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Developing an Interactive Story for Children with Asthma

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BACKGROUND AND SIGNIFICANCE

Asthma, an obstructive airway disease characterized by recurrent episodes of breathlessness and wheezing, is the most prevalent chronic illness among children in the United States.¹ Minority and low socioeconomic status patients are the most likely to be hospitalized for asthma.² The impact of this disease is striking: not only is asthma the number 1 cause of hospitalizations for children aged 3 to 12, it also results in a total of 10.5 million missed school days per year.³

The tragedy is that many of these hospitalizations and missed school days are preventable. Better asthma management could save millions of dollars per year and spare patients with asthma and their families the trauma of a hospital stay.⁴ Because children spend a significant

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amount time at school, it is important that they engage in self-care activities and seek help with self-management during these hours.

DEVELOPMENT OF AN INTERACTIVE ASTHMA PROGRAM

Okay with Asthma (OKWA) is a program for school-aged children that was designed for the school environment but may be well suited for home or clinic use.

Biobehavioral Family Model

OKWA uses the Biobehavioral Family Model (BBFM)⁵ as a framework for the content, and therefore, promotes self-management skills with the help of family, peers, community, and health care providers. It also focuses on the importance of psychological and emotional functioning, including acceptance of asthma. Although OKWA will experience ongoing revisions owing to the nature of Internet sites, here we report the results of feasibility and usability testing with children as users of the program during focus groups.

It is clear that asthma management should include more than just information about medications and their uses. Asthma management includes identifying symptoms, reducing triggers that cause asthma, monitoring lung function, and knowing when and how to get help from others. In the BBFM, Wood and Miller⁵ propose 3 overlapping “realms of functioning” that help determine the course of chronic childhood diseases: psychological and emotional functioning, social functioning (including family, school, peers, work), and biologic functioning (including the actual disease process). When these areas are balanced, the patient experiences a state of well-being. This state is interrupted if there is dysfunction in any of the realms. To keep balance, the child must draw on all available resources, including the family, health care providers, community, and peers.⁵

Studies have demonstrated the importance of the family in managing chronic conditions.⁶ Encouraging strong family functioning can reduce child stress and improve asthma control.⁶ Like other chronic conditions, asthma carries a strong psychosomatic component. Increased levels of child stress are correlated with increased asthma severity⁷⁻⁹ and, therefore, may be considered an asthma trigger.

A child with well-managed asthma must feel secure in family relationships and know the family is reliable for problem solving.⁷ Thus, an asthma education program using the BBFM would encourage a child to consider family members as resources to aid self-management; however, according to the BBFM, the family must not be the sole resource for managing chronic illness.⁵ Dysfunctional families, or even families with limited financial means or a mother working outside the home, often have difficulty managing asthma,¹⁰ and sometimes caregivers do not model effective coping strategies.

Keeping in mind that children spend most of their waking hours in school or school-related activities, the BBFM suggests that teaching children to seek resources at school could be empowering and helpful in managing asthma.⁵ Existing literature supports school-based interventions, showing that they can help increase knowledge¹¹ and self-management.¹² Many children report concern about having an asthma attack at school and need

encouragement to seek help from providers there.¹³ Some research, however, shows programs with the greatest benefit involved advanced providers. Children who demonstrated fewer school absences during and after a school intervention program were those who met with an allergist and received a plan for asthma management.¹²

Hand-in-hand with the health care resources, the BBFM encourages accessing community resources. One study showed that home visits by a trained community health worker improved quality of life and reduced symptomatic days for patients in the Seattle area.¹⁴

Last, the BBFM proposes that peers be viewed as a resource for maintaining self-management of chronic diseases. In fact, evidence shows that children may rely on peers as an important part of their self-management. Peer acceptance, independent of asthma-related support, is correlated with healthy asthma lifestyle choices.¹⁵ In the same study, it was found that parental support was only slightly more influential than peer support on asthma-related behaviors, such as managing asthma flares, avoiding causative substances, and maintaining a healthy level of physical activity. Educational initiatives led by peers can have an especially significant impact on attitudes and perception of quality of life, particularly in boys who have fewer family resources.¹⁶

All 4 factors outlined in the BBFM (family, health care, community, and peers) are significant in the management of chronic diseases like asthma. Researchers and providers would benefit from using this model to create educational materials that address not just one, but all of the factors, including the psychosocial strategies that are hallmark concepts of the BBFM.⁷⁻⁹ One way to encourage children to manage their own asthma is to offer a BBFM-based educational program they can use at school.

