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Understanding the Impact of Patient Engagement in Effective Management of Chronic Conditions

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This is to certify that the doctoral study by

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has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2025

Abstract

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MPA, Delaware State University, 2018

BS, Delaware State University, 2016

Professional Administrative Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Public Administration

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November 2025

Abstract

This study was developed to address the partner site's need for an evidence-based approach to improving patient engagement among elderly individuals managing chronic diseases. Low engagement, often driven by poor provider–patient communication, non-compliance, and limited use of healthcare technology, was identified as a barrier to effective self-management and optimal health outcomes. Guided by the social cognitive theory, behavioral, cognitive, and environmental factors influencing engagement and self-efficacy were examined. Two practice-focused questions examined: identifying barriers to engagement and the impact of the provider–patient relationship on outcomes. The purpose of the project was to develop an evidence-based approach to enhance patient engagement. A quantitative, cross-sectional survey of 20 participants aged 50 and older was conducted to measure engagement, communication, and technology use. Analysis using multivariate logistic regression revealed a positive relationship between patient engagement and health outcomes, while highlighting gaps in disease knowledge and medication adherence. The provider–patient relationship emerged as a significant factor in influencing engagement. The study found that patient engagement improves health outcomes, with few manageable barriers. Surveys effectively assessed engagement. Applying the social cognitive theory in public administration supported behavior-based strategies that enhanced self-efficacy. Recommendations included health literacy, chronic disease, and nutrition education to support older adults managing chronic conditions. The study has implications for public administrative practice and positive change through improved health literacy and engagement in older adults.

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Dedication

This research is dedicated to my elderly patients, family, and friends for all their support and encouragement during the educational journey. Your unconditional encouragement has been a light in the dark while working on this research. It has given me the energy to keep going, even in the most challenging times. I appreciate you all and will continue the drive to educate and search for ways to improve patient engagement.

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I want to acknowledge my husband, Jeron, who is my life partner, who always has my back, and encourages me when I want to give up. I love you always. My children: Jeron Jr and Christina, you are my love, joy, and breath; all I do is for each of you. I love you. I want to thank my parents, Joyce and Leon, my sister, and my friends for always believing in me, encouraging me, and making me laugh when I want to cry, for helping me to see the good during the bad times. I love each of you. My graduate partner and friend, April, thank you for pushing and encouraging me many times throughout this journey. I love and appreciate you.

I want to thank my chair, Dr. Richard Worch, and co-chair Dr. Michael Brewer, for your continuous patience, support, and dedication to my educational goal. I appreciate you and your help in reaching my academic goal.

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Section 1: Introduction to the Problem

Introduction

Patients with chronic health care conditions need to engage in their healthcare for a positive outcome and address the barriers such as communication, non-compliance, and accessibility to technology (Phillips, 2018). The need to improve how the elderly population could effectively engage in their healthcare depended on understanding why and what the barriers were. Through my research, I helped identify and understand the best way to address the obstacles to improving the healthcare outcomes of elderly populations. Patient engagement within the aging population dealt with complex chronic health conditions. The problem the study site faced was to determine the causes of poor patient healthcare outcomes and how to change them. Before any changes occurred, I evaluated the healthcare barriers. Hence, issues such as poor doctor–patient communication, noncompliance with treatment plans, medications, and appointments, as well as limited use of healthcare technology, continue to hinder effective care. The most consistent positive outcome of interventions to improve self-care was improvement in self-efficacy, an essential element of self-management. Most studies of self-management programs reported improvements in patient satisfaction, coping skills, and perceptions of social support, although the focus tended to be on short-term outcomes rather than on long-term effects. (Wagner, et al., 2001)

The discussion of healthcare is an important topic for everyone, not just the sick, but also the caregivers. It was a concern that everyone, healthy and sick, could relate to and looked for ways to improve. Hence, the most critical aspect was the overall outcome.

The focus of that outcome could range from several factors and aspects. Many patients focused on only their current healthcare provider, facility, test, lab, and/or medication. Good health outcomes that left patients feeling secure were the number one priority. A significant part of that security was making sure that people could access and have quality healthcare services. A healthcare service that could meet the needs of everyone, and was reasonable and reliable, was the key to making sure that poor outcomes were avoided. The question that many patients faced was whether the service provided would be affordable, educational, and prevent future poor outcomes. The promotion of preventive healthcare across organizations, professional societies, and public and private facilities has faced persistent challenges, which have contributed to suboptimal patient outcomes. Therefore, examining the ineffective factors affecting the patient population was essential to understanding the causes of poor healthcare outcomes.

Healthcare outcomes were based on several factors, which resulted in a person's overall health being either good or bad. Therefore, legal, laws, regulations, and political aspects are used. The legal aspects of healthcare, such as the Health Insurance Portability and Accountability Act (HIPAA), patient information privilege, and patient rights, play a pivotal role in how that outcome was determined. Laws and regulations, such as HIPAA, were put in place to secure health information, build a level of security, and ensure the protection of personal information to protect providers and patients (Phillips, 2018). It also addressed the continuity of care among providers in providing healthcare information. When the political aspect of healthcare came into play, there were several areas to address, such as coverage, which could be changed by a policy change. The

Affordable Healthcare Act (AHA) changed due to political party opinion (Phillips, 2018). Healthcare policies were the foundation of presidential nominees and political parties. So often, healthcare policies determine whether insurance companies could reject or deny patient's healthcare coverage based on their present and prior health issues. Hence, the increased rise in non-insured patients, poor healthcare outcomes, and the "No patient turn away" pledge by many healthcare organizations. When examined closely, we could see how legal, laws, regulations, and political aspects affected patients' healthcare outcomes.

The problem that the study site faced was how to change poor patient outcomes and what the causes were. The concerns about these issues continued to increase; therefore, people died every day from preventable causes, and available healthcare services were limited. The facts I explored in this graduate project highlight that poor outcomes were a pivotal concern for healthcare providers. If so, where was the need for improvement, and where could the study site start to correct and improve patient outcomes? If the issue of patient engagement was not changed, there would continue to be a lack of education for the elderly population about their healthcare. It could accompany more health problems and concerns that lead to hospitalizations or even death. Therefore, a decline in the elderly population raises concerns about the potential impact on future generations. The problem could not go unchanged, nor could society afford not to address it. Patient engagement involved patients, families, and caregivers in improving health care and safety. While some editorials have questioned patients' willingness to engage in their care, the evidence consistently demonstrates that patients overwhelmingly desire some form of involvement across a range of healthcare settings.

However, it was essential to acknowledge that patients' preferences, self-efficacy, and power dynamics may have impeded engagement in safety initiatives (Sharma et al., 2018).

Overall, allowing the issue to continue in its previous state without change or being addressed resulted in unnecessary casualties. The study site had the knowledge, resources, and technology to address it with positive change. The effort required to implement those changes did not place additional stress on medical providers, patients, or families compared to maintaining the status quo. No change led to additional problems that weighed heavily on the patients and their chronic healthcare conditions. Therefore, this caused an increase in casualties due to their chronic healthcare conditions and a decline in overall medical care for the entire population. The use of resources, money, and time was worthwhile in solving the issue of patient engagement among the elderly population because it could extend the population's lifespan. Every effort used in addressing the problem aided in helping in several different aspects, personally, medically, and mentally. The benefits outweighed the costs of money, time, and resources. “Patient-centeredness” is a distinct dimension of healthcare quality, valued not merely for its association with other aims such as safety and effectiveness, but as a critical goal in its own right. Its proper incorporation into new health care designs involved some radical, unfamiliar, and disruptive shifts in control and power, out of the hands of those who gave care and into the hands of those who received it. Such a consumerist view of the quality of care itself had important differences from the more

classical, professionally dominated definitions of "quality" (Swartwout, Drenkard, McGuinn, Grant, & El-Zein, 2016).

Problem Statement

The study site wanted me to determine a viable solution to mapping an evidence-based process that would effectively improve patient engagement in managing chronic disease conditions. Patients were not engaged in disease management processes that improved their healthcare outcomes. A breakdown in provider-patient communication has led to non-compliance and issues associated with leveraging technology. The study site was incorporated in 1969. The study site was an early adopter that recognized the benefit of providing a gathering place for the aging population in the community. By implementing a novel place, the study site created a model of care for its aging population, which required social and interactive needs. The study site was a non-profit organization committed to providing programs and services that enhanced the quality of life with respect and dignity for individuals aged 50 and older. The site addressed the comprehensive needs of its client population by providing services that included social, recreational, fitness, and education opportunities. There were limited services and programs related to health that addressed the aging population's complex chronic health conditions. The study site did not coordinate care for clients with chronic health care conditions or social determinant needs. They faced challenges in getting clients actively engaged in managing their chronic conditions due to a lack of health literacy, which is essential for understanding and effectively managing their care. This concern profoundly impacted the elderly population because they were typically dealing with more than one

diagnosis, which added a layer of complexity to their ability to manage their diseases. The lack of a primary focus on health promotion and disease prevention over time has led to poor outcomes regarding patient health (Vermeire et al., 2001). The goal was to address these issues that caused the aging population not to be involved in their disease process. Thus, uncovering the underlying factors contributing to low engagement may serve as a foundation for initiating effective services and programs within the organization

There continues to be a lack of services and programs that aided in educating the aging population in community centers. As a result, patient engagement remained limited, contributing to ongoing challenges in improving healthcare outcomes for the aging population. Without the study, the organization could not provide focus-centered programs and services for educating patients. Hence, addressing patients' needs in healthcare aligns directly with the organization's mission as a community-based center. The fact that patients were not engaged was perplexing, and the need to understand the barriers was important. Many barriers left elderly patients unwilling to express themselves or ask for help. These barriers caused a lack of provider-patient communication, an increase in noncompliance, and issues with technology amongst the aging population. It was also known that patients could become and wanted to be more engaged, but they first needed to understand these barriers and how they were changed, eliminated, or improved.

Several public-sector programs and services for the aging population were valuable to the public service area. My study supports the public administration field by

using knowledge of policies and policy formation to investigate the areas that needed to be changed within healthcare patient engagement. We needed to understand how they could best meet the aging population's needs and improve them by providing public educational programs, services, and/or training. Public administration could aid in policymaking, initiating engagement to develop, implement, and evaluate national, state, and local health policies.

