2017

Quality Improvement Initiative About Patient Engagement With Clinicians in a Community Hospital

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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
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Walden University
2017

Abstract

Quality Improvement Initiative About Patient Engagement With Clinicians in a Community Hospital

by

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MN, University of Toronto, 2011

BSN, University of Toronto, 2008

Project Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University
August 2017

Abstract

Chronic kidney disease (CKD) is a global health problem and efforts are needed to improve the care of individuals affected by the disease. A recent strategy for improving care within the healthcare system is patient engagement. Nurses and other health care clinicians can apply patient engagement into their clinical practice to improve the care they provide to their patients. Therefore, the purpose of this project was to increase the knowledge and awareness of patient engagement among clinicians who work with CKD patients. This quality improvement project used Lewin's force field analysis to analyze driving and restraining forces to help develop and implement strategies to develop an e-learning module. The project used practice-focused questions to determine if knowledge about patient engagement and the Shared End-Stage Renal Patients - Decision Making Tool could improve staff knowledge and awareness about patient engagement. A quantitative pretest, posttest approach was used to compare pretest scores to posttest scores after the e-learning module was viewed. Nine clinicians participated in the project study. Results showed that clinicians' knowledge and awareness about patient engagement increased from a mean pretest score of 5.22 to a mean posttest score of 6.22, (p = 0.08617). The sample of only 9 participants may have contributed to the lack of statistical significance after viewing the educational presentation. The e-learning module will provide positive social change as staff and students of renal programs learn about and apply the principles of patient engagement to their clinical practice.

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Dedication

I have dedicated this DNP project to my dear loving mother who has taught me the value of hard work, commitment, and dedication. The kindness, love, guidance, encouragement, and continued support that I received all my life have helped me to pursue my dreams in my professional and personal life.

Acknowledgments

First, I would like to give thanks to God for all that he has done in my life.

I would like to acknowledge and thank in particular my parents, especially my mother, Aunty Cordy, Aunty Maurine, and Aunty Madge for their continued and on-going support throughout my nursing career. I would also like to acknowledge and thank the rest of my family for their on-going support and encouragement.

A special thanks to my practicum clinical preceptor and the Chronic Kidney Disease /Nephrology program at my practicum site. Finally, I would also like to thank Walden University and all faculty members of the DNP program for their contribution in supporting me in this DNP program, and for my success in achieving this doctoral degree but also advancing nurses in academic scholarship, clinical scholarship, and leadership skills.

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Section 1: Nature of the DNP Project

Introduction

Chronic kidney disease (CKD) is recognized as a global health issue with increasing numbers of individuals affected by this disease as well as high health care costs in treating and managing the disease (Eckardt et al., 2013; El Nahas & Bello, 2005; Levey & Coresh, 2012). CKD is a progressive chronic illness that can lead to premature death if it is not appropriately managed and treated (Eckardt et al., 2013; El Nahas & Bello, 2005; Levey & Coresh, 2012). Patient engagement has become a new concept and theme for improving patient and health outcomes associated with chronic illnesses (Bruni, Laupacis, Martin, & University of Toronto Priority Setting in Health Care Research Group, 2008; Cancer Care Ontario [CCO], 2015; Ontario Renal Network [ORN], n.d.; Verma et al., 2013). Within the province of Ontario, there is an expectation that renal programs begin to incorporate patient engagement into clinical programs as well as clinical practice (Bruni et al., 2008; CCO, 2015; ORN, n.d.; Verma et al., 2013). Hence, administrators, managers, leaders, and even front line clinicians are expected to incorporate patient engagement into policies and practices (Bruni et al., 2008; CCO, 2015; ORN, n.d.; Verma et al., 2013).

Researchers have found that patient engagement positively impacts current nursing and clinical practice, and that health care professionals can support their patients to have a more active role in health care decision-making (Bruni et al., 2008; CCO, 2015; ORN, n.d.; Verma et al., 2013). However, it is important that nurses and other health care clinicians learn about patient engagement so that they can incorporate and apply the concept into their clinical practice. In this DNP project I addressed the issue of patient engagement by focusing on developing an e-learning module for health care clinicians to learn more about patient engagement. The social impact that is expected to occur from the DNP project is that the e-learning module can be used in clinical programs to teach clinical staff and students about patient engagement, which can contribute to improved clinical practice where clinicians' support their patients to be more actively involved in the management of their disease.

