Public Health Initiatives within Continuum-care Facility

By

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A Field Experience Report

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Abstract

The focus of this experience was to provide a community with motivating factors and tools for health promotion. In the first phase of the experience, the student concentrated on public health promotion pertaining to residents and employees of Meadowlark Hills Retirement Community and residents of the surrounding Manhattan, Kan. area, by aiding in the coordination of a community-wide health and wellness fair. In the second phase of the experience, the student provided an environment where employees of Meadowlark Hills Retirement Community could participate in healthful lifestyle choices through development of a corporate fitness challenge. Lastly, the student developed, facilitated and continues to offer a dementia education and training session for direct-care employees of Meadowlark Hills.

The field experience contains a broad range of public health aspects and provides the opportunity to work with a variety of ages and health statuses of employees and residents of a retirement community, of which have a wide-spectrum of health concerns and areas of focus.

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Acknowledgements

To my parents, whose eternal support, unwavering love and willing sacrifices have opened doors I never thought imaginable. I hope I've made you proud.

To my siblings, the vastness of our differences has fostered the opportunity for me to become a cultured, enriched and independent person. I thank you for that.

To my fiancé, without your simple, yet unforgettable distractions - this report would have been finished in half the time. You make my life interesting.

To my Grandma Rall, my only wish in life is to have a family that is as devoted and everlasting as the one you have created.

Chapter 1 – Introduction

The core of public health can be defined simply by enhancing populations' ability to increase control over and improve their health. The basis for public health focuses on studying the risks involved with the health of populations then determining systems, policies and services to alleviate those risks by studying behavior theories and models of change (Contento, 2011). Sciences, such as epidemiology and biostatistics, help us to understand the risks to the health of populations.

The history of public health began long before it could be declared as a major at a university. Early public health initiatives are documented as far back as the bubonic plague epidemic. However unfounded the interventions to treat the plague may have been, those efforts were initiated to improve public safety. Similarly, the father of epidemiology, Dr. John Snow, played a vital role in public health initiative amidst the cholera outbreak in London in 1854. By pinpointing the largest incidence of cholera and removing the handle of the Broad Street pump, he simultaneously made a public health statement and helped to developed a science that would later be studied by many.

Public health initiatives have consistently been morphing and growing to meet the ever-changing needs of society, especially as we look back over the past century and have seen prevalence of diseases change drastically. The Centers for Disease Control and Prevention (CDC) is the nation's disease prevention and health promotion agency. The CDC concentrates on an array of health threats including chronic disease and occupational health.

Chronic diseases, such as heart disease, stroke, cancer and diabetes are the leading causes of death in the world, comprising of over 60 percent of all deaths (World Health Organization,

2013). Risk factors, including high-fat diet, physical inactivity or tobacco use, for these chronic diseases are preventable and minimized through behavior modifications. Supplying appropriate education and/or opportunity to avoid risk factors is one of the many techniques of promoting public health and preventing chronic disease.

It is important for students in public health fields to acquire experience and skills to effectively and ethically promote health. The student's public health field experience was completed at a retirement community in Manhattan, Kansas, Meadowlark Hills. A retirement community provides a channel for delivering health promoting programs to diverse populations, including high-risk individuals, the working cohort, and full-time students, working part-time. Not only are employees directly affected by their work environment, so too are the residents of the same community. For health promotion to be effective, it should be designed with the target audience in mind. An understanding of the recipients' health and social characteristics, beliefs, attitudes, values, skills, and past behaviors (AARP, 2009) is essential in delivering health promotion programs.

The field experience was divided into three main concentrations. The student assisted in the organization and facilitation of the community-wide wellness fair. Secondly, an employee wellness opportunity was developed to promote well-rounded diet and exercise regimens. Lastly, an employee training and education program that better equips employees to care for residents diagnosed with dementia, was developed and facilitated. The target audience of the field experience was a retirement community's employees and residents, two very different populations. The overall focus of this experience was to improve the availability of resources and provide education and foster opportunities to make informed health choices.

Goals and Objectives

1. Learn to organize and facilitate community wellness fairs
2. Experience the challenges and successes of recruiting for employee wellness programs and overall organization of health promotion programs
3. Improve skills in oral communication by facilitating employee training classes
4. Directly observe public health promotion, education and disease prevention
5. Enhance networking skills among professional acquaintances
6. Improve written communication skills by creating health packets, vendor packets and advertising tools
7. Seek the correlation and practical use of core classes and electives of the Masters of Public Health Program and field experience

Activities performed to fulfill objectives

1. Facilitate, organize and work the community wellness fair
2. Develop, initiate and facilitate employee fitness challenge
3. Promote and recruit for the employee wellness opportunity
4. Determine winners by calculating self-reported data for employee fitness challenge
5. Develop and initiate dementia training for caregivers associated with Meadowlark Hills
6. Evaluate overall experience

Chapter 2 - Background

Framework

Successful interventions related to public health need a framework in behavior change theories and models. Models are important in public health because they help to design interventions and evaluate if interventions are being effective. Behavioral theories including the Social-Ecological Model, Health Belief Model and the Transtheoretical Model are ideal when attempting community-focused interventions (Contento, 2011).

The Social-Ecological Model can be used as a framework in prevention strategies at varying levels. There are two key concepts of the Social-Ecological Model. Behavior affects, and is affected by, multiple levels of influence; individual behaviors shape, and are shaped by, the social environment (McLeroy, 1988). Hence, the five levels of the Social-ecological Model are: intrapersonal, interpersonal, organizational, community and public policy. This model emphasizes the importance of social and physical environments that shape health patterns (McLeroy, 1988).

The Health Belief Model explains how people's behaviors are influenced by personal beliefs and perceptions of their own health and wellness. Personal perceptions form by the severity of the illness, susceptibility of the individual to the disease and threat to the negative health outcome (Contento, 2011). In the simplest description, the Health Belief Model states that people's beliefs influence their actions, especially when it comes to health behaviors (Contento, 2011).

The Transtheoretical Model is a behavioral change model that explains an individual's readiness to adopt a positive behavior through five basic stages and the corresponding processes

of change. The five stages of change are precontemplation, contemplation, preparation, action and maintenance. In the first stage of change, precontemplation, the individual lacks ownership or responsibility over the health behavior and exhibits no intention to change. A person in the second stage, contemplation, has identified a behavior to be negative and is considering changing this behavior or adopting a new behavior to improve wellbeing. An individual has entered the preparation stage, the third stage of change, when the decision to make a change has been made. This is when the individual's perception of benefits outweighs the barriers to change and he/she begins to develop a plan. The person has entered the action stage when true change has occurred. After the change has been adopted into the person's lifestyle for six months, they have entered the final stage of change, maintenance. However, the last stage of change is not absolute with the persistent threat of relapse (Prochaska, J.O. et al. 1992). The Transtheoretical Model is not linear, as many people cycle through the stages of change or skip stages all together (Prochaska, J.O. et al. 1992).

Interpreting a model is only the first step in identifying opportunities for intervention. Understanding models in behavior change is not enough; as public health professionals, we also know how to apply this model, by developing an approach focused on the target audience and their current stage of change and perceptions.

Demographic and health of older adults (age 65 years and over)

Never before have populations lived for so long. Consequently, the total population of older adults has increased to record numbers. The 2010 census indicated there were more people age 65 years and over than in any other census (U.S. Census Bureau, 2011). The increase in the aging population is evidenced by comparing the number of older people (age 65 and over) in the

past to current numbers. In 1900, the United States was inhabited by 3.1 million people aged 65 and over and has steadily increased to reach its all-time high level of 40.3 million in 2010 (see Figure 1) (U.S. Census Bureau, 2011). The percentage of the older adult population comprising the total population has been trending upward, as well. In percentage of total population, older adults have increased from 4.1 percent in 1900 to 13.0 percent in 2010 (U.S. Census Bureau, 2011). In 2011, adults that reached the age 65 had an average life expectancy of an additional 19.2 years (20.4 years for females and 17.8 years for males) (Administration on Aging, 2013).

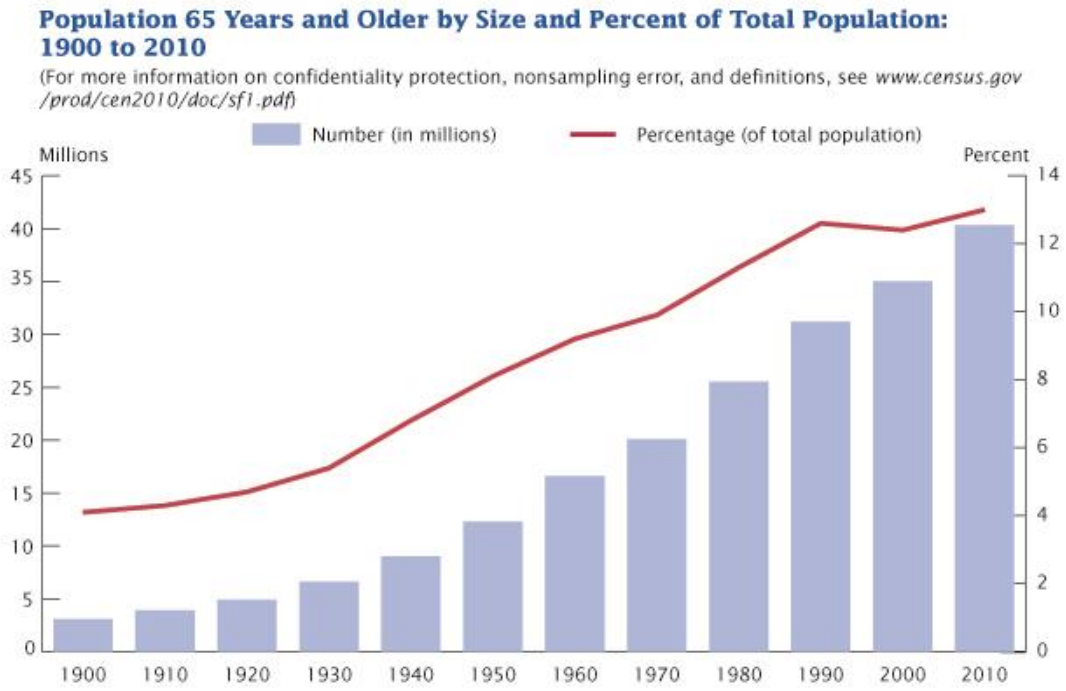


Figure 1: Population 65 Years and Older by Size and Percent of Total Population: 1900-2010, 2011

Source: U.S. Census Bureau, decennial census population, 1900 to 2000; 2010 Census Summary File 1.

In 1900, the leading causes of death were tuberculosis, pneumonia, diarrheal diseases and enteritis; by 1946, the leading causes of death were heart disease, cancer and forms of accidental death (Scutchfield & Keck, 2003). This transition came from the discovery that the major causes of death were the result of microorganisms and poor sanitation. This understanding led to prevention strategies focusing on public health policy and laws to protect entire communities (Scutchfield & Keck, 2003).