The discipline of public administration's ability to get policies on health change opened the opportunity to reduce the estimated 83 million people in the United States who have three or more chronic health conditions (Blumenthal et al., 2014). Equipping our aging populations with the knowledge, skills, and abilities to successfully manage their chronic disease conditions and improve their overall health and wellness was part of our public administration discipline. This study was important to the field of public administration because it provided not only a service to people but also showed that changes in public services were providing what was needed to serve and meet the needs of the public. Public administration provided these services to the public by obtaining grants and state and federal funds for off-site organizations out of pocket. As well as working to change current and future health policies to initiate patient engagement. The organization's history with patient engagement was a concern from the clients' perspective. The organization had several educational programs, classes, and seminars for the aging population. The organization could not focus on issues that directly affected the aging population's ability to engage. Therefore, the resources went unused, and patients remained in the same state of mind regarding their health care.

Patient engagement was a central pillar of health policy. The Affordable Care Act emphasized patient engagement and activation, with initiatives that focused on shared decision making, wellness, and self-management (Greene et al., 2015). The study site had the aspect of education but lacked the initiation aspect of engagement. Therefore, the site only allowed the patient to see the resources but did not help them understand how to use them or correctly engage in their full potential. The study site had not expressed this problem as an issue within the organization, but knew it was an important attribute to the well-being of patients. The study site has always explored and continues to explore resources that could contribute to aiding in the problem. The problem was not just due to unavailable resources, but also a lack of quality resources and utilization knowledge. The stakeholders were interested in solving the problem as it could have improved their health. The medical community continuously discussed health information technology and quality of care. The new managed care environment established by relatively recent reforms had created a need for quality-of-care data and performance metrics. This change had increased the expectations held by stakeholders such as consumers, health care organizations, and insurers. As a result, health care organizations had started to pay significantly more attention to patients and performance outcomes (3 Ways to Achieve Quality Health Care and Improve Patient Outcomes, 2024).

A growing body of evidence shows that more activated patients had better health outcomes and care experiences. However, there was limited evidence to date about the impact on costs. Emerging evidence indicated that interventions that tailored support to the individual's activation level and built skills and confidence effectively increased

patient activation. Furthermore, patients who started at the lowest activation levels tended to increase the most. We concluded that policies and interventions aimed at strengthening patients' roles in managing their health care could contribute to improved outcomes and that patient activation could—and should—be measured as an intermediate outcome of care that was linked to improved outcomes (Hibbard & Greene, 2013). The leading solution to improving patient healthcare outcomes was to have patients more involved in their overall healthcare. Hence, this led to a better understanding of patient engagement, increasing the importance of strategies to reform healthcare. The interrelationship of the three major entities in the service triad: the healthcare organization, the clinicians (team of physicians, nurses, medical assistants, office staff), and the patient, as well as needs associated with health care performance (Cowing et al, 2009). The alternative to the problem of poor patient healthcare outcomes was to continue in the present state in which healthcare services were provided. Therefore, ongoing challenges such as poor provider–patient communication, nonadherence to treatment protocols, and limited integration of healthcare technology continue to impact care quality and outcomes. The alternative would only leave providers and patients frustrated with the healthcare system. Hence, providers experienced mental fatigue as they struggled to help patients understand their medical diagnoses, treatments, and medications. In the same aspect, the patients feel disvalued and confused about treatments, diagnoses, and medications.

These entities served the overall role of ensuring that patients' healthcare outcomes resulted in favorable improvement. The terms patient engagement and patient activation were often used interchangeably. The terms were frequently used to convey

different meanings and sometimes poorly defined. Patient activation emphasized patients' willingness and ability to take independent actions to manage their health care (Hibbard & Greene, 2013). This definition equated patient activation with understanding one's role in the care process and having the knowledge, skill, and confidence to manage one's healthcare. Activation differed from compliance, in which the emphasis was on getting patients to follow medical advice. I used patient engagement to denote a broader concept that included activation; the interventions designed to increase activation, and patients' resulting behavior.

Such as obtaining preventive care or engaging in regular physical exercise. The focus on activation and engagement rather than compliance recognized that patients managed their health on their own, the vast majority of the time, making decisions daily that affected their health and costs (Hibbard & Greene, 2013). The importance of having a patient engaged in their care was the central aspect of the patient's overall care. It was a big part for both the provider and the patient. The provider portion came into play when they explained a diagnosis to a patient in a manner they could understand. Hence, the patience that was needed on the provider's part was to take the time and be sensitive to the patient's needs. Many times, patients complained that their provider did not explain or take the time to ensure they understood the diagnosis, treatment plan, and options for care. To some extent, this made patients feel they were on their own in understanding the diagnosis and addressing their healthcare concerns. Consequently, patients were frequently left to seek out their own solutions to improve their healthcare, often without adequate support or guidance.

This study helped build health improvement programs for elderly clients with chronic diseases. It addressed the gap between what the elderly population felt was the problem and what the study site had failed to address as issues that created the problems.

Purpose

The purpose was to identify the factors and barriers that impede patient engagement, decreasing opportunities for effectively managing their chronic disease condition. Similar problems in other organizations have found viable solutions by using a patient assessment, which evaluated the patient's level of engagement, understanding, and compliance with their care. Healthcare organizations used patient satisfaction surveys to create quality improvement initiatives, monitor employee performance, and pinpoint service gaps (3 Ways to Achieve Quality Health Care and Improve Patient Outcomes, 2024). I aimed to improve patient engagement in effectively managing their chronic disease conditions and increase the study site’s ability to improve its aging population's health literacy. I identified the factors and barriers that impeded patient engagement, which helped to develop opportunities via programs, educational seminars, and services that improved the patients' ability to manage their chronic disease effectively. Survey questions were used to identify the areas that affected patients' ability to engage. Exploring the areas better helped the study site address the areas that needed attention and what services it could provide to educate them.

The primary stakeholders affected by the problem were the clients. In any medical care system, the patient is the central figure—recognized as such by all involved, including physicians, nurses, medical assistants, receptionists, billing staff, and even

health insurance providers. This recognition plays a critical role in shaping the quality of patient care. Consequently, several pivotal factors—such as access to care, wait times, availability of information, administrative processes, communication, and ancillary services—are essential components in delivering effective healthcare. Accessibility and availability of both the physician and the outpatient medical facility were assured to all those who required health care. The waiting times for all services were minimized. They could only be addressed effectively through a continual review of patient responses and other data, such as surveys and assessment tools, that provided this feedback to make the necessary system changes. Patient information and instructions about all procedures and treatment options, both medically and administratively, were made very clear. Health care providers and their staff formed an effective link between the patient's experience and ultimately led to better health care outcomes (3 Ways to Achieve Quality Health Care and Improve Patient Outcomes, 2017). Communicating with both the patient and the patient's caregivers about diagnoses, prognoses, treatment options, and follow-up could avoid a lot of frustration, anxiety, and overall complacency. Creating a Patient Activation Measurement Tool (PAM) to assess the patient's engagement in health care could significantly enhance interactions with patients and their families. Ancillary services, such as frequent communication from the physician via mail, email, and video/text messaging, were provided and accessible to patients and their caregivers.

Nature of the Administrative Study

The elderly population at the study site between the ages of 50 and 80 were asked these questions. This population had one or more chronic diseases, such as diabetes,

hypertension, cardiovascular disease, or hyperlipidemia. The quantitative methodology was used in the research via survey questions. It would have been a more effective way to collect the data and document the input from the patients. The data were generated from survey questions based on the PAM tool, “valid, highly reliable, unidimensional, probabilistic Guttman-like scale that reflected a developmental activation model. Activation appeared to involve four stages: (1) believing the patient role was important, (2) having the confidence and knowledge necessary to act; (3) actually taking action to maintain and improve one's health, and (4) staying the course even under stress.” (Hibbard, et al., 2004, p.1005)

This tool assessed 13 domains that evaluated the client's level of engagement. There was a good rationale to support using this survey tool, as cited by the researchers who developed it. They wrote in their review of the literature that patients who were able to self-manage symptoms/problems, engage in activities that maintained functioning and reduced health declines, be involved in treatment and diagnostic choices, collaborate with providers, select providers and provider organizations based on performance or quality, and navigate the health care system, were likely to have better health outcomes (Hibbard, et al., 2004). The PAM tool inaccurately gauged patient engagement.

The data from this quantitative methods study helped develop education and training to support improving health literacy by decreasing knowledge deficits.

Significance

This study contributes to a better understanding of patient engagement, advances knowledge within the field of healthcare, promotes positive social change, and supports

the organization by equipping the elderly population at the site with the knowledge, skills, and abilities to effectively manage chronic conditions and improve overall health and wellness. This study was significant at the study site, as it provided both guidance and a practical toolkit to support the education of the elderly population. It offered assurance to both the elderly participants and the organization by contributing to improved healthcare outcomes—not only for current clients but also by establishing a foundation that can be adapted for other age groups. This study helped fill the gap in patient engagement by examining the barriers that impede the patient's ability to improve their health care outcomes. Addressing these barriers allowed the organization to identify effective solutions. This study contributed not only to the organization but also to the broader public discourse by highlighting key healthcare issues and offering strategies to address them. As a result, it benefited the organization’s patients and enabled the organization to better utilize publicly available internal resources. The study's purpose was to improve the client's overall healthcare outcomes. as some factors prevented, protected, and stopped that from occurring. This PAS showed that it took the team effort of both the patient and the provider to achieve a good healthcare outcome. To address the causes, as discussed in the PAS research, of poor doctor-patient communication, noncompliance with treatment, medications, appointments, and healthcare recommendations, and a lack of healthcare technology. The claim aligned with the problem because it identified the barriers that affected the patient's ability to engage effectively. As a result, patients demonstrated a greater understanding of their healthcare, leading to more effective management and improved outcomes. The study's positive

social change was to see what effect behavior change could have on improving patient engagement outcomes.

Summary

Health in every aspect and for everyone is important, but how well a patient understands and manages their chronic disease makes a difference in their outcome. The elderly population is the most vulnerable to a lack of engagement (Phillips, 2024). In conclusion, the ongoing concern of poor patient healthcare outcomes could be addressed with an efficient tool. Hence, this reduces the pressure on the study site to explain why patients are not engaged in their healthcare. The PAM tool was noninvasive and helped direct patient care so that the study site and patient felt their needs were met. This tool could provide a more enhanced and fully engaged patient who understands and complies with their healthcare needs.

Section 2: Conceptual Approach and Background

Introduction

Patient engagement is critical within the elderly population, particularly for those managing complex chronic health conditions. The central problem addressed in this study was how to improve poor healthcare outcomes and identify their underlying causes. Key contributing factors included ineffective doctor–patient communication, noncompliance with treatment plans, medications, and appointments, as well as a lack of adherence to healthcare recommendations. Additionally, limited access to or use of healthcare technology further exacerbated these challenges.