Problem Statement

Patient engagement has been recognized as an area for improvement within the Ontario Renal Network (ORN) (Carman et al., 2013; Cavanaugh, 2015; ORN, n.d.). Changing practices and behavior requires time and strategies that can facilitate the adoption of new behavior and practice within any clinical environment (White & Dudley-Brown, 2012). The first stage to change clinical practice is ensuring that the clinical staff have the knowledge and understanding about new concepts, practices, or policies (Graham et al., 2006; Kent, Hutchinson, & Fineout-Overholt, 2009; Straus & Graham, 2009). With patient engagement being a fairly new concept within the ORN, clinicians may not be familiar with the term, and therefore implementing change relating to clinical practice may become difficult or not possible (Graham et al., 2006; Kent et al., 2009; Straus & Graham, 2009). The lack of knowledge related to patient engagement may also contribute to clinicians being at risk for not practicing to their full potential of evidence-based practice (Coulter, Parsons, & Askham, 2008; North Carolina Institute of Medicine [NCIOM], 2015). Clinicians may lack knowledge about the appropriate skills to help empower their patients to actively and effectively self-manage their own CKD, which may lead to ongoing challenges with poor health (Coulter et al., 2008; Hughs, 2008; Kelly, 2011; NCIOM, 2015).

In this DNP project I addressed the issue of improving patient engagement. I also utilized a quality improvement initiative to contribute to the development of an e-learning module that can be used among clinicians to learn about patient engagement. The expected outcome with the development of the e-learning module was to contribute to increased clinician knowledge and awareness about patient engagement. With the increase in knowledge about patient engagement, the clinician could then support their patients to become more actively involved in their health care needs and disease management (Coulter et al., 2008; Hughs, 2008; Kelly, 2011; NCIOM, 2015). Furthermore, the e-learning module could become available as a resource for health care practitioners working in other renal programs to use with their staff (Carman et al., 2013; Ryan & Sawin, 2009). The significance of this doctoral project was the development of an e-learning module for clinicians; this e-learning module would increase the knowledge and awareness about patient engagement among clinicians and also help clinical programs to improve patient and health outcomes associated with CKD.

Purpose

There are limited published research and quality improvement initiatives within the renal programs of Ontario that address patient engagement. However, the province of Ontario's recommendation for renal programs to improve patient engagement provided opportunities for knowledge translation, research, and quality improvement projects to occur within the renal programs of Ontario (Carman et al., 2013; Costantini, 2006; Novak et al., 2013; Swartwout, Drenkard, McGuinn, Grant, & El-Zein, 2016; Verma et al., 2013). Hence, the purpose of this project was to increase the knowledge and awareness of patient engagement among clinicians who provide care to patients living with CKD. The DNP project provided an opportunity for clinical staff and students within the CKD/nephrology clinical program of a community hospital to learn about patient engagement, which could also be used to support the clinical program efforts to improving patient engagement practices. In this project I applied quality improvement processes to: (a) determine what is the CKD staff knowledge, perceptions, or understanding about patient engagement and (b) create an e-learning module that could be used as a learning resource or tool for future new staff and students within the CKD/nephrology department.

Project Practice Questions

The project questions were:

1. What is the CKD staff knowledge, understanding, or perceptions about patient engagement?
2. Can knowledge of the Shared End-Stage Renal Patients-Decision Making (SHERPA-DM) tool for CKD patients improve staff knowledge of patient engagement?
3. Can the educational presentation about patient engagement increase knowledge about patient engagement?

4. What are the clinicians' perceptions of the educational presentation and its relationship to patient engagement in clinical practice?