Currently, the major causes of death and morbidity are chronic disease. In 2005, 133 million Americans had at least one chronic disease (Wu & Green, 2000). Chronic diseases are long-term illnesses that are rarely cured but highly preventable (Federal Interagency Forum on Aging Related Statistics, 2012). Causation can be attributed to many factors. A combination of genetic, environmental and lifestyle factors contribute to a person's predisposition to chronic disease. Lifestyle choices such as the use of tobacco, excessive use of alcohol, unhealthful dietary patterns and sedentariness are risk factors that are avoidable and often result in premature death or disability and compromised quality of life (Rosner, 1994). Environmental and lifestyle factors are potentially controllable by individuals or society and contribute to 70 percent of premature mortality in the United States (Rosner, 1994). Behavior change occurs when an individual has willingness to change and belief that their own actions affect them directly (Contento, 2011).

Longevity and Quality of Life

After discussing the aging demographic of the country, it is imperative to include the elderly and aging population in the public health initiative, as evidenced by the growing number and complexity of their needs. There is not a precise definition of quality of life; however quality

of life will always be related to the situation perceived by the individual according to their environment (Romero, 2013). Health Related Quality of Life (HRQoL) encompasses the concept of situational measures of physical and mental health, according to the CDC (Centers for Disease Control and Prevention, 2014). The goal of public health, in respect to aging, is to increase self-reported measures of HRQoL indicators (Romero, 2013).

Longevity would be considered desirable if the majority of that time was not spent in ill health or plagued by chronic disease. About one-fourth of people with a chronic condition have one or more daily activity limitation (Anderson, 2004). Among the most common chronic diseases are heart disease, stroke, cancer and diabetes which contribute to the decline in functioning and ability to live at home in the community (Federal Interagency Forum on Aging Related Statistics, 2012). Results of a survey taken that asked people to rate their health as excellent, very good, good, fair, or poor, indicated that 76 percent of people age 65 and over rated their health as good, very good, or excellent (Federal Interagency Forum on Aging Related Statistics, 2012). However, in 2009, about 41 percent of people age 65 and over enrolled in Medicare reported a functional limitation (Federal Interagency Forum on Aging Related Statistics, 2012). Approximately 25 percent had difficulty with at least one activity of daily living and four percent were living in a healthcare facility (Federal Interagency Forum on Aging Related Statistics, 2012).

Older age is associated with increased morbidity rates from chronic disease (Rowe & Kahn, 1998). However, modifiable behavioral factors can be protective of quality of life and functionality seen in the elderly (Seeman & Chen, 2002). Additionally, behavioral interventions can influence levels of functioning, independent of the presence of chronic conditions (Seeman

& Chen, 2002), benefits that can be hopeful for those with existing chronic conditions and for those experiencing the aging process.

Leading Causes of Death

Cause of death varies greatly when divided into by age quartiles (see Figure 2). External forces, such as accidents, homicide, or suicide are leading causes of death in ages one to 24. As age increases, the cause of death shifts from external forces to chronic diseases. From the previous facts, chronic disease should be a great concern to the population, young and old. Preventative efforts must be addressed throughout life.

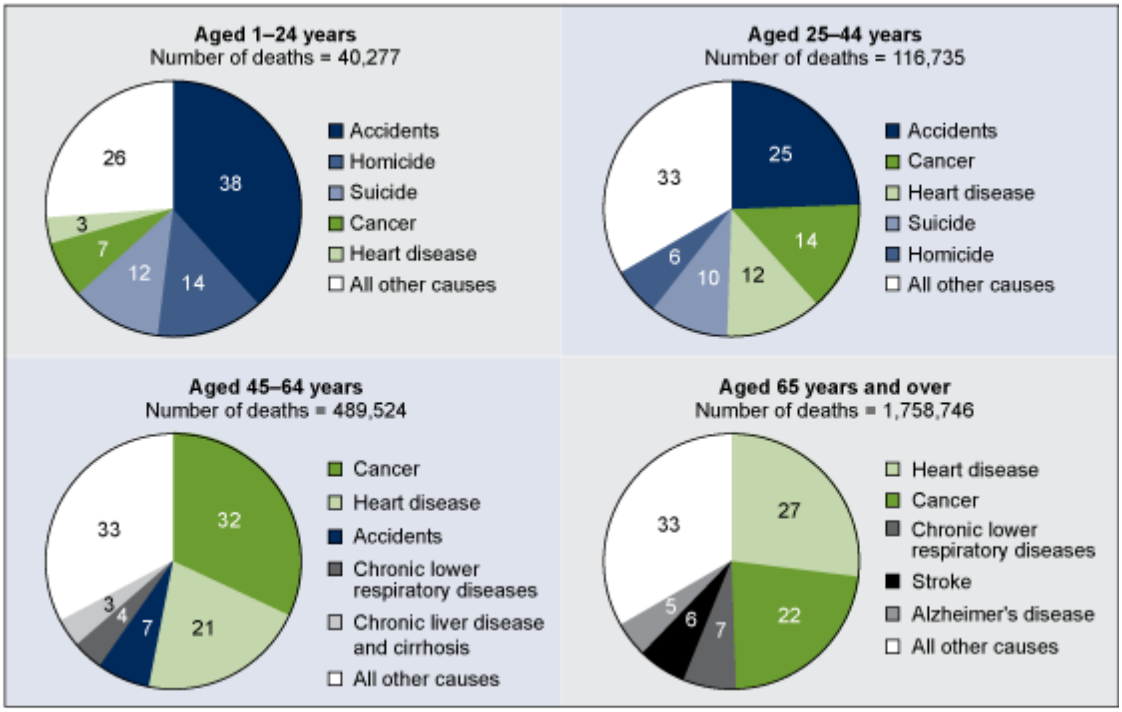


Figure 2: Percent distribution of five leading causes of death, by age group: United States, preliminary 2009

Source: CDC/NCHS, National Vital Statistics System, Mortality.

Health care vs. Health

The increasing population will add pressure to our healthcare delivery system (Rosenthal, 2003). The oldest members of the generation of individuals born between the years of 1946 and 1964, often referred to as the "Baby Boomers," have begun entering the older adult cohort. It is important to meet the needs of this growing cohort, yet current long term care systems are inadequately prepared to meet the diverse needs of the increasing population (Guo & Castillo, 2012).

The magnitude of the aging population isn't the only hurdle in the health care system. The United States ranks second in the world in health care expenditure, at 17.9 percent of gross domestic product in 2010 (Central Intelligence Agency, 2013). Despite spending enormous sums on health care, Americans are less healthy than their counterparts in other developed countries (National Research Council, 2013).

The nation lacks focus on prevention of disease. Our health care system targets people who are ill and overlooks preventative care, as evidenced by 75 percent of our health care dollars going to treatment of chronic disease (CDC, 2014) instead of prevention of chronic disease. In short, our health care system is not designed to prevent chronic illnesses. However, preventing chronic diseases, in large populations, such as reducing blood pressure, blood cholesterol and monitoring blood glucose can dramatically reduce health costs. (Food and Agriculture Organization, 2003).

As a nation, we can become healthier and drive down health care costs with government-supported public health efforts that embrace prevention as a priority. Laws under the Affordable Care Act, which include the Prevention and Public Health Fund, support prevention and wellness

efforts. The major prevention provisions include waiving cost sharing for preventative services and screenings such as blood pressure and cholesterol tests, mammograms, colonoscopies, vaccines and tobacco use screening and interventions (Haberkorn, 2013). Other prevention provisions include providing new funding for community preventive service and creating workplace wellness programs (Haberkorn, 2013). Likewise, the national objective, "Healthy People 2010" and "Healthy People 2020," provide objectives based on established benchmarks to improve the health of all Americans (Healthy People, 2014). These and other government supported public health initiatives can benefit the nation's health status my encouraging healthy collaborations, empower the individual toward making educated decisions in regard to health and measuring the effectiveness of prevention strategies (Healthy People, 2014).

Accessibility of resources within a continuum-care facility

The adequacy and availability of services available for the aging community is important to consider (Mueller & MacKinney, 2006), especially those living in retirement communities. Accessibility to health care, therapies, exercise outlets, education, broad and nutritious food choices, social interactions and other resources is imperative to achieving optimal health (Mueller & MacKinney, 2006). Other services provided through residency may include meal preparation, laundry and cleaning services, and help with medication administration or preparation. Availability of such services through the place of residence may help older Americans maintain their independence and avoid increased institutional care (Federal Interagency Forum on Aging Related Statistics, 2012). In 2009, about three percent of the Medicare population age 65 and over resided in community housing which provided at least one of these services (Federal Interagency Forum on Aging Related Statistics, 2012). Among residents of community housing with services, 84 percent reported access to meal preparation

services; 80 percent reported access to housekeeping/cleaning services; 73 percent reported access to laundry services; and 48 percent reported access to help with medications (Federal Interagency Forum on Aging Related Statistics, 2012). Continuum care services should be all-encompassing, where nursing care makes up only one aspect of the needs of the individual, and emphasis should be placed on non-medical factors such as social support and residential services (Guo & Castillo, 2012).

Workplace health promotion programs

The workplace is regarded as a suitable environment to target employees in promotion of healthy dietary behaviors (Chu, Breucker, & Harris, 2000). The worksite has been suggested as a potentially effective setting for improving health decisions for a variety of reasons. First, targeting a workplace population will encompass diversity of social classes, age groups and gender (Chu, Breucker, & Harris, 2000). Corporate-based wellness programs have the opportunity to reach a great deal of people. Organizations possess the ability to create an environment that offers wellness support due to their pre-existing communication channels and social networks (Chu, Breucker, & Harris, 2000).

As many Americans spend a major portion of their day at work, it is fitting that the workplace can function as a setting for a health promotion opportunity. Effects of worksite health promotion programs have been shown to reduce tobacco use, dietary fat consumption, blood pressure, total serum cholesterol levels and absenteeism due to disease or disability while improving worker productivity and morale (Goetzel, 2008).

According to the World Health Organization (WHO), the workplace, along with other institutions such as schools, universities and hospitals have been established as priority settings

for health promotion. A health promotion program in the workplace puts an emphasis on improving the organization and environment by increasing control and self-efficacy, by allowing employees to participate in enhancing the health culture (Administration on Aging, 2013). Evidence indicates that workplace health promotion programs have improved overall health (Hutchinson & Wilson, 2012) and increased physical activity of participants (Conn, Hafdahl, Cooper, Brown, & Lusk, 2009).

A retirement community is a complex facility to target employees for improved diet choices because the food that is produced and offered within a nursing home is intended for elderly residents, who are at increased risk of weight loss. Calories are often added to meals to maintain or increase weight of weight-loss prone residents. Many employees depend on the workplace to provide daily meals (Lachat, Roberfriod, Huybregts, Van Camp, & Kolstern, 2009). In a retirement community, this can be a dangerous combination for employees. These employees may unintentionally consume excessive calories in this scenario. Changing the meal plan of a retirement community is not a feasible option. However, an alternative may be to offer a low-calorie option for all employees at meal times, even though this may be costly. Another option would be to offer nutrition education or a wellness program to the organization, which may be more cost-effective for the company.