As many issues were covered and set aside, the continued lack of healthcare services was unavoidable (Johnstone, 2015). In this graduate project, I explored the following: did poor healthcare outcomes play a pivotal role for the physicians providing healthcare treatment? If so, where was improvement needed, and where could correction and improvement of overall patient healthcare outcomes begin?

RQ1 What are the barriers patients face that hinder them from being effectively engaged in the management of their healthcare conditions?

RQ2 How does the relationship between provider and patient impact patient healthcare outcomes?

Concepts, Models, and Theories

This conceptualized framework established a consistent metric system that stakeholders such as care provider organizations, insurers, and health agencies could use to benchmark overall quality performance. The survey gave stakeholders ongoing and

current data regarding organizational performance status because consumers provided feedback within 48 hours to 6 weeks of discharge. The concept that supported the study was the social cognitive theory (SCT). SCT integrates concepts and processes from cognitive, behavioral, and emotional behavior change models (Schunk & DiBenedetto, 2023). When applied to counseling interventions for disease management, it was proven effective. A key outcome of interventions based on SCT is an increase in self-efficacy, which is essential for effective self-management and improved self-care. SCT is relevant to patient engagement as it examines the behaviors and emotions underlying why patients may not follow their healthcare providers' recommendations. The theory emphasizes that learning occurs within a social context, involving a dynamic and reciprocal interaction between the person, environment, and behavior.

This framework aligns with the study's background by exploring patients' behaviors and interactions with providers, medications, and treatments. Therefore, SCT could improve the patient's view of engagement and address the issues from the patient's behavior standpoint. The data consisted of survey questions answered by clients that evaluated the client's level of engagement.

Hence, allowing the study site to see what areas were needed to help clients understand their disease management process. Accessing the quality of care was not new in healthcare; the rapid growth of the managed-care industry in the United States led to various definitions and perceptions of quality (Cowing et al., 2009). Client engagement could be seen in increased patient portal access, decreased misdiagnoses, and deaths due to a lack of treatment and medication regimen. It also evaluated the client's increased

communication with providers and compliance with treatment, with feedback provided to the providers. The primary objectives were to enhance these key areas and support measurable improvements in clients' overall healthcare outcomes, through collaborative efforts between healthcare providers and patients. The terms in the study may have had multiple meanings, including poor, deprived, disadvantaged, underprivileged, older, geriatric, guidance, and informed.

Relevance to Public Organizations

Poor doctor-patient communication, noncompliance with treatment, medications, appointments, and healthcare recommendations, a lack of healthcare technology, and policies such as the HIPAA and the ACA were essential to diminishing poor patient healthcare outcomes. Concerns about these issues continued to increase, therefore causing a burden on the health care community in terms of preventing poor health care outcomes versus improving health care outcomes (Johnstone, 2015). Poor communication in the doctor-patient relationship was one of the significant issues that led to poor health care outcomes, such as death (Vermeire et al., 2001). People tended to keep things to themselves as a form of self-protection so that they were not vulnerable to others, which was a significant cause of poor communication. In healthcare, this was not a concept that patients could use when talking with their doctors about their well-being. Non-compliance regarding patient healthcare was an issue that fell heavily on the patient's decisions. Non-compliance covered various areas, such as medications, recommendations, appointments, prognosis, and therapeutic regimens. Low compliance

with prescribed medical interventions was an ever-present and complex problem, especially for patients with chronic illnesses (Vermeire et al., 2001).

Doctor-Patient Communication

Communication was defined as the act of conveying intended meaning to another entity through the use of mutually understood signs and semiotic rules (Communication, 2017). The basic steps of communication were the formation of communicative intent, message composition, message encoding, signal transmission, reception of signal, message decoding, and finally, interpretation of the message by the recipient. (Communication, 2017). Communicating means to have a conversation. Communication is an ordinary function in human lives. This is necessary to make contacts, explain things, exchange ideas, convey information, give instructions, and remove misunderstandings. Communication is indispensable for existence.

Communication, however, has a more specific meaning in management science (Communication, 2017). An open line of communication that patients could relate to was critical when patients communicated with providers. This helped to reduce confusion and open lines of understanding with patients. Healthcare was mainly an information business. Care quality, efficiency, and outcomes depended on effectively capturing and managing patient information. There was no healthcare without management, and there was no management without information (Mamlin & Tierney, 2016). Hence, ineffective communication could cause issues regarding patient healthcare that should never have arisen. In any case, with all things, some barriers affect communication efficiency. Barriers to effective communication could retard or distort the message and intention of

the message being conveyed, which might have resulted in the failure of the communication process or an effect that was undesirable (Communication, 2017).

Types of Barriers

Physical barriers are often due to the nature of the environment. Staff shortages were another factor that frequently caused communication difficulties with patients. System design faults referred to problems with the structures or systems in place in an organization (Communication, 2017). In organizations, there was a lack of patient-provider roles and responsibilities, which could lead to confusion and a lack of trust in the medical relationship.

Attitudinal barriers came about because of problems with providers in the healthcare organization. These may have been brought about by poor patient management, a lack of patient consultation, or personality conflicts between provider and patient. Hence, resulting in delay or refusal to communicate, patients' attitudes may have been due to a lack of motivation or dissatisfaction with the provider. Therefore, providers may have been disabled from carrying out medical orders and tasks or resisted continuing a patient's care.

Research showed that communication was described as a problem by patients and providers, either due to problems with diagnosis, a lack of patient involvement in the discussion, or inadequate information to the patient. Studies had shown that 50% of psychosocial and psychiatric problems were missed, that physicians interrupted patients an average of 18 seconds into the patient's description of the presenting problem, that 54% of patient problems and 45% of patient concerns were neither elicited by the

physician nor disclosed by the patient, that patients and physicians did not agree on the main presenting problem in 50% of visits and that patients were dissatisfied with the information provided to them by physicians (Stewart, 1995). Communication was a very complex and important element of daily life. The success of an organization depends on how extensively and intensively communication is carried out.

Communication was described as a tool of management (Mamlin et al., 2016). The three steps of key communication were to give feedback, embrace face-to-face time, and listen to the patients. Yes, anyone could have steps to improving or correcting the process of doing something, but were the patients willing to communicate to their provider (Stewart, 1995)? Face-to-face time was embraced. A large part of communication came from reading patients' and providers' body language and facial expressions, not to mention tone of voice. These necessary cues were missed when communication was done constantly through chats and emails. This left room for misinterpretation and lost information. Email was still a great way to communicate significant bits of information, especially for patients who preferred and were more technologically advanced. Listening to patients' concerns and respecting their feedback helped make patients feel more at ease. That meant taking actions to show that providers respected their patients' wishes regarding their care.

Noncompliance

Noncompliance was defined as a person's informed decision not to adhere to the therapeutic regimen (Vermeire et al., 2001). Medical noncompliance was identified as a significant public health problem that imposed a considerable financial burden upon

modern health care systems (Vermeire et al., 2001). Trust between physician and patient was pivotal to health care outcomes. A collaborative partnership between patient and physician was based on mutual goals and a shared understanding of problems and their potential solutions. It was often difficult for the physician to realize an inherent power imbalance between physicians and patients. Physicians were comfortable in the world of health care, whereas patients were often insecure and/or anxious about it, leading to non-compliance with their health care (Mamlin et al., 2016). Noncompliance was widely present and a complex program, especially for patients with chronic illness, cultural barriers, and socioeconomic class. Lack of compliance with medical advice and treatment was an ongoing frustration for doctors and caregivers. Poor compliance and overall non-compliance with treatments may have significantly impacted clinical outcomes.

Compliance was a word with negative connotations, and it suggested yielding, compliance, and submission (Vermeire et al., 2001). Noncompliance was a failure or refusal to comply and, in essence, implied disobedience. Compliance had been defined as the extent to which the patient's actual history of drug administration corresponded to the prescribed regimen (Vermeire et al., 2001). Hence, compliance was the assumption that medical advice was good for the patient and that the patient followed the medical advice precisely. The process of seeking, receiving, and following treatment and advice had many stages and many opportunities for noncompliance. These stages may have included delay in seeking care, nonparticipation in health programs (screening), breaking of appointments (follow-up), failure to follow doctors' instructions and recommendations (treatment) (Vermeire, et al., 2001). Further types could have been perceived as receiving

a prescription, but not having it made up at a pharmacy, filling out the prescription, and not taking the medicine, taking an incorrect dose, taking medication at the wrong times, forgetting one or more doses of the medication, stopping treatment too soon, either by ceasing to take the medication sooner than the doctor recommended, or failing to obtain a recurring prescription. Hence, non-compliance may have been intentional or unintentional.

However, the Royal Pharmaceutical Society of Great Britain had changed its terminology from compliance to concordance, which meant agreement and harmony (Vermeire et al., 2001). Concordance allowed the patient to be the decision maker. Compliance was the extent to which an individual chose a behavior that coincided with clinical prescription, whereas concordance was a patient's considered choice. Adherence was also proposed as an alternative to compliance and was growing in popularity. Adherence reduced the attribution of greater power to the doctor in the doctor-patient relationship, which the term compliance brought (Vermeire et al., 2001). The question of how to measure compliance was perplexing for many, not just the physicians, but for the patients and their caregivers as well (Stewart, 1995). The complexity of the problem had prevented the development of a gold standard for measurement. Therefore, the method for measuring noncompliance was, by itself, a significant barrier to compliance research and patients' healthcare outcomes (Welch et al., 2007). Because of the difficulties in measuring compliance, no estimate of compliance or non-compliance could be generalized. However, poor compliance was to be expected in 30-50% of all patients, irrespective of disease, prognosis, or setting (Vermeire et al., 2001). Many factors caused

patients to be noncompliant. It was how they reacted to those factors and how their actions affected healthcare outcomes. Factors that had been found to relate to high compliance included the degree of disability, perhaps due to increased supervision, and parental medication administration (Cowing et al., 2009). Other factors contributing to non-compliance included patients' unresolved concerns, including the diagnosis, absence of symptoms, time between taking the drug and its effect, and the fear of adverse effects (Vermeire et al., 2001).

Among these factors, several other factors affected the older population. The complexity of the regimen and poor communication were often mentioned as common causes of non-compliance, especially in elderly patients with memory disorders, which made them unable to follow complex sets of instructions (Vermeire et al., 2001). Noncompliance was a complex issue that must have been decided based on the patient's trust and willingness to believe in the provider's ability to operate in the patient's best interest.