Computer-Based Learning

Systematic reviews have repeatedly shown that interactive health communication applications positively affect knowledge, attitudes, behavior, and clinical outcomes.¹⁷⁻¹⁹ Studies also indicate that computer-based learning (CBL) is especially helpful for elementary school students, as programs can help improve knowledge and attitudes²⁰ and increase problem-solving skills.²¹ Interactive games also have shown great promise, both in increasing knowledge and improving clinical outcomes. An interactive game developed to improve asthma control among children aged 7 to 17 entitled “Watch, Discover, Think, and Act” was shown to increase self-efficacy, knowledge, and internal attributions.²² Another study showed that low-income children who used the program had fewer asthma-related hospitalizations than their counterparts in the comparison group.²³ They also reported fewer asthma symptoms, less activity restriction, and better self-management behaviors than participants in the control group.²³

OKWA

OKWA is an Internet-based program (www.okay-with-asthma.org), developed in 2003, that uses interactive narrative to teach asthma management to children aged 8 to 11. This award-winning program encourages users to describe their feelings and asthma support systems as they interact with a prewritten narrative and then add text to create their own stories. Because of the successes of the first version of OKWA, the developers planned a second

version that uses similar, but more refined techniques supporting interactivity. The aim of this study was to test OKWAv.2.0's feasibility and usability (design, interactivity, functionality, and interface) during the development process by using focus groups with 8-year-old to 11-year-old children with asthma.

SELF-MANAGEMENT

The 2 main foci in developing OKWAv.2.0 were the program's content and delivery method. For the program to be most effective, its content must provide asthma self-management strategies that address all aspects (biopsychosocial) of the disease. In asthma, as in other chronic conditions, emphasis is placed on the concept of self-management. Children are urged to follow daily maintenance recommendations, perform regular monitoring, and appropriately treat acute and severe exacerbations. A Cochrane review of educational interventions found that an increased emphasis on self-management was correlated with increased lung function and a greater perception of self-control of the condition. Self-management also decreased loss of productivity and reduced asthma-focused emergency room visits.²⁴ The key to increased self-management is education.^{25,26} Some children and families are unable to manage the disease because they have little concept of their ability to do so,²⁶ but educational interventions can help empower patients and caregivers to take control. Although research has indicated that patient education by a health care provider is helpful, some studies are investigating the role trained laypeople play in asthma education. Horner and Faloudi¹¹ found that classroom instruction by a lay educator improved students' knowledge of skills and perceived self-efficacy related to asthma control.

TODAY'S SCHOOL-AGED LEARNERS

Another crucial component in the success of OKWAv.2.0 is its attention to the specific needs of today's learners. To engage children,²⁷ programs must adopt multimedia-rich delivery methods that entertain while educating, especially programs designed to promote healthy behaviors.²⁸ In addition to using a multimedia-rich delivery system, OKWAv.2.0 uses interactive narrative, another effective strategy for educating children.

Engagement is a term often used to describe a user's relationship with an educational medium, including CBL programs. For learning to take place, a user must be engaged with the material.²⁹ Engagement can be defined as the user having positive emotional responses while his or her complete interest is held by the program; this may or may not include becoming unaware of time and the presence of others.³⁰ One theoretical framework for constructing engaging materials is the Engaging Multimedia Design Model, now renamed the Norma Engaging Multimedia Design (NEMD).³¹ In a study that examined children's interaction with the computer game "The Sims," Norma Said identified 5 factors that facilitated engagement: simulation interactivity, construct interactivity, immediacy, feedback, and goals.³¹ Simulation interactivity describes the child's ability to "become" a character in the story, whereas construct interactivity refers to the availability of activities for the child to create or build in the virtual world. Immediacy is the user's ability to observe all the actions and interactions that take place in the system. Children need feedback to show that their choices matter; without consequences, there would be no point in performing the actions.

The model's final tenet is goal setting. Whether the goal is set extrinsically (by the game developer) or intrinsically (the child determining own goals), it is important for there to be goals to achieve.³² The NEMD is one of the models used to guide the usability and feasibility testing of OKWAv.2.0 in this study.