Health promotion programs may include nutrition education, personal goal-setting, change of environmental or social factors, availability of an exercise facility, accessibility of healthful foods, food preparation demonstrations, support groups, meal planning and a reporting procedure. Technology can be used in health-promoting programs such as social media, online nutrition and calorie references, online exercise and energy expenditure logs and recording

devices such as a pedometer or watches or bracelets that utilize global positioning system to track activity.

While there are costs associated with offering a health promotion program within a corporation, there are several benefits for employers. Even programs that have very little cost associated with implementation have been effective at multiple levels. For example, *Trust for America's Health* estimates that an investment of $10 per person per year in community-based programs, focused on combating issues from physical inactivity, poor nutrition and smoking, could yield more than $16 billion in medical cost savings annually (Trust for America's Health, 2008). Cost saving may be attributed to reductions in health care costs and decreased employee turnover; however, other beneficial factors employers may experience include decreased absenteeism, increased work productivity and morale and an enhanced organizational image in the community (Bulaclac, 1996; Steinhardt & Carrier, 1989).

The site

Meadowlark Hills Retirement Community (MLH), founded in 1980, is a not-for-profit continuum-care facility that offers lifestyle choices on all care levels including independent living, assisted living, healthcare, skilled nursing, specialized care, transitional care, rehabilitation services and home health services. MLH, an interdenominational retirement community sponsored by the Manhattan Retirement Foundation and founded with the involvement of six Manhattan churches, employees over 400 full-time, part-time, as-needed and contracted employees. MLH provides quality, person-centered care to residents by investing in training and education for all employees.

According to a survey of older persons by the American Association of Retired Persons (AARP), the majority would prefer to live in their own homes for as long as possible (AARP, 2009). The Centers for Medicare and Medicaid Services (CMS) added a set of quality ratings for nursing homes, called the Five-Star Quality Rating System. The system rates facilities on three domains: health inspection surveys, quality measures and staffing levels (Abt Associates, 2013). Overall rating of Meadowlark Hills in the CMS Five-Star Quality Rating Systems was five stars (CMS, 2013). A meta-analysis found that not-for-profit nursing homes, like Meadowlark Hills, generally deliver higher quality of care (Comondore et al., 2009).

The uniqueness and diversity of the community in which the field experience was conducted created a fantastic learning environment. Residents of a retirement community are prime targets for public health initiatives. The Health Belief Model suggests that a person needs to be motivated to take action to improve health. A person who believes they are personally susceptible or vulnerable to a certain disease can be more easily motivated to make changes to promote or prolong health (Contento, 2011). This statement makes the older population cohort a great place to initiate public health interventions because they are more easily set in motion (Contento, 2011).

A retirement community is an interesting place to conduct a public health promotion program because employees (caregivers) directly affect the wellness of residents. Therefore, an employee-focused initiative can go full-circle and affect the entire community. For instance, improving the understanding of caregivers to better provide care for residents, especially those afflicted with dementia, will reduce caregiver burnout and increase quality of care received by residents (Takai, Takahashi, Iwamitsu, Ando, Okazaki, Nakajima, Oishi, & Miyaoka, 2009).

Chapter 3 – Field Experience

Health and Wellness Fair

The Health Belief Model is based on health views that govern an individual's perception of their own personal relationship to a particular disease (Contento, 2011). The beliefs include: personal susceptibility, severity of the disease, perceived efficacy of the behavior and barriers to adopting the behavior. Beliefs and perceptions can have direct effects on behavior.

According to the first view of the Health Belief Model, adolescents may feel invincible, especially to the subject of chronic disease; however older adults feel more vulnerable to chronic disease and may initiate an action to be taken (Contento, 2011). This makes a retirement community a prime opportunity to offer health behavior recommendations, especially to combat conditions to which residents feel susceptible to. Providing information or resources may help the individual increase self-efficacy toward making a health behavior change (Contento, 2011). According to the Transtheoretical Model, it can be assumed that Wellness Fair attendees are in the contemplation or preparation stage of change (Contento, 2011). Individuals in these stages of change are ideal targets of a wellness fair because of they are close to the threshold of change (Contento, 2011).

According to the Social Ecological Model, wellness fairs are characterized into the "organizational" level of support (Contento, 2011). Meadowlark Hills, as an organization, implemented the annual community-wide wellness fair. Offering education and resources at one communal event is an effective delivery method to reach large audiences. The type of education and resources available must match the target audience. Hosting a health and wellness fair at a retirement community needs to largely focus on chronic disease awareness, education on

diseases associated with the aging population and resources to manage functional losses of the aging process.

The Department of Health and Human Services has identified three separate categories of older persons:

1. Entering old age - Usually between the age of 50 years and the official retirement age, nearing the conclusion of their work experience and/or have raised their children to adulthood.
2. Transitional phase – Usually between the ages of 70 to 80 plus, within the transition between active lifestyle and frailty.
3. Frail older people – Usually over the age of 80 years, defined by vulnerability as a result of health problems such as dementia. These individuals are in need of institutional care.

The demographics of residents of Meadowlark Hills are illustrated by Figure 3, with the majority of residents categorized as the frail older person. However, this population group differs from the national norm as 49 percent continue to live independently through MLH's independent living apartments (Figure 4). A probable explanation is that residents have resources and services readily accessible to them to postpone the need for increased institutionalization.

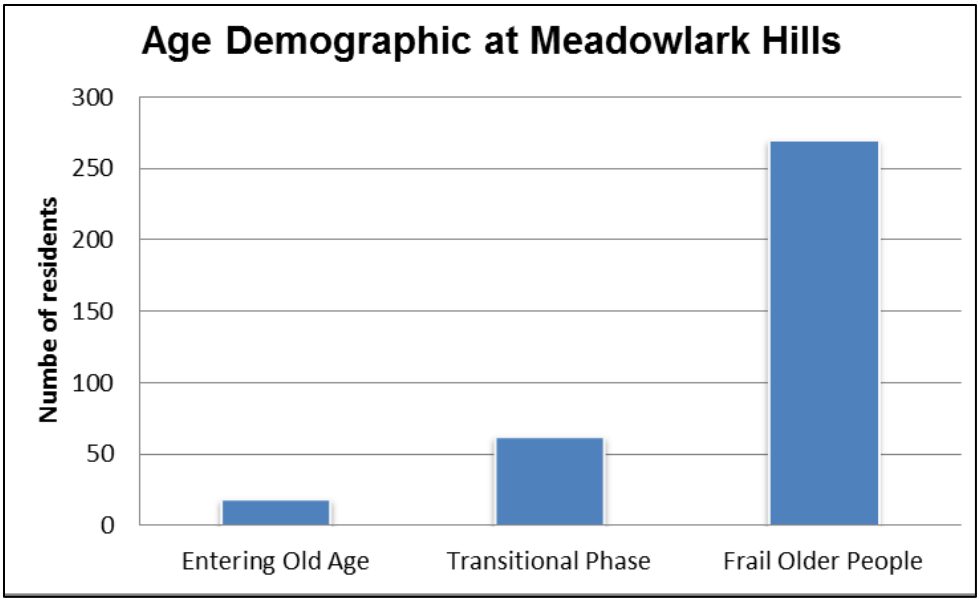


Figure 3: Age Demographic at Meadowlark Hills, 2014

Source: Adapted from Meadowlark Hills census reports

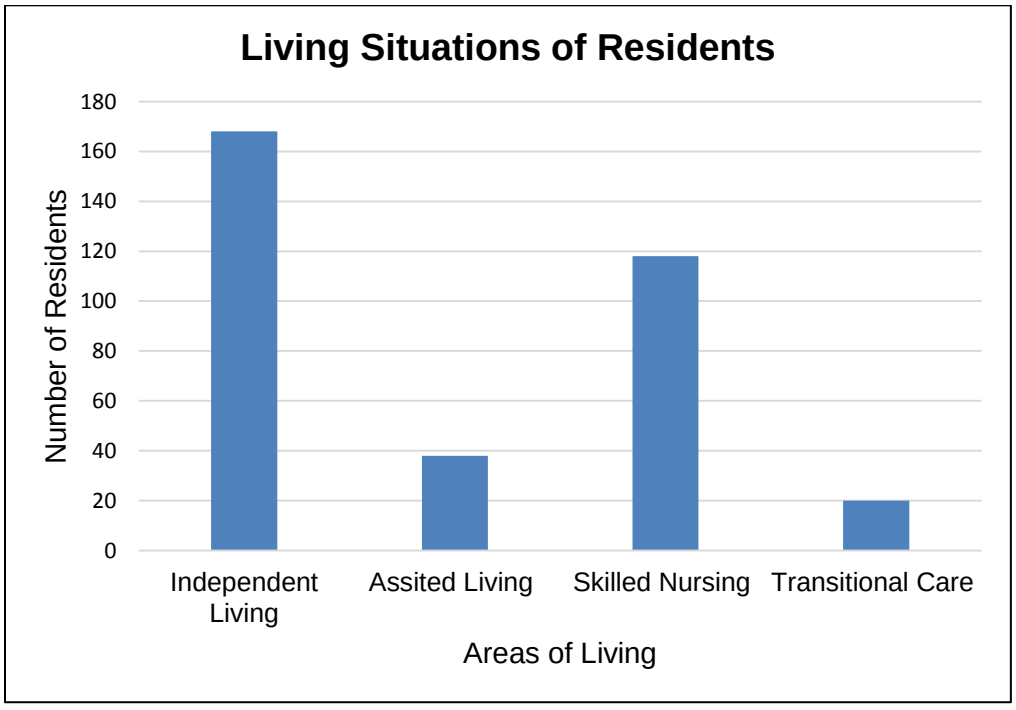


Figure 4: Living Situations among Residents

Source: Adapted from Meadowlark Hills census reports, 2014

Consequently, when addressing public health issues within the older population, a professional must recognize the population as heterogeneous. Older populations may be the most diverse group within the age demographic and experience complex personal, social and health care needs (Reed, Inglis, Cook, Clarke, & Cook, 2007). It is also important to recognize that when targeting older populations for health promotion, the professional needs to work to identify and acknowledge the health beliefs, values, feelings, attitudes and priorities. By first addressing these values, the public health professional can help set realistic and achievable health care goals or help to maintain health. For example, it would not be a priority within the target population of a retirement community to promote breast feeding. A better aim for public health initiative in the older population is prevention of morbidity or disability in order to enhance quality of life (Reed, Inglis, Cook, Clarke, & Cook, 2007).

The 2012 Meadowlark Hills Community-wide Wellness Fair was open to Meadowlark Hills' residents, employees and the surrounding community. The main focus of the fair was dedicated to resources for aging well. However, employees could benefit from the programs at Meadowlark Hills that are available to them, such as the fitness services (exercise groups, personal training sessions and Caul Fitness Center) or employee wellness program.

