4 (overweight), however, in spite of their overweight status they report low primary and secondary diagnoses of diabetes, hypertension, and cardiovascular disease and appear to lack an understanding of the correlation of obesity and chronic diseases. With this knowledge, the investigator is able to plan future wellness education that targets the association of obesity to chronic disease.

Future research opportunities identified, may expound on the findings from this study. Utilizing a team approach could allow a more extensive investigation with the prospect of a larger sample size and a broader study. Additional opportunities for qualitative studies could provide outcomes that address patient, provider, and health care leader's individual perspectives that can be trended and analyzed in detail. Through these studies, future wellness programs may benefit rural populations at the local and national level.

Cynthia Reed, MSN, FNP-C

Doctor of Nursing Practice Candidate

Oregon Health and Science University School of Nursing