Health Information Exchange-Technology

With the advancement of technology and the increased use of technology in health care, Congress understood that privacy could be eroded; therefore, it established updated rules. The U.S. Department of Health and Human Services (HHS) published a final Privacy Rule in December 2000, which was later modified in August 2002 (Rights, 2024). This rule set national standards for protecting individually identifiable health information by three types of covered entities: health plans, health care clearinghouses, and health care providers who conducted the standard health care transactions

electronically (Rights, 2024). HHS published a final Security Rule in February 2003 (Rights, 2024). This rule set national standards for protecting the confidentiality, integrity, and availability of electronic protected health information (Rights, 2024). With a rapid increase in technologically driven communication in the past several decades, individuals increasingly faced condensed communication in email, text, and social updates.

In contrast, this led to a notable change in how younger generations communicated and perceived their self-efficacy to communicate and connect with others. With the ever-constant presence of another "world" in one's pocket, individuals were multitasking both physically and cognitively as constant reminders of something else happening somewhere else bombarded them (Communication, 2017). Consequently, the health care system was afflicted with physicians being unable to easily access patient information, prescriptions, and diagnoses being written illegibly on paper, and limitations on monitoring patients. It was then, with the advancement of technology, that these problems began to improve and provide more personalized service. Hence, it provides a platform for publishing general health information and allowing patients to gain more comprehensive knowledge about their medical conditions and treatment. Many technologies were being adopted by the medical field, such as electronic patient records (EPR) and sensor networks for remote patient monitoring.

EPRs replaced medical information that was once stored in paper format with the ability to store it electronically in a digital format—using EPRs allowed for easy accessibility and use. Therefore, health care groups created "web portals". These web

portals provided personalized patient information and services to be shared via the internet (AHRQ, 2020). The web portals provided a set of individualized services to allow patients access to their medical records, clinical laboratory results, and other pertinent components of the electronic patient records that were once before only available to physicians and other health care providers (Meingast, et al., 2006).

Additionally, these records included different types of data, such as physicians' notes and MRI results. Using EPRs allowed for real-time access to health care records, independent of the user's physical location. This means one could review information from a doctor's visit or the treatment they received at a hospital from the comfort of their home. Electronic patient records reduced the number of erroneous incidents due to illegibility and inconsistency. EPRs could be backed up more easily than paper-based records, which could prevent data loss. EPRs were linked to a local database that collected all the information for the records of patients at a specific location. For example, although in the same network, each hospital had its own electronic patient information database. The use of local databases allowed for data transmission via the internet so that a physician at one hospital could view a patient's information from another hospital. EPRs were linked with these web portals so that patients' data could be transmitted not just between physicians, but also to the patient at home and other health care providers.

In addition to the advancement of technology, in-home patient monitoring debuted in the health care arena. In-home patient monitoring provided sensor networks and real-time in- home monitoring (Mamlin, et al., 2016). These in-home monitoring

devices provided different types of sensors that could be used at home to monitor a patient's vital signs, such as electrocardiogram sensors (Meingast et al., 2006). This information was sent back via wireless communication technologies such as Bluetooth to a local base station, such as a personal computer, that was located within the patient's home. The in-home monitoring devices could not only evaluate the data sent back to the sensors but also send an alarm to a central monitoring station for the physicians. This allowed the health care providers to take the necessary steps to aid the patient (Mamlin et al., 2016). There are many benefits to using these two technologies; electronic patient records and in-home monitoring systems can be integrated. Once sensor data was transmitted to the monitoring station, it could be incorporated in the patient's EPR (Meingast et al., 2006). While technologies could improve the overall quality of healthcare, delivery remained problematic. However, the benefits of technology had to incorporate the privacy and security concerns of all users, such as patients, physicians, and insurance companies. The use of EPRs and in-home monitoring systems increased the danger of a security breach in which the security and privacy of the individual's health care information was at stake (Cowing, et al., 2009). Policies such as the Health Insurance Portability and Accountability Act of 1996 (HIPPA) Privacy Rule that was implemented by the U.S. Department of Health and Human Services (HHS) helped reassure that security and privacy was maintained (Rights, 2024). Connecting personal healthcare information to the internet exposed it to cyberattacks that, compared to paper-based medical records, were not vulnerable to personal health information being exposed (Miller et al., 2005). Once health care information was available electronically, it was a

gateway for hackers to access the records. Data access, storage, and integrity were key challenges when implementing EPRs and in-home sensor networks (Meingast et al., 2006).

Some of the key security and privacy issues included questions about data ownership, the type and amount of data to be stored, and the appropriate storage location. Additional concerns involved determining who could access a patient's electronic medical record (EMR), and to whom this information could be disclosed—with the patient's consent. It was easy to think that they belonged to the patients; however, this was an unsettled dilemma. It had been the object of recurrent, highly publicized lawsuits and congressional inquiries (Meingast et al., 2006). The data belonged to the patient. Hence, some insurance companies may have wanted to own the data or refused to cover the patient's medical expenses. Third-party rights were also a concern, as the question was raised whether they had the same authority as the data owner (the patient). It was unclear what level of privacy and security protection must have been maintained when data was transferred to a third party (Meingast et al., 2006). The type of data and the amount that should have been stored depended on the amount of data stored in the central location. Doctor's notes, MRIs, and lab results were examples of data that was stored in patient's paper-based records (Meingast, et al., 2006). The universal concern was whether all the raw data should have been stored in a centralized location or just the immediate information that was required for diagnoses. At any rate, any extra information would not have had a significant impact on patient care but may have further compromised the individuals' privacy.

Where the health data should have been stored was perplexing but pivotal to maintaining privacy and security. This was a question of centralized and decentralized storage (Meingast et al., 2006). Who could view a patient's medical record/EPR was divided into two categories. The first category was for users with read/write privileges, such as doctors and nurses, who could view and edit the patient's record. The second category was for users with only read privileges, such as insurance companies, who had limited viewing options but could not edit them. Finally, to whom should this information have been disclosed without the patient's consent? There were situations in which the patient's health information, at times, needed to be disclosed to people other than authorized users. This happened only in emergencies when it was crucial for the patient to receive necessary care.

Policies

Healthcare outcomes were based on several factors that resulted in a person's overall health being either good or bad. The legal aspect of healthcare, such as the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191, was enacted on August 21, 1996. Sections 261 through 264 of HIPAA required the Secretary of HHS to publicize standards for the electronic exchange, privacy, and security of health information (Rights, 2024). Patient information privilege and rights played a pivotal role in determining that outcome. Laws and regulations, such as HIPAA, were implemented to secure health information, build a level of security, and ensure the protection of personal information to protect providers and patients. It also addressed the continuity of care among providers in providing healthcare information. Hence, effective

communication within the healthcare system serves as the foundation of good patient care. The more patients informed providers of their health issues, the better and easier the healthcare treatment would and should have been. While medical care forms the foundation of overall care, its effectiveness is significantly compromised in the absence of clear communication within the healthcare setting. However, just like all things, time changed, and policies made it harder to follow the concept of communicating with patients. Therefore, HIPAA was divided into two regulations:
Privacy and Security (Rights, 2024).

Privacy Rule standards addressed the use and disclosure of individuals' health information, called "protected health information" by organizations subject to the Privacy Rule — called "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information was used (Rights, 2024). This rule was implemented by the Office of Civil Rights (OCR) and enforced with voluntary compliance activities and money penalties. A primary goal of the Privacy Rule was to ensure that individuals' health information was adequately protected while allowing the flow of health information needed to provide and promote high-quality health care and protect the public's health and well-being. The rule struck a balance that permitted important uses of information while protecting the privacy of people who sought care and healing. Given that the health care marketplace was diverse, the rule was designed to be flexible and comprehensive to cover the variety of uses and disclosures that needed to be addressed. The Privacy Rule applied to health plans, health care clearinghouses, and any health care provider who transmitted health information in electronic form (Rights,

2024). Security Rule Standards established a national set of security standards for protecting certain health information that was held or transferred in electronic form. The Security Rule operationalized the protections contained in the Privacy Rule by addressing the technical and non-technical safeguards that organizations called "covered entities" had to put in place to secure individuals' "electronic protected health information" (e-PHI) (Rights, 2024). This rule helped to protect not only the patient but also held providers to a standard of security concerning patient health information. A primary goal of the Security Rule was to protect individuals' health information privacy while allowing covered entities to adopt new technologies to improve the quality and efficiency of patient care. Given that the health care marketplace was diverse, the Security Rule was designed to be flexible and scalable, so a covered entity could implement policies, procedures, and technologies that were appropriate for the entity's particular size, organizational structure, and risks to consumers' e-PHI (Rights, 2024).

Politics played a role in the delivery of healthcare. One important aspect was the degree of coverage, which could be changed by a policy change. Hence, the Affordable Care Act (ACA), which changed as a matter of a political party's opinion. For many decades, healthcare policy had been the foundation of presidential nominees and political parties. Healthcare policy often had been determining whether insurance companies could reject or deny people healthcare coverage based on present and prior health issues, including being misdiagnosed. Therefore, the increased rise in non-insured patients, poor healthcare outcomes, and the "no patient turned away" pledge by many healthcare organizations contributed to healthcare outcomes. When examined closely, it was

possible to see how laws, regulations, and political aspects affected patients' healthcare outcomes. On March 23, 2010, the Affordable Care Act (ACA) was signed into law to help address these concerns (Obama, 2016). Within the United States, it was noted that the degree to which healthcare was provided was often determined by who a person was or where they lived. The phonetic causes of poor healthcare outcomes were access, quality of care, and inadequate care coordination. The Affordable Care Act had expanded healthcare coverage among all Americans. It had removed many financial barriers, closed the "doughnut hole" for Medicare, and decreased the financial barriers of medications (Kocher et al., 2010). This also included coverage of young adults. It had increased the expansion of eligibility for Medicaid to people with incomes up to 138% of the poverty level; it was the largest such expansion since the inception of the program in 1965 (Blumenthal et al., 2014). The law included provisions requiring all health plans to offer dependent coverage until they turned 26. The young-adult provision had been popular across the political spectrum (Blumenthal et al., 2014).