This experience provided the student opportunity to learn, from a methodical standpoint, the logistics of facilitating a wellness fair. From a public health standpoint, the experience helped to developed further understanding of how providing resources and alternative thinking patterns can improve the health quality of a community. In the role of administrator, the student was responsible for communications with the internal and external vendors before, during, and after the health fair, greeting and registering each vendor that attended the health fair and paperwork management.

The student's initial work with the Community-Wide Wellness Fair began by learning more about the Meadowlark Hills Wellness Partners, a division of Meadowlark Hills Retirement Community focused on providing health and wellness opportunities that encompasses all facets of an individual's wellness. The Wellness Partners are focused on assisting individuals in the aging process by providing a proactive, preventative vision of health and wellness. Services are designed to promote healthy aging, stabilize chronic diseases and provide resources to improve quality of life.

Meadowlark Hills identifies all areas of wellness as playing a role in the individual's holistic health. This is evidence by providing an on-campus physician and clinic, routine dental hygiene clinics, routine podiatry clinics, weekly blood pressure clinics, nutritional therapy, immunization clinics, hearing aide check-ups, physical therapy, speech therapy, occupational therapy, support groups, educational seminars and forums, book clubs, bible study, common interest groups, financial planning support, volunteer opportunities, religious worships and countless social gatherings. The annual Community-wide Wellness Fair offers education on internal opportunities, as well as, external resources from the surrounding community. Vendors of the wellness fair had the opportunity to offer health education and an avenue to showcase resources to meet the needs of holistic health initiatives.

At the initiation of the field experience, the Wellness Fair committee had already solicited potential vendors. The student's responsibilities included: follow-up phone calls to vendors, accountability for vendors' registration process, contact lists and development of a vendor information packet. The packet included a cover letter, map of the facility, layout of Wellness Fair, suggested items to bring and history of Meadowlark Hills (see Appendix A). Another responsibility was to create place cards for every vendor. The place card had the

organization's name and the suggested "Pillars of Wellness" correlated to that specific vendor (See Appendix B).

The Wellness Partners of Meadowlark Hills utilized a program called "Pillars of Wellness." Among the pillars are physical, emotional, spiritual, financial, stewardship, intellectual, social, cultural, occupational and environmental health. Wellness fair attendees were asked to complete a survey that asked them to rank their security of each area of wellness on a scale of green, yellow or red representing the extent or strength of one's wellness (see Appendix C). The survey indicated that attendees are least secure about their physical health (see Figure 5). This exercise helped the individual identify areas of additional emphasis needed at the wellness fair. For instance, if they listed financial as an area of concern (red) they could visit the vendors that aid in financial wellbeing.

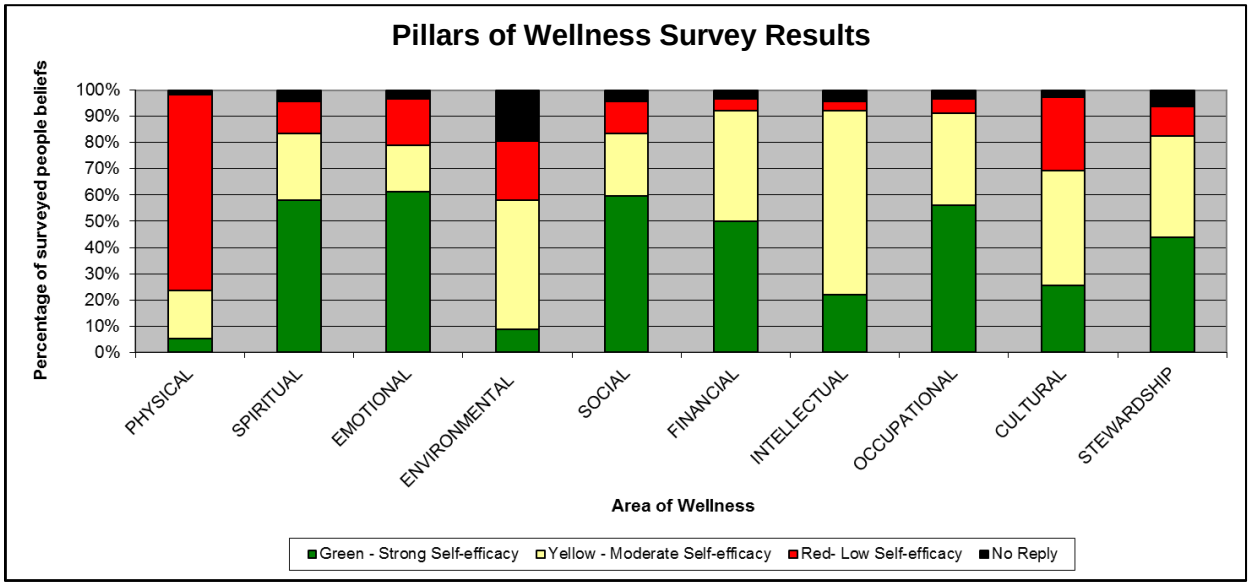


Figure 5: Pillars of Wellness Survey Results

Data Source: Survey at 2012 Wellness Fair, Meadowlark Hills

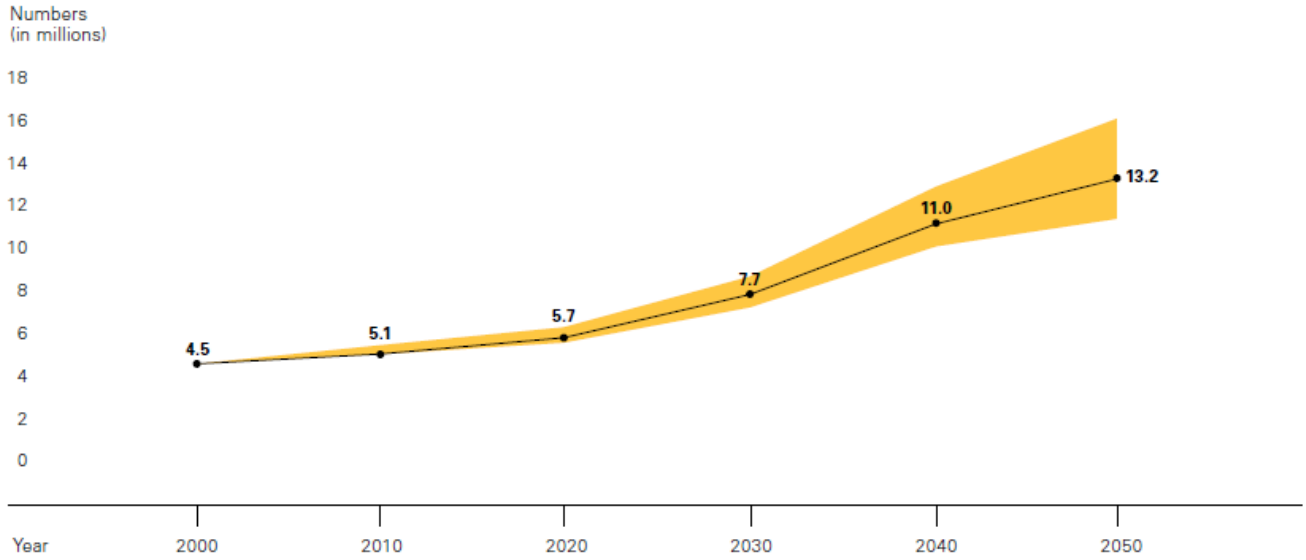
As we have seen through the Health Belief Model, beliefs can influence behavior. In addition, the Theory of Planned Behavior has shown us that individual motivation and attitude influence behavior (Contento, 2011). Attitude can be defined as the negative or positive response to a situation. At the conclusion of the wellness fair, participants were asked to fill out a satisfaction survey (see Appendix D). The results of the survey indicated overall satisfaction of with the wellness fair.

Dementia education & training for the direct-care providers

Dementia is a group of symptoms characterized by loss of core abilities, caused by nerve cell death or malfunction (Alzheimer's Association, 2014). This decline will eventually interfere with daily functioning and is often complicated by the presence of additional abnormalities of mood, perception and behavior. Co-symptoms include anxiety, depression and memory loss (Greening, Greaves, Greaves, & Jolley, 2009). One in 100 people are diagnosed with some form of dementia, while one in eight older Americans have Alzheimer's disease, the most common form of dementia (Greening, Greaves, Greaves, & Jolley, 2009). As our population ages, the incidence of dementia will progressively increase (see Figure 6).

Age is an important determinant of having dementia as indicated by the majority of individuals diagnosed being over the age of 65 years (Miniño, 2010). It is important to note, however, that dementia is not a normal part of aging (Alzheimer's Association, 2014). Genetic inheritance is another factor, especially for early onset dementia (Alzheimer's Association, 2014). Individuals with the Sigma-4 form of the gene apolipoprotein-E are at increased risk of developing Alzheimer's disease (Alzheimer's Association, 2014). Other risk factors include

hypertension, diabetes, smoking, obesity and hyperlipidaemia, incidence of head trauma, and excessive use of alcohol and other substance abuse (Alzheimer's Association, 2014).



Numbers indicate middle estimates per decade.

Colored area indicates low and high estimates per decade.

Figure 6: Projected Numbers of People Age 65 and Over in the U.S. Population with Alzheimer's disease

Source: http://www.alz.org/downloads/facts_figures_2012.pdf

The changing nature of health care delivery system has stimulated greater emphasis on health education and provider-focused quality improvement strategies (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007). In industrialized countries, approximately 60 percent of all residents in nursing facilities have some type of dementia (Weyerer & Schäufele, 2004). Difficulties arise when caring for a person with dementia due to communication problems between the caregiver and the person with the disease (Hagen & Sayers, 1995). Depression, feelings of burden and caregiver stress are common and serious health problems seen in caregivers of people with

dementia (Guo & Castillo, 2012). Training support and education for caregivers are important in providing quality dementia care. Caregivers specifically trained in dementia are better equipped to care for an adult with dementia, by increasing their level of care competency (Kuske et al., 2009) and improving their communication strategies (Haberstroh, Neumeyer, Krause, Franzmann, & Pantel, 2011). A trained caregiver can ultimately improve the quality of life of their care recipients through improved communication and social interaction (Haberstroh, Neumeyer, Krause, Franzmann, & Pantel, 2011). Additionally, providing a dementia training program reduces the feelings of caregiver burnout (Gavrilova et al., 2009).

According to the Social Ecological Model, in-services and training programs are characterized into the "organizational" level of support. The public health student developed a training program for caregivers (Certified Nurse Aides, nurses, companions, chaplains, etc) of Meadowlark Hills who specifically care for or interact with residents with dementia, providing them with knowledge, skills, attitudes and applicable interactions and intervention techniques. The program development began with a prototype of a three-phase course with the following objectives: (1.) introducing caregivers to the struggles and everyday hardships faced by people with dementia in hopes of developing empathy; (2.) followed by behavioral understanding; (3.) communication techniques.