INTERACTIVE NARRATIVES

Narratives, or stories, are an essential component in oral history, passing of traditions, and presenting lessons for preschool and school-aged children. As technology advances, narrative continues to be an essential experience; even computer games rely on narrative to give meaning to virtual activities.¹⁹ To be effective, narratives must have a consistent and coherent plot containing elements of drama as well as character believability and empathy. The narrative must provide some aspects the user can control, and should promote positive emotions for the duration of use. Interactive narrative (IN) is a nonlinear story that allows users to select information, scenes, and characters (interactive) while developing a sequence of events (narrative) that culminates in a lesson or event.^{33–35}

Unlike traditional forms of story, IN encourages active learning because the learner manipulates the content and plot of the narrative based on their input.³⁶ Interactive narratives have the potential to meet a learner's needs and encourage expression of thought and feelings while creating one's own personal asthma narrative. Interactive narrative as an intervention has been successfully used to increase knowledge and decrease symptoms and emergency room visits in children with asthma.³⁷

OKWAv.2.0 allows the user to construct multiple, nonlinear stories. In fact, it is a story tree where branches of the story are different but each story shares the same trunk of characters and lessons pertaining to asthma Fig. 1. The interactivity of the story tree is designed to engage learners using the methods presented in the NEMD.³¹ Using this design model may capture and retain the attention of children better than previous asthma programs, giving them multiple opportunities to express their own experiences and potentially learn new information with each use. Because children will likely create stories that are based on their own illness narrative or one they desire, OKWAv.2.0 may give families and health care providers, including school nurses, information about a child's perceived illness they might not otherwise receive.³⁸

BUILDING WITH CHILDREN

OKWAv.2.0 was built using an iterative process, which requires the user to evaluate and give feedback at intervals while the program is being developed. In this way, developers are interacting with users throughout the entire process of developing a program. This process, known as rapid prototyping,³⁹ is common in the software development industry but may not be as common while building applications for children because software testers are from the same demographic for which the program is being built. This requires children to participate in focus groups, which occurred in this usability study. Usability rules or heuristics, developed by Jakob Nielsen, a nationally recognized expert in Web design and usability testing, guided the testing and analysis of content and functionality for OKWAv2.0.

According to Nielsen,^{40–42} Web-based applications are evaluated on 5 components: *learnability*, *efficiency*, *memorability*, *errors*, and *satisfaction*. Nielsen^{40–42} also states that testing should occur by the same users who represent the population for which the application is designed. For this reason, children with asthma helped develop OKWAv2.0 and gave feedback and suggestions at intervals during the year that OKWAv2.0 was developed.

SELECTING ASTHMA CONTENT AND NARRATIVES

To test the feasibility and usability of OKWA, the asthma content for OKWAv2.0 was updated and reflects the National Asthma Education and Prevention Program, Panel 3.⁴² The report was thoroughly examined and a list of key content was created to be included in each of the story branches. A childhood asthma expert who practices in a regional children's acute care hospital reviewed the asthma curriculum for accuracy and completeness.

Next, the research and development team created a list of activities, settings, and storylines that would appeal to children. Those children acquainted with the developers were informally polled and selected their 2 favorite story ideas. A storywriter incorporated the asthma content into 2 narratives: children snowboarding and children on a school playground. Because the storywriter was not a health care provider, it was necessary to consult with her frequently to explain content and ensure the asthma curriculum was incorporated appropriately. The 2 narratives served as a foundation or trunk for the story trees. The stories were broken into scenes. At various points in the 2 stories, a decision point was added so that a user could determine the sequence of the narrative based on their decision (refer to Fig. 1). The decision points created a total of 5 different stories, or branches, per story tree.

GRAPHICS AND FUNCTION OF OKWAV.2.0

A graphics artist created the scenes and characters, including character parts, such as arms and feet in various positions, to create the animation effects. The characters are ethnically and culturally diverse to represent communities across the United States. The same characters were used in both story trees and in all the branches of the story tree. Children who volunteered from local churches were audio recorded while reading lines from the stories, only after giving verbal consent, which was also recorded and is stored with the audio files. Once the stories came to life with characters, select scenes were drafted onto a Web page so that children in focus groups could begin evaluating components of OKWAv2.0. The program was built with Flash authoring software and can be viewed on all operating systems and browsers using the most current Flash player.