It set the bar in terms of health coverage across America. Since its passing, 16.4 billion people had health care insurance due to the ACA, which represented an 80.3% increase for Hispanics and a 7.3% increase for African Americans (Blumenthal, 2010). Meanwhile, healthcare coverage between men and women and young and old adults was vastly different and was no longer a debate. It was mandated that health plans not charge a difference in coverage based on gender or age. Coverage within the ACA-mandated health plans had to be sold at four distinct levels of actuarial value (Blumenthal et al., 2014). The healthcare markets that were issued marked the end of high overcharged fees.

All were operated under the management of a public administrator to ensure that the ACA terms were being met and benefiting the public. It was no longer up to health plans to set prices or exclude coverage for preexisting health conditions. The ACA continued to help improve healthcare by selling subsidized insurance in the private insurance market, which helped to ensure people who had healthcare coverage could benefit from the ACA. The biggest and most important aspect of the ACA was the Medicaid eligibility program explanation, which was covered 100% by the federal government until that year, which was then reduced to 90% (Kocher et al., 2010). The Affordable Care Act had made significant progress towards solving long-standing challenges facing the U.S. health care system related to access, affordability, and quality of care (Obama, 2016). There was then an opportunity for Americans to receive qualified healthcare insurance without the concern of overcharges or potential low care by providers.

These four causes were the reason behind poor patient healthcare outcomes. Understanding their role in the problem was pivotal to ensuring the solutions targeted all the areas that needed to be addressed. With an understanding of what each cause consisted of, we could then evaluate the solution. In the majority of Western countries, patient engagement in health and social care policies was well established, with the government committing to foster interventions, research projects, and methodologies that prioritized the "patient's voice" and the "patient's active roles in their own healthcare" (Mockford, et al., 2011). It has led to more responsive services and better care outcomes. From a nursing perspective, the need to give patients better and more reliable information and more control and influence over their healthcare was particularly emphasized. The

role of nurses constituted a core component in the organizational aspects of care such as care coordination, continuity of care, and health information exchange: this may have supported the attainment of optimal, patient-centered outcomes defined by a care planning process driven by a robust partnership between nurses, physicians, and patients (Barello, et al., 2012). By building partnerships with patients and families and fostering their engagement in the care process, nurses could develop an appropriate plan of care, addressing issues such as symptom and drug management and meaningful discharge goals (Grant et al., 2009). In parallel, health care was increasingly delivered in the outpatient setting, with shorter inpatient stays, more frequent care transitions between the hospital and other care sites, growing shared responsibility among members of patient care teams, and increasingly complex management of chronic diseases in the home and community (Sarkar, et al., 2009). Healthcare organizations had been in a battle to improve patient healthcare outcomes. The rise in poor patient health outcomes had increased, partly due to a significant problem with patient engagement. This had proven to be a wicked problem that had been very difficult to solve. The solutions employed to address this concern had been unsustainable. A concerted effort to find methods to engage diverse patient populations was warranted to partner with them to improve their healthcare outcomes. This project sought to understand the problem by mapping causes, barriers, stakeholders, and solutions.

We faced the problem: how could we change poor patient healthcare outcomes? Before any changes occurred, we had to evaluate the causes, such as healthcare causes. Hence, poor doctor-patient communication, non-compliance with treatment, medications,

appointments, and healthcare recommendations, a lack of healthcare technology, and policies like the Health Insurance Portability and Accountability Act (HIPAA) and the Affordable Healthcare Act (ACA) were essential to diminishing poor patient healthcare outcomes. Hence, there were rising concerns about the overall health care outcomes of patients, especially the elderly population.

Individuals were expected to decide whether and when to seek care, which plans and providers met their needs, how to manage their health, and how to cope with sometimes conflicting advice from providers and friends and family, all amplified by advances in communications and information technology (Clancy, 2011). Recognizing the imperative to center on the patient, a learning health care system was one in which patients and their families were key drivers of the design and operation of the learning process. When patients, their families, other caregivers, and the public were full, active participants in care, health, the experience of care, and economic outcomes could be substantially improved. People had to make informed choices about insurance and clinicians, coordinate communications among providers, and manage complex treatments independently. Not doing so risked preventable illness, suboptimal outcomes, and wasted resources (Gruman et al., 2010). Combinations of more convenient care, information, reminders, self- monitoring, reinforcement, counseling, family therapy, psychological therapy, crisis intervention, manual telephone follow-up, and supportive care (Wagner, et al., 2001). With these concepts being implemented, there was still a lack of patient engagement. For individuals to realize the benefits of health education, it also required a high level of engagement. Population studies had documented a gap between

expectations and the actual performance of behaviors related to participation in health care and prevention. Significant clinical benefits had been seen from trials of self-management or lifestyle interventions across conditions such as diabetes, coronary heart disease, heart failure, and rheumatoid arthritis (Adams, 2010).

Organization Background and Context

The study site was officially incorporated on March 4, 1969. The study site is an early adopter that recognized the benefit of providing a gathering place for the aging population in the community. By implementing a novel place, the study site created a model of care for its aging population, which required social and interactive needs. The study site is a non-profit organization committed to enhancing the quality of life for individuals aged 50 and older through programs and services delivered with respect and dignity. The site addresses the comprehensive needs of its client population by providing services that include social, recreational, fitness, and educational opportunities. This study was necessary to help identify and address critical challenges within the aging population. The study site faced challenges in coordinating care for clients with chronic health conditions and unmet social determinant needs. Additionally, efforts to engage clients in actively managing their chronic diseases were hindered by low health literacy, which limited their ability to understand and effectively manage their conditions. Engagement concern profoundly impacted the elderly population because they were typically dealing with more than one diagnosis, which added an additional layer of complexity to their ability to manage their diseases. The study site quickly evolved into a social service organization dedicated to serving the elderly. As a non-profit organization,

it is committed to enhancing the quality of life for individuals aged 50 and older by providing programs and services delivered with respect and dignity. To address the comprehensive needs of its clients, the organization offers a range of services, including social, recreational, fitness, and educational opportunities. The organizational terms used in understanding this study included patient, client, elder population, chronic disease, disease process, engagement, healthcare, participation, communication, and health care outcomes.

Role of the Doctor of Public Administration Student/Researcher

The professional context was based on the healthcare profession's perspective on patient care. The professional relationship to the study site was solely based on the population of clients it catered to. My role as the researcher in the project was to collect and analyze survey data. My relationship to the project was as a healthcare professional. I had no relationship with the project's participants and/or institutions besides the project itself. Data sources were obtained from primary and secondary sources. Primary sources included oral histories from the study site clients. Secondary sources included the Department of Aging, the Department of Public Health, medical professionals, the Centers for Medicare & Medicaid Services, and the U.S. Department of Health and Human Services. Both sources informed of this quantitative research study. In this case, we evaluated poor patient healthcare outcomes by assessing patients' level of engagement in their healthcare. This initiative enabled the study site to develop a comprehensive care plan designed to address the specific needs of its client population. The solution that was implemented was evaluated systematically and non-systematically. Systematic evaluation

looked at the order of the implemented process and researched how fundamental it would be to solve the problem.

The nonsystematic evaluation looked at implementation by assessing the process. Both proved valuable tools in continuously implementing the programs, either through modification or termination. The details of how a program underwent development helped ensure that its development was beneficial to the patients. No matter what way the program developed or who proposed it, it was constantly subjected to a process. A process that assured it was a program that would withhold effective standards. The program was evaluated based on the improved outcomes of patient healthcare.

The impact of the programs could be observed through increased patient improvements, noted in patient–provider communication and treatment compliance, with feedback provided to healthcare providers to inform ongoing care. The primary objectives were to enhance these areas and support improvements in overall healthcare outcomes, achieved through active collaboration between providers and patients.

The patients had to be able to check with providers to make sure their questions regarding treatment and medication were addressed. Hence, they were ensuring they evaluated every opposition with providers to improve their overall healthcare outcomes. These outcomes were displayed in increased communication between providers and patients, compliance with healthcare, improvements in technology use, and the implementation of legal policies. Providers, patients, caregivers, and healthcare insurance companies were all expected to participate in the overall outcome of patient care. The providers were expected to communicate so that patients could fully understand and

explain the various treatment options. They were expected to give patients and other healthcare providers access to patient medical records and collaborate with them regarding the patients' overall treatment. The patient was expected to comply with the treatment plan, be informed of how well the providers communicated the plan, have access to medical information via technology, and understand treatment, medication, procedures, and prognosis. Health insurance companies were expected to design patient experiences to be pleasant and to be advocates for the patient. Health insurance companies were expected to exert power because they controlled the purse strings. Additionally, health insurance companies were expected to put patients at the center of their operations, segmenting them into discrete groups, understanding their needs and expectations, and designing care and solutions to make their lives better (Cowing et al., 2009). The type of data that would have been needed to evaluate the solutions implemented would have come via patient surveys, electronic record dashboards, research spreadsheets, and graphs. The information was collected via surveys. The data source came from patient feedback via survey. The data was analyzed via graphs, and surveys feedback from all participants involved.

The evaluation of the implemented solution varied based on the patient's healthcare outcomes. The use of the information obtained helped improve future healthcare concerns over time. The data collected and analyzed played a significant role in the solution.

Role of the Project Team (If Applicable)

The project collaborators were used to provide patients/clients that fell within the study's guidelines. Hence, allowing the surveys to be distributed and collected in a manner feasible for the patients/clients in the community. The members were presented with patient's age, and chronic disease, and aggregated, organized, and compared the evidence extracted from the study. Therefore, after the quantitative data was synthesized, the outcome was placed into one of the following frequency analyses: a meta-analysis graph style presentation. The data acquisitions included a collection timeline indicated by due dates. The researcher already had functional tools that were used to aid, such as a planner, a written calendar, and a digital calendar. The additional aid of Excel, Gantt charts, and a PEST analysis diagram also helped. Despite criticism of patient-satisfaction measures, patient-experience surveys that were designed and administered appropriately provided robust measures of the quality of health care and offered insight into a dimension that was otherwise difficult to measure objectively (Manary et al., 2013). The researcher used a timeline schedule that helped to meet set deadlines, such as acquiring the organization, identifying subjects for the survey, distributing, and collecting data from notebooks and verbal discussions.

8 weeks: pre-surveys to evaluate the client's level of engagement.

8 weeks: Engagement tool to target areas needing improvement via education and use of flyer

8 weeks: post-surveys implementations.

Patients are responsible for giving feedback regarding reviewing the survey questions within 1-2 weeks after the completion of the survey.

The study Site was responsible for providing patients/clients with the guidelines to complete the study survey provided within the pre-survey phase.