The first phase of the training utilized a dementia sensitivity program called The Virtual Dementia Tour created by P.K. Beville., which uses simulations to experience the age-related medical conditions, physical and mental challenges of dementia. The Virtual Dementia Tour provides staff with a better understanding of the difficulty of confused persons with dementia than traditional classroom-setting trainings (Beville, 2002). Results from the simulation indicated that caregivers have lack of understanding of the limitations facing persons with dementia which

often lead to agitation between staff and residents that could potentially result in unnecessary medication use (Beville, 2002).

The Virtual Dementia Tour begins with a pre-test (see Appendix E) to evaluate the participants understanding of dementia, empathy for the person with dementia and stress level. The participant is dressed in the following sense-depriving clothing: latex gloves followed by gardening gloves, goggles, hard rubber insoles and noise canceling head-set. Each piece of clothing is intended to sensitize the participant to the common functional losses of dementia or other limitations of aging. For instance, the double gloves are meant to simulate the loss of tactical sensation and fine motor skills, making it difficult to feel hot or cold, trouble buttoning a blouse or using eating utensils. The lenses of the goggles were darkened with a minimally translucent yellow paint. This illustrates the aging eye and the need for increased illumination compared to a younger eye. The goggles' central vision was also impaired by a round sticker. This simulates macular degeneration, the age-related eye condition that reduces the central visual field. The insoles that the students are asked to wear in their shoes simulates discomfort from poor circulation or from sedentary lifestyles. It could also simulate tingling from peripheral neuropathy, commonly associated with age. Lastly, the head phones constantly steam muffled noises and background chatter to confuse the participant and simulate the inability to concentrate, often seen in people with dementia. This also demonstrates partial hearing loss. After the student is dressed in the sensitizing articles of clothing, they are asked to complete a variety of activities of daily living. They are observed by the training instructor but no further instruction is given during the simulation.

Following the sensitizing activity, the participant is asked to complete a post-test and asked to refrain from discussing their experience until everyone has the opportunity to complete

the activity. The results of the pre-test and post-test indicated participants showed an increase in anxiety following the activity and decrease in ability to perform simple tasks during the activity. Figures 7 and 8 display notable results from the pre-test and post-tests from the sensitizing activity. These results show that following the sensitivity activity, the student better understands the emotional needs of persons with dementia and the students feel people with dementia are more justified in inappropriate behaviors they may be expressing. This experience creates an increase understanding of the disease and fosters empathy for the resident; hopefully leading to a more patient and informed caregiver that will experience less feelings of burden.

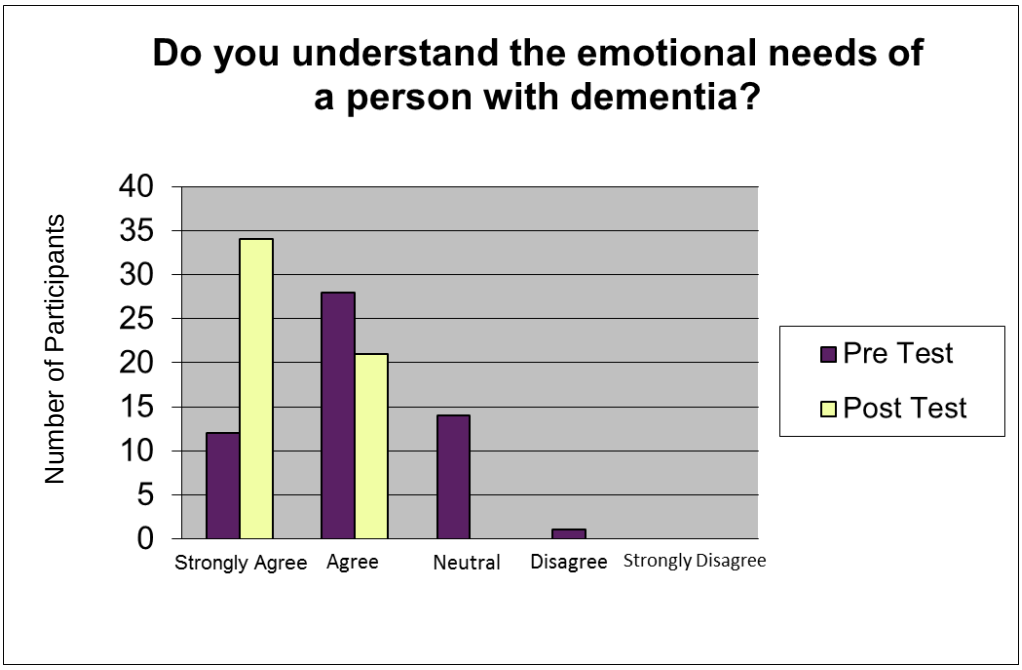


Figure 7: Results of pre-test and post-test – Emotional Needs

Source: Adapted from survey of employees in dementia training for the caregiver at Meadowlark Hills

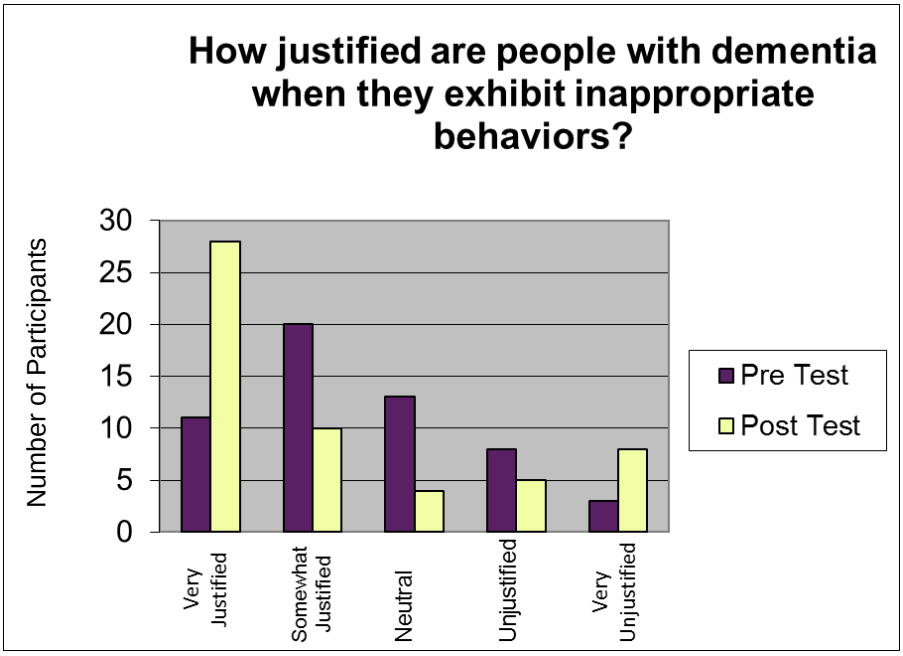


Figure 8: Results of pre-test and post-test – Justification of Behavior

Source: Adapted from survey of employees in dementia training for the caregiver at Meadowlark Hills

The second portion included an open discussion session where participants could express how the sensitivity activity affected them. Some responses to the activity include: "It truly impacted me and now I understand how dementia can affect your everyday life, the way you think and act;" "The activity made me very anxious and irritated because I was unable to carry out simple tasks or remember what was asked of me."

The last portion included a lecture that delineated practical skills to utilize in caregiving situations. The seminar was concluded with an overall evaluation. Through the training process we hoped to see that specific education and intervention procedures coupled with sensitivity and awareness activity would result in an enhanced work environment by adding applicable skills to use in the caregiving process. The evaluation of the seminar indicated that participants felt

increased empathy and understanding of demented persons. Despite the short duration that the education has been available for retirement community employees, positive indications have been seen through increasing employee morale seen in the follow-up interviews. Further work is needed to reveal the extent to which caregivers need to be trained in dementia-care.

Corporate Fitness Challenge

The purpose of this field experience was two-fold. First, the experience allowed the student to understand and implement practical and theoretical material taken from the classroom to a professional setting while experiencing the challenges and successes of recruiting for employee fitness programs. The second purpose of the fitness program was to provide participants with the necessary tools to increase self-efficacy and motivation to meet their goals within the corporate fitness challenge. For this portion of the field experience, the student is referred to as the "Challenge Coordinator."

Health behavior change programs require an understanding of the components of theory-driven interventions. There have been many theories and models used to design behavioral and social focused programs. The Health-Belief model is based on the concept that a person's awareness of health risks will increase the likelihood of adopting a desired behavior. Based on this model, the fitness program should be initiated by an assessment of employees' perception of susceptibility to disease and their personal beliefs that adopting a desired lifestyle choice would benefit them.

The Classic Learning Theory emphasizes that reaching a particular goal is achievable by modifying small behaviors. Behaviors that are steps toward a final goal are initially set with rewards for small accomplishments along the way.

The Social-Ecological Model explains that behavior change is affected by social surroundings at varying levels. These levels include individual, interpersonal, community, organizational and societal factors. The Transthoretical Model for behavior change is also important in beginning a health promotion program in an organization. The Transtheoretical Model is an assessment of the individual or organizational willingness and acceptance for behavior change. The stages of behavior change include precontemplation, contemplation, preparation, action and maintenance or relapse. Perceptions of individuals and leaders of the organization were explored before the health promotion program was initiated. The previously stated models were used in assessment, development and facilitation of the fitness challenge.

Although the mission of Meadowlark Hills is to enhance the quality of lives of residents of the community, there is concern for health of employees, as well. The health-consciousness is supported by the physical environment, leaders in the organization and community mind-set. The physical attributes of MLH that support healthy living are an on-site fitness center, walking trails and sidewalks that interconnect areas of the 55 acre plot and a large community space that is often utilized for group-fitness classes and trainings. The organization also supports employee and resident health, wellbeing and fitness through the employment of the Fitness Leader, personal trainers and massage therapists. Finally, MLH offers a year-round benefit package that includes an Employee Wellness Program. This program is based on awarding healthy behaviors with points and redemption of points used to financially support other healthy behaviors. For instance, an employee that uses the fitness center at least three times a week will be awarded one point for that behavior that can be later redeemed to pay for a massage. The Corporate Fitness Challenge in conjunction with the other forms of support, enhance Meadowlark Hills awareness of health.

A preliminary survey was conducted among employees at Meadowlark Hills (see Appendix F) in an effort to tailor the Corporate Fitness Challenge to the needs and interests of the population. The surveys indicated that employees were open to the idea of joining a team for fitness competition. This reveals that employees could be considered in the contemplation or preparation stage of behavior change. The drive to make a lifestyle change may have been due to consideration of their susceptibility to obesity, heart disease or a number of other diseases that are attributed to a sedentary lifestyle or poor eating habits.

The survey helped to identify the perceived barriers to participating in or adhering to a corporate fitness challenge. The barriers identified from this population were lack of time or motivation to exercise, self-discipline, laziness, and busy schedules due to family, work and school. The most desired reward system or prizes included massages, personal training sessions and gym memberships. Others included boxing classes, GNC gift card or day at the spa. The highest ranked group fitness activities were exercise group, walking groups and nutritional information sessions. The best time of day for activities was evening or late afternoon. Ninety-three percent of the surveyed individuals were willing to donate five dollars to the winner's pot, discussed later in this report.