Nature of the Doctoral Project

A quality improvement plan approach was used to develop the e-learning module (Hodges & Videto, 2011; Kettner, Moroney, & Martin, 2013; Laureate Education, 2011a, b). As a part of the process, a needs assessment was conducted using Lewin's force field analysis (LFFA) to facilitate in developing the e-learning module (Hodges & Videto, 2011; Kelly, 2011; Kettner et al., 2013). I used the LFFA to identify and assess the operational process for the ability of clinicians to use the e-learning module within the CKD/nephrology program. The focus of the e-learing module was around CKD and patient engagement, and therefore, the sources of evidence to support this project was from organizations such as Ontario Renal Network (ORN), Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines, National Kidney Foundation (NKF), National Institute of Diabetes and Digestive Kidney Disease, Cancer Care Ontario (CCO), Quality Improvement, Health Quality Ontario (HQO), Canadian Institute for Health Information (CIHI), Agency for Healthcare Research and Quality (AHRQ), and clinicians working within the renal programs of Ontario. I also completed a literature review using the OVID, PubMed, and CINAHL databases, as well as engagement with clinicians (doctors, nurse practitioners, clinicians) within chronic kidney disease and nephrology programs.

Significance

To facilitate meeting the provincial mandate for improving patient engagement within Ontario (ORN, n.d.), the target population for this quality improvement doctoral project was the clinicians who work within CKD/nephrology program at a community hospital within the province of Ontario. The clinicians would be positively impacted by this project because they would be able to learn about patient engagement, which would also help to improve their clinical practice.

The key stakeholders that would contribute to the quality improvement initiative included the clinicians within the program such as the program manager, nurse practitioner (NP), nephrologists, nurses, social workers, and dieticians (Hodges & Videto, 2011; Kelly, 2011; Kettner et al., 2013). Other stakeholders could also potentially include representatives from hospital departments such as health information systems, finance department, as well as external members from community based organizations such as the ORN (Hodges & Videto, 2011; Kettner et al., 2013; Laureate Education, 2011a, b; Salabarria-Pena, Apt, & Walsh, 2007). The goal of identifying these stakeholders was to involve them in the decision-making process, needs assessment, and have them participate in activities within the planning and implementation process of the project (Hodges & Videto, 2011; Kettner et al., 2013; Salabarria-Pena et al., 2007). Engaging the stakeholders in the project provided for opportunities to obtain information and data that positively contributed to meeting the objectives and goals of the this quality improvement initiative project (Hodges & Videto, 2011; Kettner et al., 2013; Salabarria-Pena et al., 2007). Furthermore, with the involvement of the stakeholders in the quality improvement plan, the stakeholders could ensure that the e-learning module would be applicable, relevant, and reflect the needs of the clinicians within the CKD/nephrology deaprtment (Laureate Education, 2011a, b; Salabarria-Pena et al., 2007).

The ability to provide an opportunity for clinicians to learn about patient engagement would facilitate to the contribution of improving clinical practice and the delivery of health care (White & Dudley-Brown, 2012; Zaccagnini & White, 2013). Furthermore, the outcome obtained from this quality improvement initiative would facilitate collaboration with other health care professionals and health care facilities with patient engagement activities within Ontario (Verma et al., 2013). The collaboration between health care professionals and health care organizations could further contribute to increasing research and other quality improvement initiatives, building upon current knowledge and practices and improving current practices within health care (Verma et al., 2013).

Summary

There are current initiatives to improving health outcomes for patients affected by CKD (CCO, 2015; ORN, n.d.; Verma et al., 2013). Patient engagement has become a health strategy in improving health outcomes for chronic illnesses (CCO, 2015; ORN, n.d.; Verma et al., 2013). Patient engagement is relatively a new concept or term within the renal programs (ORN, n.d.). To facilitate uptake of patient engagement in clinical practice, there should be quality improvement strategies geared toward health care practitioners. In this project I attempted to contribute to quality improvement initiatives relating to patient engagement within the renal programs of Ontario. The aim of the quality improvement initiative was to increase the knowledge and awareness of patient engagement among clinicians.

Section 2: Background and Context

Introduction

There are limited patient engagement research and quality improvement initiatives that are available for health care practitioners within the renal programs of Ontario (Carman et al., 2013; Ryan & Sawin, 2009). The lack of research and quality improvement initiatives related to patient engagement could limit the ability for renal program nurses and other clinicians to incorporate patient engagement practices into their clinical practice (Cavanaugh, 2015; Murray, n.d.; Murray, Bissonnette, Kryworuchko, Gifford, & Calverley, 2013; ORN, n.d.; White & Dudley-Brown, 2012). Hence, for this DNP quality improvement initiative, the purpose was to optimize the opportunity for nurses and other clinicians to learn about patient engagement. The practice questions addressed in this DNP project were:

1. What is the CKD staff knowledge, understanding or perceptions about patient engagement?
2. Can the knowledge of the SHERPA-DM tool for CKD patients improve staff knowledge of patient engagement?
3. Can the educational presentation about patient engagement increase knowledge about patient engagement?
4. What are the clinicians’ perceptions of the educational presentation and its relationship to patient engagement in clinical practice?