CONDUCTING FOCUS GROUPS

Methods and Procedures

After this the study was approved by the institutional review boards of the affiliated university and the local public school board, children with asthma between 8 and 11 years of age were recruited from primary schools in a metropolitan area in the southeastern region of

the United States. The School Health Coordinator for the county helped identify schools in the inner city region with higher prevalence of asthma, and lower socioeconomic families based on the public school free-lunch program. Nurses at each school reviewed school records, identified potential participants, and then addressed and distributed a recruitment letter, which was sent home via the child. To ensure that confidential information about a child's health record was not revealed until after consent from a parent was obtained, the researchers were not privy to those families who received the recruitment letters. The recruitment letters, however, were returned to the researchers and included family contact information and the child's name. This process ensured the confidentiality of children whose families opted not to participate in this usability study. After parental or guardian consent and child assent were obtained, 6 focus groups were scheduled at 5 different schools. Some of the focus groups occurred during lunch, others occurred before the instructional day began or during the gym period. Scheduling was an important aspect of the process to ensure the study did not interrupt instructional time during the school day. The focus groups, lasting between 30 and 45 minutes, occurred in either the computer laboratory or the library at each school, with each child using a computer because the program is Internet based. Children were given headsets so that each child could work independently at his or her own pace. Children were neither given instructions about how to navigate the program nor were they given help while viewing unless they were unable to proceed. This technique is an important aspect in determining faulty navigation and functioning and to observe children exploring with the mouse. Children were encouraged to seek assistance if necessary and revisit scenes or sections as often as desired. During focus groups, a member of the research team made observations and field notes while children were quietly viewing the program and during the question-and-answer portion of the focus groups. The activities of each focus group varied, as well as the number of users, ages, and race. See Table 1 for a description of the demographics for all focus groups.

Focus group 1 (FG1) evaluated the characters and 3 scenes from the snowboarding story and 2 scenes from the school playground story. The scenes had limited function and very few features, so the children could focus on the characters and the navigation structure from one scene to the next. Scenes with multiple characters were created with limited function. Children were instructed to begin the program from the home page and visit the pages as often as desired. Children were also instructed to remove their headset once they had previewed all pages. After all children completed this activity, they were asked to describe: (1) what they liked and disliked about the scenes, (2) their favorite character and why, (3) what they expected to happen next, (4) how they moved from one page to the next, (5) what they heard, (6) how they would go back to previous pages, and (7) what they learned about asthma.

Focus group 2 (FG2) evaluated 1 complete snowboarding story and 1 complete school playground story, which incorporated the feedback from FG1. Each story included interactive buttons that reinforced asthma content and gave trivia facts, such as famous persons with asthma. The 2 stories included voices for all characters, as well as animation in both stories. During FG2, children focused on the navigation to move from one scene to the next, active icons and links to learn more information, and how to change from one story branch to the other by answering the decision-point questions. Children were encouraged to

explain how to (1) move from one page to the next, (2) make the story change, (3) get more information about asthma, and (4) make the characters talk. Finally, children were asked to explain what they liked or disliked and what they would change about the program.

Focus group 3 (FG3) and focus group 4 (FG4) were nearly identical in their purpose, only FG3 reviewed scenes, decision points, navigation, and functionality of portions of the snowboarding story tree, whereas FG4 reviewed portions of the school playground story tree. Both focus groups were designed to ascertain engagement and the 5 factors as identified by the NEMD. Sample focus group questions included the following: (1) Have you ever been in a situation like Jake in the story? (2) What buttons did you push and what did they do? (3) Tell me all of the different things you saw and learned about in the story. (4) What happened to Jake and what did his friends do?

Focus group 5 (FG5) and focus group 6 (FG6) were identical and incorporated the greatest number of design and functionality changes based on feedback from FG3 and FG4. FG6 was the same as FG5 because the developers wanted a broader audience to review the entire OKWAv2.0 program and make recommendations for improvements. Questions in FG5 and FG6 were broad, open-ended questions to encourage children to express any thoughts, ideas, and likes and dislikes about OKWAv2.0.

Data Analysis

Field notes taken during each focus group were entered into an evaluation tool at the end of the focus group, as the information guided each developmental stage of OKWAv2.0. Each item listed in the tool was evaluated by the research team to determine if it was a flaw in the program or merely a preference by the user. Those items deemed preferences were considered by the developers only if the preference appeared on multiple occasions, which never occurred. Those items deemed usability flaws were scored and ranked according to the importance of correcting the function and the feasibility of addressing the flaw. Those items ranking highest were addressed and changed in OKWAv2.0 before the next scheduled focus group. See Table 2 for a sample evaluation tool.