Workplace health promotion programs should be supported by all levels of the Social-Ecological model to ensure success and increase participation from all employees. At the intrapersonal level, interventions consist of changing the health-related beliefs and behaviors of the individual, specifically the employees within Meadowlark Hills. Interventions at this level consisted of fitness assessments, goal setting, self-monitoring techniques and the use of positive reinforcements. Employees had the opportunity to have their body mass index calculated to assess body composition as well as an assessment of baseline timed-mile speed. This was

conducted by the Fitness Leader at Meadowlark Hills. When fitness assessments are compared to norms within the individuals' age group, they can be used as an indicator of health status or susceptibility to disease, such as obesity, heart disease and hypertension.

Each participant's personal heath objectives and goals were identified. The participants were asked to set goals that would be evaluated at the end of the eight-week program that were achievable, realistic and challenging (see Appendix J). Goal-setting should be focused on specific and attainable, short-term goals in order to increase participants' efficacy to perform the desired behavior (Brawley & Rogers, 1988). Self-monitoring techniques were made available to participants in their fitness packet (see Appendix K) that included personal weight log, self-timed mile recording log, exercise log and diet log (along with other documentation used to acquired points) to help visualize their success as they attain small goals. This is an example of the Classic Learning Theory that suggests confidence of participants will increase as they meet small goals and result in continued adherence to a program because they are reaping the benefits of the behavior change. Participants were also encouraged to use online diet and exercise logs to record their intakes and outputs. These could be printed and substituted for the logs included in the participant packets.

The first hurdle of this program was the proposal to acquire money to successfully complete the program. The program was allotted $1000 to be used to fulfill basic requirements of the program. This money was used to incorporate positive reinforcement though tangible items (see Appendix G). These items were used as rewards for the team that scored the highest points each week (weekly winners were not chosen by cumulative scores but by weekly scores; this helped participants that had one low-scoring week stay competitive and therefore decrease drop-out rates). Also, to register, employees had to pay a small fee and fill out registration form (see

Appendix H). Investing in something monetarily, such a gym membership or registration for the fitness program makes the individual feel more responsible for the outcome that investment bring (Goetzel, 2008). Monetary incentives have been shown to be very effective in increasing participation rates (Goetzel, 2008). The registration fees were used as a winner's pot that was awarded to the overall winner.

Workplace health promotion programs need support at the interpersonal level, which focuses on behavior change within small groups or effects by people in direct influence. The methodology used in creating a team-based fitness challenge was to use social support of their teammates as a strategy to improve adherence. Teams could consist of one, two or three members but every team had to have a distinctive team name for scoring purposes. This framework emphasized the influence of friends, coworkers or professional staff at Meadowlark Hills as sources of encouragement and support for each other, to help overcome fears and anxieties often associated with beginning a fitness regimen (Hobson, Hoffman, Corso & Freismuth, 1987). Participants were not required to work within a team but it was encouraged by the opportunity for more point accumulation as teamwork activities earned each participant points. This was developed to help support the people that were less motivated by encouragement of others in the same situation.

Weekly meetings were conducted off-site at a local gymnasium. This effort was to incorporate the family dynamic into the program and to offer fun, uplifting activities as an added benefit of joining the program (see Appendix G). Families, significant others or roommates were encouraged to attend the gymnasium activity. Activities included dodge ball, capture the flag, knock-out, etc.

A social-media page was created as a platform to communicate with participants of the fitness challenge, as well as to spread awareness and communication. The social-media management was done through a Facebook page. Participants were encouraged to join the page to keep informed on winners, activities and special announcements. Facebook has shown to be a cost-effective tool used in recruitment of health surveys and other nutritional education programs (Lohse, 2013).

Thus, to incorporate constructs of support by the interpersonal level, the program; (1.) encouraged the individual to pair up with teammates; (2.) utilized social media as a form of communication; (3.) offered social activities.

Based on the Social-Ecological model, interventions to improve health and wellness should target the community or organization, to create a health-conscious culture. Some interventions may rely on management to support these efforts to change the way health is viewed within the organization. Meadowlark Hills was supportive of a fitness program by allowing funds to be used to stimulate participation and interest.

Meadowlark Hills is at an advantage due to their existing fitness center. The Caul Fitness Center is open 24-hours a day and available to any employee and their spouse, over the age of 18. Other family members can purchase an economical membership to the center. Thus, Meadowlark Hills management creates a supportive environment for physical activity. The fitness center is conveniently located on the Meadowlark Hills campus and consists of a variety of exercise equipment. At least one shower is available in this area.

There were a total of 48 Meadowlark Hills' employees that registered for the Corporate Fitness Challenge. About eighty percent were full-time employees. Seven percent were

contracted employees. Eleven percent were part-time or as-needed employees. Registration included paying a five dollar fee into the winner's pot, to be awarded at the conclusion of the challenge. Following registration, a kick-off event was held for all participants to receive their Fitness Packet and an explanation of the challenge. The Fitness Packet included a schedule of events, deadlines and weigh-in days throughout the eight-week challenge, list of prizes, list of activities that earn the participant points, activity documentation for earning points (diet log, exercise log, group activity log, timed-mile log) and goal setting documentation. At the kick-off event, a T-shirt design challenge was held among teams.

Participants were asked to agree to the following guidelines and conditions of participating in the Fitness Challenge:

- Participate in the challenge without the use of unhealthy enhancements, such as diet pills, water pills or laxatives
- Weight loss should be the result of improved eating and exercising habits
- Complete documentation process honestly to maintain a fair competition
- Allow your team name to be announced as winners
- Allow any data collected to be anonymously used for graduate report writing purposes

The Fitness Challenge was calculated by a point based system. Each desired behavior that was completed (or at least documented) earned the participant points. The documentation process was completed on the honor system (except weight and height measurements were taken either by the Challenge Coordinator or the MLH Fitness Leader). Participants whose goal was to lose weight could partake in weekly weigh-ins. Not participating in the weigh-ins had no effect

on scores, neither did gaining weight. Points were only obtained by losing a percentage of body weight. A participant would obtain one point for every one-half percent of body weight lost.

Points could also be awarded for documenting a timed-mile speed, which meant that if the participate was able to improve their mile speed from their baseline time, they were awarded points (see Appendix I). If a member of a team participated in a race or marathon, points were awarded (see Appendix I). Also, if the team completed health initiatives, together as teamwork, each person on the team would earn points for the cumulative score (see Appendix I). Resident involvement was another opportunity to gain points for your team. The stipulation was that the health initiative had to occur when the employee was not working (see Appendix I). Table 1 clarifies how points were achieved by participants.

Table 1: Description of Point Calculation

Category	Criteria	Points	Notes
Weight Loss	-0.5%	1.0	Measured against original weight Final score calculated by comparing ending weight with original weight
Timed Mile	-2%	1.0	Improve time by 2% of initial speed
Exercise Log	0	-	Number of Days Performed
	1	-	
	2	-	
	3	1.0	
	4	1.5	
	5	2.0	
	6	2.5	
	7	3.0	
Diet Log	0	-	Number of Days Performed
	1	-	
	2	-	
	3	1.0	
	4	1.5	
	5	2.0	
	6	2.5	
	7	3.0	
Resident Interaction	1	5.0	Number of Times Accomplished
Goals Accomplished	1	5.0	Number of Times Accomplished
Race/Marathon Participation	1	3.0	Number of Times Accomplished
Teamwork	1	2.0	Number of Times Accomplished

At the conclusion of the Corporate Fitness Challenge, there were nine teams (a total of 24 individuals) continuing to submit documentation for points toward completion of the eight-week challenge. There were three teams that didn't submit any documentation. The Corporate Fitness Challenge dashboard shows overall results and could be accessed throughout the challenge (see Appendix L).

Table 2 indicates the total number of goals reportedly accomplished by participants were 43.3 percent. This figure does not take into account the goals that were established at the beginning of the challenge if the participate dropped out. For example, at the beginning of the

challenge there were 93 goals set, however only 48 of the goals were reported on as having accomplished or not having accomplished.

Table 2: Goals Reportedly Achieved in Corporate Fitness Challenge

Goals		
	#	%
Total % Of Goals Achieved		43.3%
Number of Goals Achieved		
0 Goals	28	58.3%
1 Goal	6	12.5%
2 Goals	9	18.8%
3 Goals	5	10.4%

Throughout the challenge, participants could acquire reports on personal progress via the Challenge Coordinator (see Appendix M). For instance, a participant could view their weight loss by week and percentage of weight loss by each week. The personal report would also show timed-mile speed and the change from initial, number of times they documented exercising or logged their diet, amount of resident interaction, amount of times participated in a race and amount of times participated in a teamwork exercise. Total points that the participant acquired from these activities could be found in this report. Lastly, the report showed current team standings and average team points.

The Corporate Fitness Challenges was successful in applying interventions at many levels of the Social-Ecological Model. However, there are improvements that could be made at each level to enhance the effectiveness of the program and increase participation.

Assessments at the individual level included an initial weight and height measurement, used to calculate BMI. However, there are better forms of accessing body composition than a

BMI calculation, such as skin fold measurements or bioelectrical impedance analysis (Kamimura, 2003). There are several techniques at varying levels of complexity, however simple skinfold thickness analysis is comparable with the more sophisticated methods (Kamimura, 2003) and would be cost-effective to incorporate into a program. This would add quality improvements to the challenge.

Other improvements could include increased accessibility of professional help or direction, including education workshops. This is particularly helpful for participants that lack the know-how of healthy meal planning, preparation or nutritional label reading. Adding an initial training session on these topics could increase the participant's self-efficacy to consciously eat healthful foods or reach other goals.

The Corporate Fitness Challenge promotes interpersonal interventions by using the teamwork model, offering activities open to family members and providing social exercise events. It is important for members to form relationships and receive encouragement and support from each other.

To improve future challenges held at Meadowlark Hills, it would have been beneficial to conduct follow up interviews of successful participants as well as those that dropped-out. Offering a fitness challenge regularly would help in continued success and improved health culture of the organization.

The Corporate Fitness Challenge attempted to improve the health-promoting environment at the community and organizational level. One improvement would have been to introduce the opportunity at the supervisor level and stress the importance of their positive expression of the program to their staff.

Chapter 4 - Reflection

In all, this field experience provided a learning opportunity that combined previous years of education and curriculum into a practical application that I found very fulfilling. During my experience, I had the opportunity to design, evaluate and implement a program and training series based on modern teaching techniques. I developed initiatives to promote healthy lifestyle choices and a training session to improve the work environment, which required self-initiation and excellent time-management. These newly developed skills will be very useful in my professional future.

A portion of my experience was spent developing a training program for employee caregivers that specifically care for individuals with dementia. This training continues to be offered, which is extremely rewarding. Even though this portion of my field experience deviated from my initial emphasis of nutrition, I found that I am very passionate in providing quality care to people that experience dementia and see the benefit that a training program can have on the caregiver, resident and the entirety of the health care system.