Summary

The study's purpose was to improve the client's overall healthcare outcomes. As we could see, some factors prevented, protected, and stopped that from occurring. This study showed that it took the team effort of both the patient and the provider to achieve a good healthcare outcome. To address the causes, as discussed in the study research, of poor doctor-patient communication, non-compliance with treatment, medications, appointments, and healthcare recommendations, and a lack of healthcare technology. The evaluation of the implemented solution varied based on the patient's healthcare outcomes. Using the information obtained could help improve future healthcare concerns over time. The policy, involved parties, and data collected and analyzed played a significant role in the solution.

Section 3: Data Collection Process and Analysis

Introduction

The problem the study site faced was changing poor patient outcomes and identifying their causes. Concerns about these issues continued to rise as preventable deaths increased and available healthcare services were limited. I explored these issues in this graduate project, examining if these poor outcomes are a pivotal concern for those providing healthcare? If so, where was the need for improvement, and how could the study site correct and improve patient outcomes? The need for the study would help address problem areas within the aging population. The study site did not coordinate care for clients with chronic health care conditions or social determinant needs. The study site was challenged in getting clients actively engaged in managing their chronic disease because they lacked the requisite health literacy skills, which would support their ability to comprehend and manage effectively. This concern profoundly impacted the elderly population because they were typically dealing with more than one diagnosis, which added an additional layer of complexity to their ability to manage their diseases.

Practice-Focused Research Question(s)

The client asked me to determine a viable solution to mapping an evidence-based process that would improve patient engagement in managing chronic disease conditions effectively. Many people then focused only on their current healthcare provider, facility, test, labs, and/or medication (Cowing et al., 2009). Patients were not engaged in disease management processes that improved their healthcare outcomes. This was due to a

breakdown in provider-patient communication, leading to non-compliance and issues associated with leveraging technology.

The study site was an early adopter that recognized the benefit of providing a gathering place for the aging population in the community. By implementing a novel approach, it is a nonprofit organization committed to providing programs and services that enhanced the quality of life with respect and dignity for individuals aged 50 and older. It addresses the comprehensive needs of its client population by providing services that include social, recreational, fitness, and education opportunities.

There are limited services and programs related to health that addresses the aging population's complex chronic health conditions. The study site does not coordinate care for clients with chronic health care conditions or social determinant needs. It is challenged in getting clients actively engaged in managing their chronic disease because they lacked the requisite health literacy skills, which would have supported their ability to comprehend and manage effectively. This concern profoundly impacted the elderly population because they were typically dealing with more than one diagnosis, which added an additional layer of complexity to their ability to manage their diseases. The lack of a primary focus on health promotion and disease prevention was evident over time.

Sources of Evidence

Identifying the factors and barriers impeding patient engagement decreases opportunities to manage their chronic disease condition effectively. Similar problems in other organizations found viable solutions by using a patient assessment, which evaluated the patient's level of engagement, understanding, and compliance with their care.

Healthcare organizations used patient satisfaction surveys to create quality improvement initiatives, monitor employee performance, and pinpoint service gaps (3 Ways to Achieve Quality Health Care and Improve Patient Outcomes, 2024). This study aimed to improve patient engagement in effectively managing their chronic disease conditions and increase the organization's ability to improve its aging population's health literacy. This study identified those factors and barriers that impeded patient engagement, which developed opportunities via programs, educational seminars, and services that helped to improve the patients' ability to manage their chronic disease effectively. Survey questions were used to identify the areas that affected patients' ability to engage. Exploring the areas better helped the organization address the areas that needed attention and what services they could provide to educate them.

Analysis and Synthesis

The data acquisitions consisted of a collection timeline indicated by due dates. I used already functional tools to aid me, such as a planner, a written calendar, and a digital calendar. The additional aid of Survey Monkey, an Excel-based tool, was used as a built-in organizing and tracking feature to collect the data, and maybe the use of the PEST Analysis Diagram also helped collect, track, and analyze the data. The systems used to record the data were via a versatile survey tool. The survey forms were distributed to each participant via a QR code link on a flyer. The participant must be over 50 years old and have had one or more chronic health care conditions. Once the information was obtained via the survey, the participant was placed in an analyzing tool containing demographic data, such as their age, and chronic health conditions. The survey results

were answered by each participant uploaded into the Gantt chart diagram. All the various aids, as stated above, helped in the process of organizing the data in order to come up with a conclusion. The integrity of the evidence was kept confidential using the following procedures. These procedures included identifying the participant by assigned number. The flyer described the topic and objective of the research and was placed in several locations within the study site. Data could be a tremendous asset when the right sources were streamlined and analyzed correctly, helping drive operational efficiencies and better patient outcomes. The data was analyzed via graphs and charts from all participants involved.

Summary

In conclusion, the evaluation of the implemented solutions varied based on the patient outcomes. Using the data obtained helped improve future health care concerns and how to improve the solutions over time. The data collected and analyzed played a significant role in the solution.

Section 4: Evaluation and Recommendations

Introduction

The study site is challenged in getting clients actively engaged in managing their chronic disease because they lack the requisite health literacy skills needed to effectively comprehend and manage their health care concerns. In addition, the lack of focus on health promotion and disease prevention over time has not equipped its clients to be active participants in their care which has led to poor outcomes (Vermeire et al., 2001). Clients typically are facing comorbidities due to their advancing age, making effective management far more complex. The goal is to address these issues that prevent the aging population from being involved in effective chronic disease management. By understanding what undergirds poor self-management of chronic disease in the cites elderly population, the agency can develop programs and services to comprehensively support their needs and meet them where they are in their disease process.

This study was critical in gaining the necessary information needed to address this issue within the study site. The study site understood the need for programs and services to improve the overall health outcomes for their aging population. By participating in the study, the site now can impact their clients health trajectory.

Data Collection

After receiving approval from the Walden Institutional Review Board (approval #07-11-24-1012074), I used SurveyMonkey, an online quantitative survey with closed-ended questions in a structured questionnaire, to collect data from 20 elderly members at the study site. The study required anonymity for all the participants regarding their

names, addresses, and other protected health information per the ethical standards of the data collected for the study. Participants were assigned an anonymous number generated according to the time they entered the data collection tool on Survey Monkey.

After receiving approval from the Walden Institutional Review Board (IRB), the data collection process commenced on July 17, 2024, and lasted 1 week.

The quantitative data for the study were recorded via an online survey on SurveyMonkey, in which the structured questionnaire recorded the participants' responses to the closed-ended questions, making it easy to analyze the data, allowing responses to be transcribed and exported. Researchers such as Ruiz et al. (2017) asserted that online tools such as Survey Monkey have easier access, avoid input and data coding errors, have faster distribution, and save time and cost for the researcher.

There was no variation in data collection from the plan presented in Chapter 3. There were no unusual circumstances, nor were there any unanticipated limitations during data collection.

Figure 1 indicates the number of participants required for the study, as determined using the Open-Source Epidemiologic Statistics for Public Health (OpenEpi) tool.

Figure 1

Number of Participants

The number of participants in the research will be no more than 20. The tool used in determining the number of participants is: Open Source Epidemiologic Statistics for Public Health: Sample Size for Frequency in a Population

Population size (for finite population correction factor or fpc)(N):100 Hypothesized % frequency of outcome factor in the population (p): 50%+/-20 Confidence limits as % of 100(absolute +/- %)(d): 20%
Design effect (for cluster surveys-DEFF): 1 Sample Size(n) for Various Confidence Levels

Confidence	Level (%)	Sample Size
95%	20	
80%	10	
90%	15	
97%	23	
99%	30	
99.9%	41	
99.99%	49	

Equation
Sample size n = [DEFF*Np(1-p)]/ [(d2/Z21-

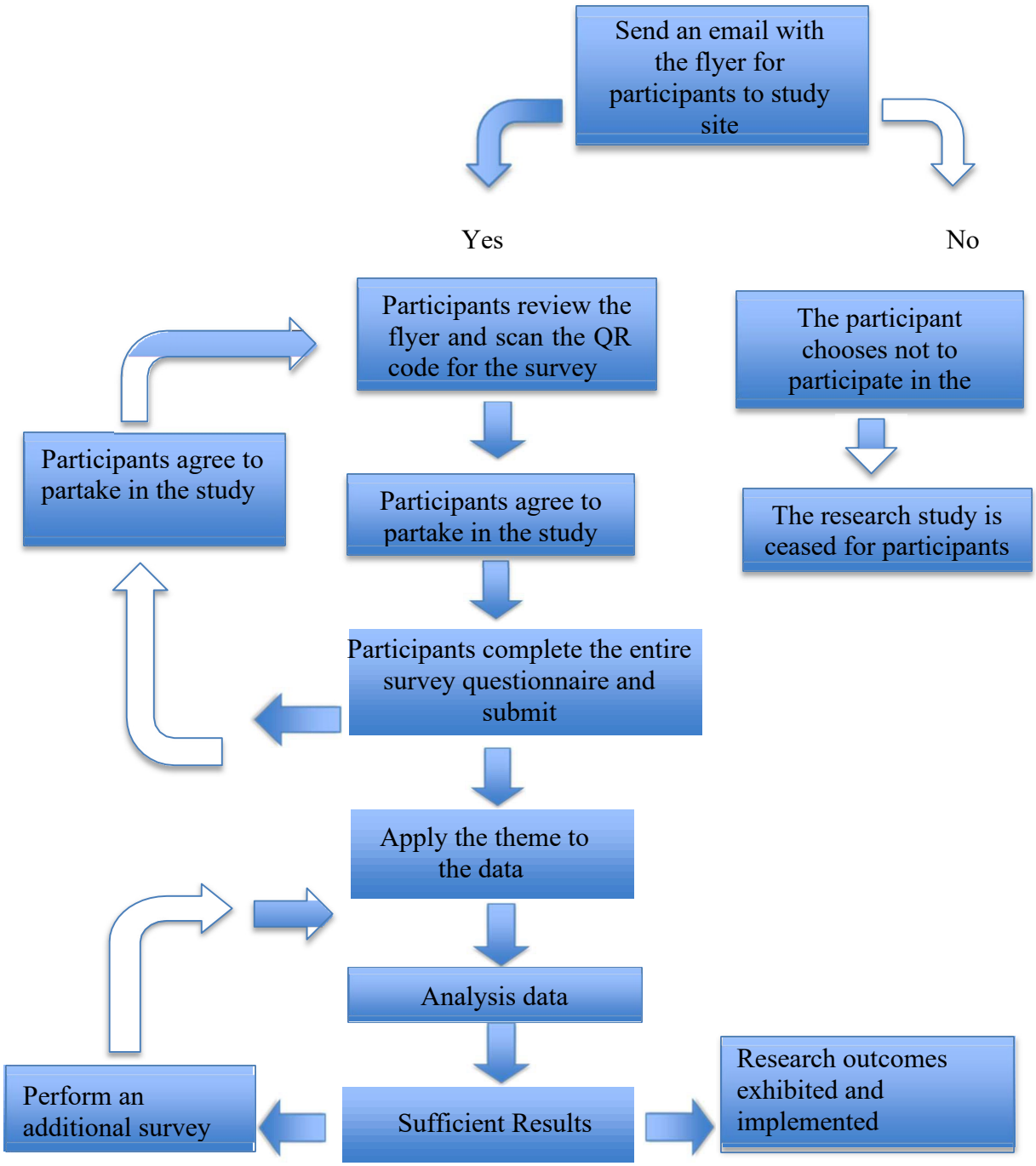
α/2*(N-1)+p*(1-p)]. Results from OpenEpi,

Version 3, open source calculator—SSPropor

Figure 2 indicates the data collection flow for the study, highlighting the steps taken to execute the study process.