Focus Group Study Results

In general, children engaged in the same activities while using OKWAv2.0. Many of the children looked over their shoulder or to the side to ensure their counterparts were experiencing the same scenes. Sometimes, the children in the focus groups would give or elicit help to their peers. Not surprising, the children appeared more comfortable relying on one another than asking the researchers for assistance. It can be assumed the children were more comfortable with one another than with the developers whom they had just met. The greatest revisions occurred between FG3–4 and FG5, in part, because FG3 and FG4 presented a complete IN with new features, icons, and buttons not seen previously. Based on user feedback, few changes were made to the storylines and scenes and no changes were made to the characters and their voices. The greatest changes occurred with the navigation and action buttons. A variety of buttons were used throughout the story pages so that users of the program could report their button preferences and researchers could observe user behavior while selecting buttons. Navigation and interactive buttons proved to be the

greatest challenge for users. It was not obvious to the users whether to click on the speaker button to increase the volume or repeat what the character said. In some cases, the only way that children could identify a clickable object was by rolling the mouse over areas on the screen to reveal the “mickey mouse glove” or active link. Instructions and a key to the icons were added at the beginning of each story Fig. 2.

During FG3, an 11-year-old user grew frustrated because she could not start the story over before getting to the end of the story. The developers did not anticipate the need for this type of navigation, but as a result of this feedback, a link was added so that a user could move to the previous page and start the story from the beginning at any scene in the story.

During one focus group, the users grew concerned that the main character asked for help from a stranger, which initiated a discussion about who should help someone with asthma. The users described ways they identified “safe” people, which was typically by their clothing. Mr Jim Hansen, the ski patrol in the snowboarding scene who helps the main character with asthma, was revised to include a red cross logo on his ski jacket along with a hat. In essence, the children helped to identify an important aspect of seeking help from others—identifying a trustworthy and safe person.

FUTURE VERSIONS OF OKWA

In many cases, users presented ideas that were not feasible to adopt in OKWAv2.0 because of budget constraints but these ideas will be considered in future versions. Some children in the focus groups wanted to pick a character representing themselves. Others wanted to create a character from parts like clothing articles, or hair and skin color. As expected, some children wanted active elements added to the story that had little or nothing to do with asthma or the plot of the story. For example, some users wanted all of the characters in the school playground story to sing a song and all of the boy characters in the snowboarding story to do somersaults on the slope.

An unexpected positive outcome occurred during FG6. Inner-city schools in a metropolitan area were targeted because of the relationship between asthma and children living in inner cities, but the school setting for the last focus group had a student body of mostly Hispanic population. In fact, the principal estimated that 80% of the students were Hispanic. Many of the teachers were bilingual in Spanish and English to communicate with the families of their pupils. Although the children were attending schools with English as the primary language, the parents or guardians were not English speaking, and, therefore, could not read English or the recruitment and consent letters prepared for this study. Spanish versions of the recruitment letter and the consent and assent forms were prepared and approved by the institutional review board. Two of the study participants in the last focus group were children of Spanish-speaking parents and required the Spanish version of the study forms, as well as an interpreter during the consent process. Future versions of OKWA will also include a Spanish version.

Not surprising, many of the children asked about a mobile application of the interactive narrative despite not owning a smart phone. Hence, a mobile version of OKWAv2.0 has

already been created (Fig. 3). Children also inquired about additional stories and suggested stories that include swimming, playing instruments, and team sports, such as soccer or baseball.

SUMMARY

OKWAv2.0 includes content from the latest guidelines of the National Asthma Education Prevention Program, Panel 3.⁴³ The program also allows children to interact with the characters and make decisions that influence the outcome of the story. This is an enhanced interactive feature that was not included in the first version. One aspect of the first version of OKWA that was lost in this version is the child's ability to add text to a comic strip story that could be printed. This feature will be considered if evaluations reveal that adding personal text and printing a story are essential to OKWA. Enhancements and revisions to OKWA resulted from feedback by children, specifically, children between 8 and 11 years of age with asthma. Obtaining evaluation data from children through focus groups is not common practice when designing health-related educational programs, but to dismiss children from participating in the evaluation and development of such programs is short sided. It is possible that programs built without children's input will be ill suited for them and appeal only to the adults who created the program.