The three main theories that guided and inspired my experience helped me to develop each program specifically for the diverse population. Learning about this framework in the classroom was imperative to understand how a population's beliefs and current situation need to be considered when selecting interventions and opportunities. What was unexpected in my experience was the diversity of the target audience of each phase of the experience. The resident population is very different from the employee population. Without catering to that fact, each portion of the experience would have suffered.

One idea about my experience that inspired me was the concept that one intervention, focusing on one particular group of people could have a ripple effect on the entire community of Meadowlark Hills. At an even greater level, these interventions could benefit even larger populations. As mentioned earlier, the cohort of Meadowlark Hills employees are from all walks of life. Some are Kansas State University students, others are associated with Fort Riley and others are long-term residents of the Manhattan area. Some will go on to be doctors, nurses or family caregivers that now have a better understanding of dementia through my training initiative. The potential for public health is endless.

The effects of planning and recruiting for the Corporate Fitness Challenge expanded my appetite to encourage others to adopt active, health-conscious behaviors into their lifestyle. The goal was to change the culture of a population so that these behaviors become an inherent desire and responsibility. During the challenge, I personally tried to lead by example. I felt a responsibility to show others my dedication to health and when enough people in an organization feel that same responsibility, true health culture change will occur.

Lastly, the field experience was an opportunity to exhibit my work ethic and initiative, which benefited me professionally. At the conclusion of the experience, I was offered a position in a leadership role within the organization. I'm grateful for the experience and the additional opportunities it has created for me.

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Appendix A

Wellness Fair Vendor Packet (2 forms)

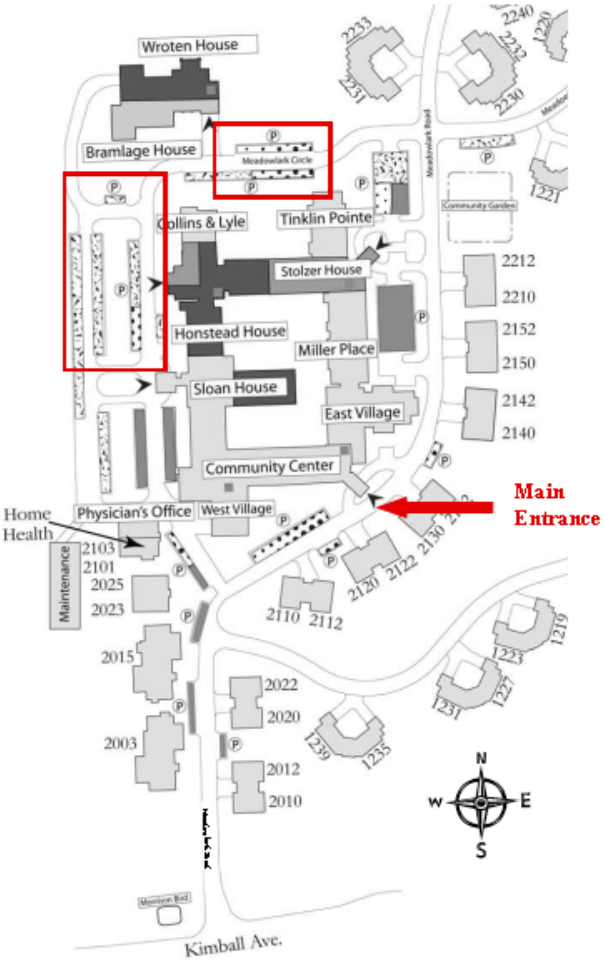
Meadowlark Hills
Wellness Fair 2012

What to bring…

- Staffing for your booth
- Information about your services
- Marketing/educational material
- Prizes or gift giveaways for the prize table
- Business cards
- Table linens if needed at your booth
- Extension cords/power strips if needed
- Technological items if necessary (i.e. laptops, projector/screen, etc.)

Parking…

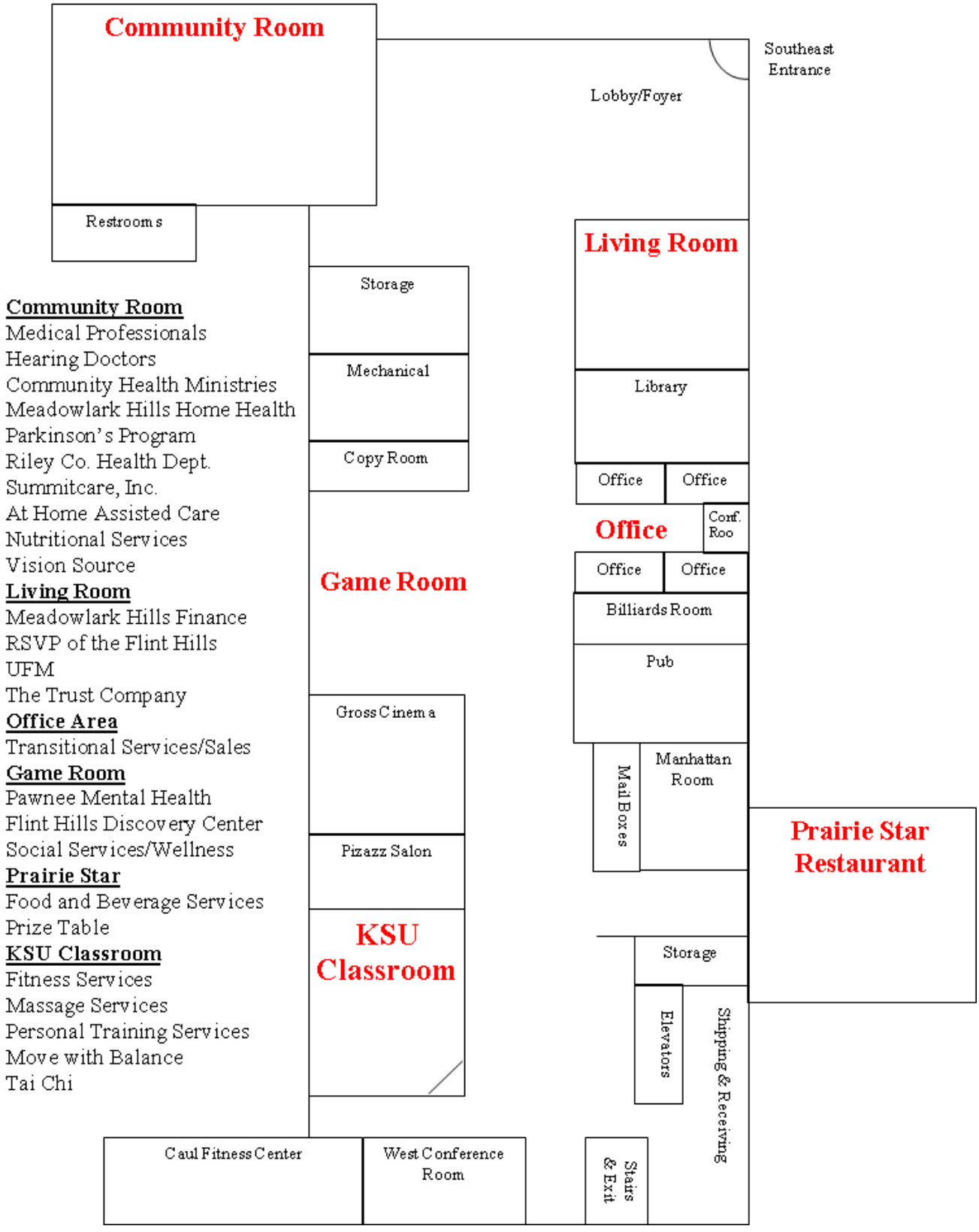
Feel free to unload your vehicle at the main entrance on the Southeast side of the Community Center (indicated by red arrow). Please park in the lots on either the north or west sides of campus (in red boxes), posted as "Visitor" or "Employee" parking. Parking is also available on streets. Do not park in numbered lots, these are designated for Meadowlark Hills residents.



Schedule of events…

Noon to 1 p.m. Vendor Set Up
1 to 4 p.m. Wellness Fair
4:15 p.m. Door Prize Drawing
4 to 5 p.m. Tear Down

Community Center



Community Room
Medical Professionals
Hearing Doctors
Community Health Ministries
Meadowlark Hills Home Health
Parkinson's Program
Riley Co. Health Dept.
Summitcare, Inc.
At Home Assisted Care
Nutritional Services
Vision Source

Living Room
Meadowlark Hills Finance
RSVP of the Flint Hills
UFM
The Trust Company

Office Area
Transitional Services/Sales

Game Room
Pawnee Mental Health
Flint Hills Discovery Center
Social Services/Wellness

Prairie Star
Food and Beverage Services
Prize Table

KSU Classroom
Fitness Services
Massage Services
Personal Training Services
Move with Balance
Tai Chi

Appendix B

Example of Vendor Place Card and Associated Pillars of Wellness

Appendix C

Pillars of Wellness Survey

Please check the corresponding color in regard to your extent or strength of ability fulfill each area of wellness.

	Description Green – I am very well in this area Yellow – I am moderately well in this area Red – I am not well in this area	**Green** 	**Yellow**	**Red** 
PHYSICAL	Encourages healthy eating and activities which contribute to wellness, including medical self-care, appropriate use of the medical system and avoiding things that impair good health.			
SPIRITUAL	Seeking meaning and purpose in human existence.			
EMOTIONAL	Assessment, awareness, acceptance and management of one's feelings and related behavior.			
ENVIRONMENTAL	Respecting nature, with respect for others living in our environment as well as respect for the physical environment itself.			
SOCIAL	Your importance in society as well as the impact you have on the world around you through healthy living and better communication.			
FINANCIAL	Understanding of your financial situation and managing it in such a way that you are prepared for financial changes.			
INTELLECTUAL	Enhances your knowledge skills with creative, stimulating mental activities.			
OCCUPATIONAL	Ability to maintain autonomy in daily and vocational life while engaging in activities that utilize one's strengths and passions.			
CULTURAL	Acknowledgement of the ideas, beliefs, values and knowledge that constitutes the shared bases of social interactions.			
STEWARDSHIP	Responsible planning, management, and charitable decision making of one's resources with respect to the environment, economics, health, property, information, religion and other valuable aspects of life.			

Appendix D

Wellness Fair Satisfaction Survey

2012 Meadowlark Hills Wellness Fair

Satisfaction Survey

Please indicate if you agree or disagree with the following statements.	**Agree**	**Disagree**
Information was beneficial.		
Type and number of vendors were sufficient.		
The event was fun.		
I was satisfied with this event.		

Comments:

_____

_____

_____

_____

_____

_____

_____

If you would like to speak to someone regarding questions or other comments, please provide your name and number and we will contact you as soon as we can.

Name:_____Number:_____

Appendix E

Pretest and Post Test of Dementia Sensitivity Activity

Please answer each question below by circling your response.