Figure 2

Research Study Data Collection Flow Chart



Findings and Implications

The online survey consisted of 13 questions, including two demographic questions, as indicated in Table 2. Participants were given a number ranging from 1-20 to protect their anonymity. Participants' ages ranged from 50 to 106 years, as indicated in Table 2. All the participants had one or more chronic healthcare conditions, as indicated in Table 1. The top chronic health condition was hypertension. The survey indicated that most participants see their healthcare provider every 3 months.

The survey consisted of the following questions.

Table 1

Patient Engagement Survey

Gender:_ Male_ Female_Transgender_ Non-binary_ Prefer not to respond.

Age: __50-60, 61-70, 71-80, 81+

Which of the following chronic health conditions apply to you?

Alzheimer's disease and other dementias	Arthritis
Asthma	Cancer
Chronic obstructive pulmonary disease COPD)	Diabetes
High cholesterol	Heart disease
Hypertension	Kidney disease
Obesity	Osteoporosis
Stroke	

1. How often do you see your health care provider for your chronic health conditions? Every 3 months

Every 6 months
Once a year
When needed
2. Are there barriers that prevent you from expressing health concerns?
Yes, please explain:
No
3. I feel that my provider addresses my health concerns.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
4. I have a full understanding (nature and cause) of my chronic health care conditions.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
5. I have someone who can advocate for me when addressing my chronic health conditions.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
6. I understand what each of my prescribed medications does.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
7. I am confident regarding discussing my health conditions with my provider.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
8. I understand the different medical treatment options available for my chronic health care conditions.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree

9. I can maintain, my lifestyle changes that are required for my health.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
10. I feel that I have the support from my providers to change my health care outcomes.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
11. I take an active role in my health care.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
12. I know how to address problems that arise with my chronic healthcare condition.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree
13. I know the signs and symptoms when my chronic healthcare condition is getting worse.
Strongly agree
Agree
Neither agree or disagree
Disagree
Strongly disagree

Figure 3 illustrates the chronic health conditions identified by participants through the survey responses.

Figure 3

Participants' chronic disease demographics

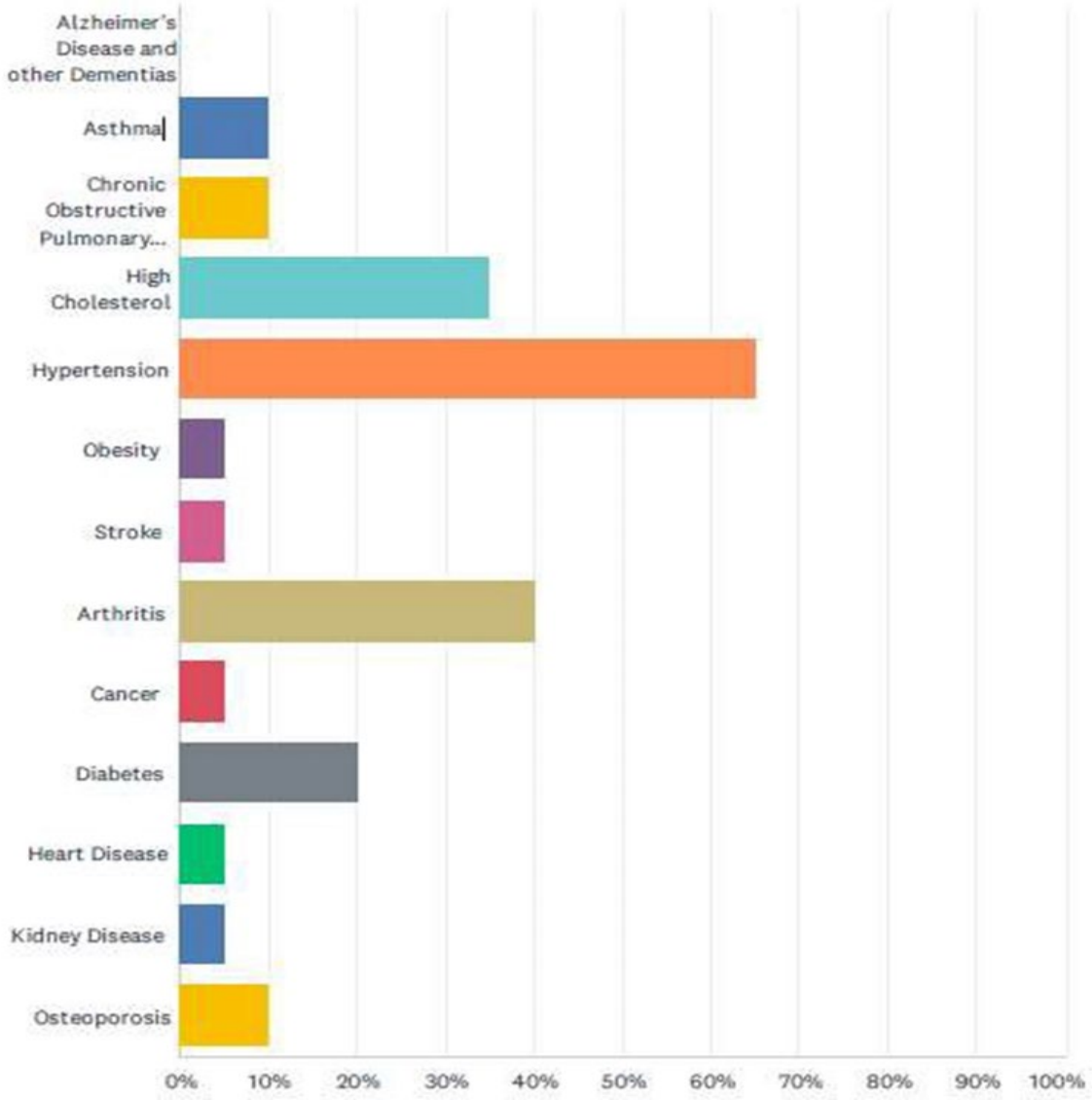


Table 2

Participants' demographics

Demographics	category	Percentage	Number of participants
Age			
	50-60	5.00%	1
	61-70	35.00%	7
	71-80	30.00%	6
	81+	30.00%	6
Gender			
	Male	15.00%	3
	Female	85.00%	17
	Nonbinary	0.00%	0
	Transgender	0.00%	0

Survey #1 Summary

Participant 1 indicated that they were a female member, in the age range of 61-70, and had one chronic health condition. The participant expressed that they see their provider every 3 months and that there were no barriers that prevented them from expressing health concerns. Participant 1 noted that their health concerns are addressed by their provider and that they have someone personal who can advocate on their behalf. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 1 noted that they are confident in discussing their health conditions with their provider, and they are able to maintain lifestyle changes that are required for their health. The participants believe they have the support of their providers. They take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #2 Summary

Participant 2 indicated that they were a female member, in the age range of 61-70, and had four chronic health conditions. The participant expressed that they see their provider every 6 months and that there are no barriers that prevent them from expressing health concerns. Participant 2 noted they did not feel their health concerns were addressed by their provider and they do not have someone to advocate on their behalf. The participant indicated they do not fully understand their chronic healthcare conditions but do understand their medications and treatment options. Participant 2 indicated confidence in communicating their health conditions to their provider and demonstrated the ability to sustain necessary lifestyle modifications to support their health. The participant believes they do not have the support of their providers in changing health care outcomes. However, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening chronic healthcare conditions.

Survey #3 Summary

Participant 3 indicated that they were a male member, in the age range of 71-80, and had three chronic health conditions. The participant expressed that they see the provider every 3 months and that there are no barriers that prevent the participant from expressing health concerns. Participant 3 noted that they feel their health concerns are addressed by their provider and that they do not have someone personal who can advocate for their health. The participant indicated that they do fully understand their chronic healthcare conditions and their medications, but do not understand their treatment

options. Participant three noted that they are confident in discussing their health conditions with their provider, and they can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, and they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening chronic healthcare conditions.