Self-paced health-education programs, such as OKWAv2.0, are useful in a variety of settings provided the content is not facility specific. Children with asthma must learn to engage resources and assistance from others in a variety of places and settings, just as is presented in the BBFM.⁵ OKWAv2.0 is intended for use in school clinics, but may be adopted for use in patient waiting rooms, hospital rooms, or at home. These programs, however, are only valued and visited frequently if the content is current, updated, and changes frequently or offers some function that invites the user to revisit the program again.

With technology advancements, it is now possible to make a story come alive in ways not possible before except through imagination, play, or with props, screenwriters, and sets. Now, stories can be interactive with multiple media, such as animation and sound, and they can change and evolve based on selections or decisions made by a user. In essence, interactive stories are the simplest forms of technology gaming but despite their simplicity, they are enticing for school-aged children. This might be because of the school-aged child's cognitive development and computer skills or it may be that children are enamored with stories: stories in story time at the library, storylines in plays, storylines in movies, and storylines in games.

Technology will continue to advance and the treatment of asthma will also improve. A wish list for future versions of OKWA is growing and includes more stories, the ability to build a character by selecting physical features or clothes, and stories in multiple languages. Additional story trees, new characters, and added interactive features will keep children visiting and learning how to seek help from others, avoid triggers, manage their asthma, and learn to live with their asthma.

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KEY POINTS

- Interactivity is key to engaging school-aged children in asthma-management programs.
- School-aged children learn in story formats; hence, story is an appropriate teaching strategy for health-education programs for children.
- School-aged children can manage their own asthma if they are confident in their abilities and they have support of their peers, family, community, and health care team.
- Asthma programs for children should include ways to avoid asthma triggers; engage friends, families, school staff, and coaches; and teach strategies, such as monitoring lung function, stress reduction, and ways to cope with having asthma.

Fig. 1.
OKWA v2.0 interactive narrative story tree.

Fig. 2.
Navigation instructions page. (Courtesy of Okay with Asthma v2.0. Available at: <http://www.okay-with-asthma.org/OKWAv2/final/OKWA2.htm>; with permission.)

Fig. 3.
Mobile application of OKWAv2.0.

Table 1

Total study demographics (all focus groups)

	FG 1	FG 2	FG 3	FG 4	FG 5	FG 6	Total
Ethnicity							
Hispanic or Latino	1	–	–	–	–	2	3
Not Hispanic or Latino	8	1	3	6	9	3	30
Race							
American Indian	–	–	–	–	–	–	–
Alaska Native	–	–	–	–	–	–	–
Asian	–	–	–	–	–	–	–
Black	4	–	2	4	4	3	17
White	5	1	1	2	5	2	16
Age							
8	1	–	–	1	2	–	4
9	2	1	1	2	3	1	10
10	2	–	2	1	4	2	11
11	4	–	–	2	–	2	8
Sex/Gender							
Male	5	1	1	4	3	5	19
Female	4	–	2	2	6	–	14
Setting							
Library	–	–	–	–	–	–	–
Computer laboratory	–	–	–	–	–	–	–
Total participants							33

Abbreviation: FG, focus group.

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Table 2

Sample evaluation tool of Okay with Asthma v2.0

Focus Group 1		Importance					Ease of Achievement					Product		
		Low.....High					Difficult.....Easy							
		1	2	3	4	5	1	2	3	4	5			
<i>Okay with Asthma v2.0</i> Content Issues		Preference or Flaw?												
I can't hear Jakes voice.		Flaw	☐	☐	☐	☐	☒	☐	☐	☐	☒	☐	☐	15
Am I supposed to click on [nebulizer]?		Flaw	☐	☐	☐	☐	☒	☐	☐	☐	☒	☐	☐	20
Do I click on [ear] to make the sound go up?		Flaw	☐	☐	☐	☐	☒	☐	☐	☐	☒	☐	☐	20
I think those trees on the slope are too skinny.		Preference	☐	☐	☐	☒	☐	☐	☐	☐	☒	☐	☐	16
What is an action plan?		Flaw	☐	☐	☒	☐	☐	☐	☐	☐	☒	☐	☐	9