1. **Do you feel you understand the emotional needs of people with dementia?**

   Strongly Agree Agree Neutral Disagree Strongly Disagree

2. **From a physical standpoint, how capable do you feel of carrying out simple tasks?**

   Very Capable Capable Neutral Somewhat Capable Not Capable

3. **What is your current state of relaxation?**

   Very Relaxed Relaxed Neutral Anxious Agitated

4. **Is it necessary to sensitize yourself to understand dementia to provide care?**

   Definitely Yes Neutral No Definitely Not

5. **How easily are ADLs (activities of daily living) completed for a person with dementia?**

   Very Easy Somewhat Easy Neutral Difficult Unbearable

6. **How justified are people with dementia when they exhibit inappropriate behaviors?**

   Very Justified Somewhat Justified Neutral Unjustified Very Unjustified

7. **In your opinion, do people with dementia generally receive the care they need?**

   Yes Sometimes Rarely No Never

Appendix F

Corporative Fitness Challenge Preliminary Survey

Meadowlark Hills Weight Loss and Fitness Challenge Survey

Please return to Household Coordinators.

1. What are barriers that would prohibit you from participating in a fitness challenge?

2. What rewards would most entice you to participate?

    a. Gym Membership to Maximum Performance

    b. Massages

    c. Gift Card to Prairie Star Restaurant

    d. Personal Training Sessions

    e. Other _____

3. What activities would you most likely be interested in participating in?

    a. Nightly group exercise workouts (Zumba, P90X, Insanity, Dancing with the Stars Workout Video, Jillian Michaels Video) to be conducted in either the Community Room or Miller Gym?

    b. Walking groups (groups will meet on campus and walk together on a designated route, about 30 minutes)

    c. Nutritional information sessions (classes on how to eat and cook healthier)

    d. Workout equipment demonstrations

    e. Other _____

Appendix G

Fitness Challenge Calendar

October 2012

Sun	Mon	Tue	Wed	Thu	Fri	Sat
	1 **Kick Off Event** 7 PM Community Room **1st Weigh In**	2	3	4	5	6
7 **Douglas Gym** 6:30-7:30 PM 3 on 3 Basketball Tourney	8 **2nd Weigh In** Documentation due by 5PM for points	9 **Old Stadium** 8 PM Stairs Prize Give-away Water Bottle and Pedometer	10	11	12	13
14 **Douglas Gym** 6:30-7:30 PM Volleyball Tourney	15 **3rd Weigh In** Documentation due by 5PM for points	16 **Old Stadium** 8 PM Stairs Prize Give-away 15 Minute Massage	17	18	19	20
21 **Douglas Gym** 6:30-7:30 PM Hip Hop Dance Routine/ Open Gym	22 **4th Weigh In** Documentation due by 5PM for points	23 **Old Stadium** 8 PM Stairs Prize Give-away 15 Minute Massage and Movie Ticket to Seth Child Cinema	24	25	26	27
28 No open gym	29 **5th Weigh In** Documentation due by 5PM for points	30 **Old Stadium** 8 PM Stairs Prize Give-away 15 Minute Massage and Personal Training Sessions	31			

Meadowlark Hills Fitness Challenge

November 2012

Sun	Mon	Tue	Wed	Thu	Fri	Sat
				1	2	3
4 **Douglas Gym** 6:30-7:30 PM Dodgeball Tourney	5 **6th Weigh In** Documentation due by 5PM for points **Old Stadium** 8 PM Stairs	6 Prize Give-away $40 Gift Card to Dicks Sporting goods	7	8	9	10
11 **Douglas Gym** 6:30-7:30 PM Capture the Flag	12 **7th Weigh In** Documentation due by 5PM for points **Old Stadium** 8 PM Stairs	13 Prize Give-away Shellac manicure and a bottle of nail polish OR $40 gift card to Best Buy	14	15	16	17
18	19 **8th Weigh In** Documentation due by 5PM for points **Old Stadium** 8 PM Stairs	20 Prize Give-away OR $50 gift card to Target	21	22	23	24
25	26	27	28	29	30 **Final Weigh In** Documentation due by 5PM for points **Grand prize** awarded on Monday	

Appendix H

Fitness Challenge Registration Forms

I would like to be placed on a team ☐
Mark if yes

Fitness Challenge

Registration Form

Our team is open to having someone placed on it ☐
Mark if yes

Team Name:

Team Captain 1: _____

Email address: _____

Paid ☐ I want to purchase a T-shirt ☐ Size: _____

Team Member 2: _____

Email address: _____

Paid ☐ I want to purchase a T-shirt ☐ Size: _____

Team Member 3: _____

Email address: _____

Paid ☐ I want to purchase a T-shirt ☐ Size: _____

To complete the registration process, fill out this form and return to Amanda Rall (785-687-8045) with registration fees. Teams can consist of groups of 1, 2 or 3 people but every team must have an original team name.

There is a $5 registration fee per team member (all entry fees will be awarded to the winners). Cash or check is acceptable. Make checks out to CASH.

Check email regularly for updates on events and activities. Also, join the facebook group "Meadowlark Hills Fitness Challenge" to find out weekly winners and prizes!

Office use only:

Registration complete ☐

Appendix I

Fitness Challenge Documentation Forms

Fitness Challenge

DOCUMENTATION DUE BY MONDAY, OCTOBER 8TH, 2012

EMPLOYEE INFORMATION

Employee Name: _____

Team Name: _____

Date: _____

INSTRUCTIONS

Answer the following questions honestly and to the best of your ability. A questionnaire needs to be turned in for points every week.

TIMED RUNNING/WALKING

Question: Have you participated in timing your mile speed? Yes or no.
Measurement: Baseline time: _____:_____ (Your baseline time is what you are competing against. Choose a time that you have achieved in the past but will also challenge you.)

Date	Time (minutes:seconds)

FUN RUN OR MARATHON

Question: Did you participate in a race or marathon during this week? Yes or no.

Date	Name of Marathon or Race	Time (hours:minutes:seconds)

TEAMWORK

Question: Have you participated in an activity with a member(s) of your team? Yes or no. (All members of the team must document teamwork individually to receive full credit)

Date	Activity

RESIDENT INVOLVEMENT

Question: Did you involve a resident in a physical activity? Yes or no. (Must be off the clock)

Date	Activity

Appendix J
Fitness Challenge Goal-setting Forms

Fitness Challenge

GOAL PLANNING DUE BY MONDAY OCTOBER 8TH, 2012

EMPLOYEE INFORMATION

Employee Name: _____

Team Name: _____

Date: _____

INSTRUCTIONS

Goals should always be: **S** – Specific **M** – Measurable **A** – Achievable **R** – Realistic **T** – Time Bound

Goal/Objective. Briefly describe each goal/objective.

1ST GOAL/OBJECTIVE

Description:

2ND GOAL/OBJECTIVE

Description:

3RD GOAL/OBJECTIVE

Description:

Fitness Challenge

GOAL PLANNING DUE BY FRIDAY NOVEMBER 30TH, 2012

EMPLOYEE INFORMATION

Employee Name: _____

Team Name: _____

Date: _____

INSTRUCTIONS

Goals should always be: **S** – Specific **M** – Measurable **A** – Achievable **R** – Realistic **T** – Time Bound

Goal/Objective. Briefly describe each goal/objective.

1ST GOAL/OBJECTIVE

Was this goal accomplished: Yes or no

2ND GOAL/OBJECTIVE

Was this goal accomplished: Yes or no

3RD GOAL/OBJECTIVE

Was this goal accomplished: Yes or no

Appendix K

Fitness Challenge Exercise and Diet Log

Exercise Log FINAL Week

Due October 8th by 5 PM

Name

Team Name

	TYPE OF EXERCISE	CALORIES BURNED (OPTIONAL)	TIME SPENT	DISTANCE (OPTIONAL)
MONDAY				
TUESDAY				
WEDNESDAY				
THURSDAY				
FRIDAY				
SATURDAY				
SUNDAY				

Diet Log Week 1

Due by October 8th at 5 pm

Name

Team Name

MONDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

TUESDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

WEDNESDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

THURSDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

FRIDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

SATURDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

SUNDAY MEAL		CALORIES
BREAKFAST		
SNACK		
LUNCH		
SNACK		
DINNER		
TOTAL		

NOTES FOR THE WEEK	

Appendix L

Fitness Challenge Exercise and Diet Log

Meadowlark Hills

Employee Fitness Challenge

Friday, November 30, 2012

Name: [redacted] **Team:** [redacted]

Initial Measurements

Height	5 Ft 6 In	*Goals:*	#1	Walk two miles without stopping
Weight	323		#2	Loose 10 pounds
BMI	52.1		#3	Documente food intake for next 60 days.
Category	Obesity			
Mile Run:	32 Min 0 Sec			

Weekly Measurements

				Wght	% Loss	Mile	Chge	Ex Log	Dt Log	Res Int	Races	Tmwk
Week 1:	10/1/12	to	10/7/12	315.0	-2.5%			4	7	1		2
Week 2:	10/8/12	to	10/14/12	314.0	-2.8%			5	7			1
Week 3:	10/15/12	to	10/21/12	314.0	-2.8%			4	7	1		4
Week 4:	10/22/12	to	10/28/12	313.0	-3.1%			5	7	2		1
Week 5:	10/29/12	to	11/4/12	311.0	-3.7%			3	7			1
Week 6:	11/5/12	to	11/11/12	312.5	-3.3%			4	7	5		1
Week 7:	11/12/12	to	11/18/12	313.0	-3.1%			5	7	5		5
Week 8:	11/19/12	to	11/25/12	314.5	-2.6%			5	7	7		7

Weekly Points

				Wght	Mile	Ex Log	Dt Log	Res Int	Races	Tmwk	Goals	Totals
Week 1:	10/1/12	to	10/7/12	4.0	-	1.5	3.0	5.0	-	4.0		17.5
Week 2:	10/8/12	to	10/14/12	5.0	-	2.0	3.0	-	-	2.0		12.0
Week 3:	10/15/12	to	10/21/12	5.0	-	1.5	3.0	5.0	-	8.0		22.5
Week 4:	10/22/12	to	10/28/12	6.0	-	2.0	3.0	10.0	-	2.0		23.0
Week 5:	10/29/12	to	11/4/12	7.0	-	1.0	3.0	-	-	2.0		13.0
Week 6:	11/5/12	to	11/11/12	6.0	-	1.5	3.0	25.0	-	2.0		37.5
Week 7:	11/12/12	to	11/18/12	6.0	-	2.0	3.0	25.0	-	10.0		46.0
Week 8:	11/19/12	to	11/25/12	5.0	-	2.0	3.0	35.0	-	14.0		59.0
Total Points				5.0	-	13.5	24.0	105.0	-	44.0	15.0	206.5

Goals		**Goal Achieved**
#1	Walk two miles without stopping	Yes
#2	Loose 10 pounds	Yes
#3	Documente food intake for next 60 days.	Yes

Team Average Points:	184.0
Team Standings:	1st Place