Survey #4 Summary

Participant 4 indicated that they were a female member, aged 61-70, and had seven chronic health conditions. The participant expressed that she sees her provider every 3 months and that there are barriers that prevent the participant from expressing health concerns, "fear of the unknown." Participant 4 noted that their health concerns are addressed by their provider and that they have someone personal who can advocate for their health. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 4 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes and take an active role in their health. However, they are unsure if they know how to address health problems that arise and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #5 Summary

Participant 5 indicated that they were a female member, aged 61-70, and had one chronic health condition. The participant expressed that they see their provider once a

year and that no barriers prevent the participant from expressing health concerns. Participant 5 noted that their health concerns are not addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 5 noted that they are not confident in discussing their health conditions with their provider, but they can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes. However, they do not take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #6 Summary

Participant 6 indicated that they were a female member, aged 61-70, and had four chronic health conditions. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 6 noted that their health concerns are addressed by their provider and that they have someone personal who can advocate on their behalf. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 6 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, and they take an active role in their health, know how to address health

problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #7 Summary

Participant 7 indicated that they were a female member, aged 61-70, and had one chronic health condition. The participant expressed that they see their provider every 6 months and that no barriers prevent the participant from expressing health concerns. Participant 7 noted that their provider addresses their health concerns and that they are unsure if someone personally can advocate for their health. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 7 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #8 Summary

Participant 8 indicated that they were a female member, aged 61-70, and had two chronic health conditions. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 8 noted that they are unsure if their provider addresses their health concerns, but they do have someone personal who can advocate on their behalf. The participant indicated that they fully understand their medications, treatment options, and chronic

health care conditions. Participant 8 noted that they are confident in discussing their health conditions with their provider, and they can maintain lifestyle changes required for their health. The participant is unsure if they have the support of their providers in changing health care outcomes. However, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #9 Summary

Participant 9 indicated that they were a male member, aged 50-60, and had one chronic health condition. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 9 noted that their health concerns are addressed by their provider and that they have someone personal who can advocate on their behalf. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 9 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #10 Summary

Participant 10 indicated that they were a female member, aged 81+, and had one chronic health condition. The participant expressed that they see their provider every 3

months and that no barriers prevent the participant from expressing health concerns. Participant 10 noted that their health concerns are addressed by their provider and that they have someone personal who can advocate on their behalf. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 10 noted that they are confident in discussing their health conditions with their provider, but they cannot maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #11 Summary

Participant 11 indicated that they were a male member, aged 71-80, and had one chronic health condition. The participant expressed that they see their provider when needed and that no barriers prevent the participant from expressing health concerns. Participant 11 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 11 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, and they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #12 Summary

Participant 12 indicated that they were a female member, in the age range of 81+, and had three chronic health conditions. The participant expressed that they see their provider every 6 months and that no barriers prevent the participant from expressing health concerns. Participant 12 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 12 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #13 Summary

Participant 13 indicated that they were a female member, in the age range of 81+, and had six chronic health conditions. The participant expressed that they see their provider every 6 months and that no barriers prevent the participant from expressing health concerns. Participant 13 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their medications, treatment options, and chronic health care conditions. Participant 13 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their

health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #14 Summary

Participant 14 indicated that they were a female member, aged 71-80, and had one chronic health condition. The participant expressed that they see their provider once a year and that no barriers prevent the participant from expressing health concerns. Participant 14 noted that they are unsure if their health concerns are addressed by their provider and that they do not have someone to advocate for their health. The participant indicated that they fully understand their chronic health care conditions and medications but are unsure if they understand treatment options. Participant 14 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant is unsure if they believe they have the support of their providers in changing health care outcomes, they take an active role in their health, unsure if they know how to address health problems that arise but can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #15 Summary

Participant 15 indicated that they were a female member, aged 71-80, and had two chronic health conditions. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns.

Participant 15 noted that they are unsure if their provider addresses their health concerns, but they do have someone personally who can advocate on their behalf. The participant indicated that they do not have a complete understanding of their chronic health care conditions, but they do understand their medications and treatment options. Participant 15 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes; they are unsure if they take an active role in their health, but know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #16 Summary

Participant 16 indicated that they were a female member, aged 81+, and had two chronic health conditions. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 16 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their chronic health care conditions, medications, and treatment options. Participant 16 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #17 Summary

Participant 17 indicated that they were a female member, aged 71-80, and had one chronic health condition. The participant expressed that they see their provider every 6 months and that no barriers prevent the participant from expressing health concerns. Participant 17 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their chronic health care conditions, medications, and treatment options. Participant 17 noted that they are confident in discussing their health conditions with their provider, and they can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #18 Summary

Participant 18 indicated that they were a female member, aged 81+, and had two chronic health conditions. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 18 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their chronic health care conditions, medications, and treatment options. Participant 18 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant

believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #19 Summary

Participant 19 indicated that they were a female member, aged 71-80, and had one chronic health condition. The participant expressed that they see their provider every 6 months and that no barriers prevent the participant from expressing health concerns. Participant 19 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their chronic health care conditions, medications, and treatment options. Participant 19 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

Survey #20 Summary

Participant 20 indicated that they were a female member, aged 81+, and had one chronic health condition. The participant expressed that they see their provider every 3 months and that no barriers prevent the participant from expressing health concerns. Participant 20 noted that their health concerns are addressed by their provider and that they have someone who can advocate for them. The participant indicated that they fully understand their chronic health care conditions, medications, and treatment options.

Participant 20 noted that they are confident in discussing their health conditions with their provider and can maintain lifestyle changes required for their health. The participant believes they have the support of their providers in changing health care outcomes, they take an active role in their health, know how to address health problems that arise, and can identify signs and symptoms of worsening their chronic healthcare condition.

There is a lack of engagement by elderly patients at the study site, leading to decreased patient engagement and poor patient health outcomes. The fact that patients are not engaged is perplexing, and the need to understand the barriers is important. Many barriers leave elderly patients unwilling to express themselves or ask for help. These barriers cause a lack in provider-patient communication, an increase in non-compliance, and issues with technology amongst the aging population. It is also known that patients can become and want to be more engaged, but first, they need to understand these barriers and how they can be changed, eliminated, or improved.

Research Question 1: What are the barriers patients face, which prohibit effective engagement and management of their healthcare outcomes concerning chronic conditions?

$H_0$1: There are no barriers that patients face that prohibit effective engagement and management of their healthcare outcomes concerning their chronic conditions.

$H_1$1: There are barriers patients face that prohibit effective engagement and management of their healthcare outcomes concerning their chronic conditions.

Research Question 2: How does the relationship between provider and patient impact patient healthcare outcomes?

$H_0$2: There is no relationship between the provider and the patient that has an impact on poor patient healthcare outcomes.

$H_1$2: There is a relationship between the provider and the patient that impacts poor patient healthcare outcomes.

The concept that supports this study is Social Cognitive Theory (SCT). SCT integrates concepts and processes from cognitive, behavioral, and emotional behavior change models. When applied to counseling interventions for disease management, it has been proven effective.

Public administration and psychology have a close relationship when looking at the behaviors of the public. How studies are conducted and analyzed within public administration requires psychological application. Public administration's information from other fields, such as psychology, helps to aid in solutions to public issues. Psychological theories influence a different approach to public administration problems, supporting or highlighting areas within public administration. Therefore, SCT can improve the patient's view of engagement and address the issues from a behavioral standpoint. Social Cognitive Theory is just one of many psychological theories that analyze people's behavior and is being used in this study.

This theory relates to patient engagement because it examines the behavior and emotions of why patients do not follow their providers' recommendations. SCT posits that learning occurs in a social context with a dynamic and reciprocal interaction of the person, environment, and behavior. Furthermore, it states that human behavior continually interacts in a three-way, dynamic, reciprocal model in which personal factors,

environmental influences, and behavior converge (Glanz, 2019). SCT synthesizes concepts and processes from cognitive, behavioristic, and emotional models of behavior change so that it can be readily applied to counseling interventions for disease prevention and management (Glanz, 2019). The theory relates to the background because it examines patients' behavior and interactions with providers, medications, and treatment. The study examines why patients display behaviors that result from not engaging in healthcare. The study aims to improve patients' behavior by understanding the barriers that hinder their healthcare outcomes.

The survey indicated minimal barriers that patients face that prohibit effective engagement and management of their healthcare outcomes concerning their chronic conditions. Therefore, even if those barriers are present, they are avoidable, supporting the theory that no barriers are present.

The second research question indicated that the relationship between providers and patients has an impact on poor patient healthcare outcomes. Hence, this supports the second theory that the relationship between providers and patients impacts poor patient health outcomes.

Therefore, the solution to the potential problem of a lack of patient engagement with their health providers with chronic healthcare conditions is minimal among the aging population. As indicated by the survey, most individuals are engaged in their healthcare. It also indicated that the majority had no barriers that prevented them from being engaged, they understood their healthcare conditions, their providers addressed

their issues, had someone to advocate for them, understood their medications and medical treatment, felt confident discussing their health condition with a provider.

Recommendations

A key challenge at the study site is engaging clients in chronic disease management, as many lack the health literacy skills required to comprehend and manage their conditions effectively. This concern profoundly impacts the elderly population because they are typically dealing with more than one diagnosis, which adds an additional layer of complexity to their ability to manage their diseases. The lack of a primary focus on health promotion and disease prevention over time has led to poor outcomes regarding patient health (Vermeire, et al., 2001). It is important that the study site has a firm understanding of the issues contributing to its aging population lack of involvement in effectively managing their chronic conditions. Armed with this knowledge, the site will have the beginning of a framework in developing the needed programs and services to support their elderly population.

The recommendations are for the study site to offer educational programs and services that would improve health literacy and knowledge of targeted chronic diseases identified in the survey such as hypertension and diabetes. In addition, nutritional education to address obesity as indicated in the survey is another recommendation. The educational programs and services would consist of internal healthy eating and cooking program. A free external resource offered by the Delaware Department of Health and Social Services is an evidence-based Chronic Disease Self-Management Program (CDSMP) developed by Stanford University. CDSMP offer comprehensive multi-lingual

training which will address the complex needs of their population. The CDSMP employs a cost-effective train-the-trainer model which then can be fully implemented at the site. Example to of the topics offered by CDSMP include healthy eating, appropriate use of medication, working more effectively with health care providers, as well as action-planning, problem solving, and decision-making.

Strengths and Limitations of the Project

The study did not encounter any limitations. The strength of the study was the accessibility of the survey. The ease with which participants could access the survey via their own personal devices and the limited time it took to answer the questions.

Section 5: Dissemination Plan

Dissemination Plan

The study with the goal of revamping or developing the support needed to effectively manage their chronic health conditions. The plan for getting the study results to the organization is to formally present the findings to the leadership team at site and send all data collected via SurveyMonkey in a secure email. This will allow the organization to review the data and effectively implement action plans at the organization's convenience.

The research shows that more active, engaged patients have better health outcomes and care experiences than less engaged patients. A solution to the problem of poor patient healthcare outcomes is evaluating patients' level of engagement. The survey process allows this to occur without interfering with participants or the organization's routine.

The survey method is the most appropriate form of collection. The issue significantly affects the aging population, ranging from 50 to older individuals who are elderly with one or more chronic health conditions. Hence, they need to visit or discuss health issues with their providers. The suitable venues for this collection would be in a setting that caters to their needs. Hence, a senior center, apartment complex, or development.

Summary

In conclusion, the primary goal of the study site is to help its patient population to improve effective management of their chronic diseases there by improving their overall

health trajectory. Through this study process, the organization now has the opportunity to meet the needs of their elderly population by addressing both their health literacy and understanding of the chronic disease management process. The underlying factors contributing to this complex issue include ineffective doctor-patient communication, non-adherence to prescribed treatments, medications, appointments, and healthcare recommendations, as well as insufficient understanding of healthcare technology and policies. Improving knowledge deficits, bolstering the study site's staff ability and capacity to support its elderly population are necessary first steps to sustain improvement.

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