Therefore, this section of the paper will discuss (a) the theories, models, and concepts that inform this project, (b) the relevance of this project to nursing practice, as well as the (c) role of DNP student for this DNP project.

Concepts, Models, and Theories

The self-management theory (SMT) and LFFA have informed this DNP project. The SMT theory provided the theoretical foundation that supports the use of patient engagement in clinical practice. The LFFA provided the conceptual model as part of the quality improvement processes to develop and implement an e-learning module within a clinical program. Both the SMT and LFFA provided the connection of how patient engagement can be applied in a clinical setting to improve patient and health outcomes for the DNP project.

The Self-Management Theory (SMT)

The underlying theoretical science for chronic kidney disease (CKD) management is self-management (Costantini, 2006; Novak et al., 2013). Self-management is often used interchangeably with self-care (Grady & Gough, 2014). However, the meaning of self-care is associated with healthy individuals and their ability to be actively involved in their care in order to help prevent an illness or disease (Grady & Gough, 2014; Johnston, Liddy, Ives, & Soto, 2008). On the other hand, self-management is the ability for an individual with an existing illness or disease to manage, on a daily basis, that illness or diesease (Grady & Gough, 2014; Johnston et al., 2008). Self-management is an element within the chronic care model (CCM) (Novak et al., 2013).While the CCM is based upon improving health outcomes at system-levels, self-management enables health programs and services to empower patients and their families in the management of chronic illness, such as CKD (Carman et al., 2013; Grady & Gough, 2014; Johnston et al., 2008; Novak et al., 2013; Kettner, Moroney, & Martin, 2013).

The SMT evolved from the definition or concept of self-management. SMT took into consideration an individual's ability to manage their symptoms and medical treatments associated with a chronic illnes (Johnston et al., 2008). Hence, the terms associated with the SMT include emotional, behavioral, and medical management (Grady & Gough, 2014; Johnston et al., 2008). The SMT also enabled individuals to manage their daily lifestyle within the context of their chronic illness (Grady & Gough, 2014). The SMT helped patients to apply health –related interventions that would contribute to a better quality of life (Grady & Gough, 2014). Furthermore, since SMT as a health care practice incorporated patient participation and involvement, SMT can lead to improved quality of care and delivery of health care by nurses, physicians, and interdisciplinary teams (Novak et al., 2013; Kettner et al., 2008). Hence, the SMT is relevant to CKD but also to address the improvement of health care associated of CKD (Grady & Gough, 2014; Johnston et al., 2008; Novak et al., 2013).

The self-management theory has been in existence for about forty years and it is still used in current society's health care practices (Novak et al., 2013). The foundation for SMT is based on decision making, problem solving, taking action, and partnership between the patient and the health care professional (Novak et al., 2013). The success of individuals living with CKD is for health care practitioners to work with patients to support and improve compliance and adherence with changes that patients have to make to their lifestyle and behavioral practices, such as diet, medication regimen, appointments, exercise, that will slow down the progression of the disease (Costantini, 2006; Novak et al., 2013). However, the focus on adherence to medical management and medical treatment has shifted, over the years, towards health care practitioners developing an understanding about the skills and supports that patients need to cope with their chronic illness (Novak et al., 2013). Hence, health care practitioners are expected to work with patients regarding health care choices and options that are patient centered and take into consideration the patients' psychosocial context (Novak et al., 2013). The movement towards health care professionals collaborating with patients enabled the opportunity for the concept of patient engagement to be applied and integrated within a health care setting (Carman et al., 2013; Novak et al., 2013); the concept of patient engagement is built upon the SMT (Carman et al., 2013; Novak et al., 2013). Patient engagement allowed for a bi-directional flow between the health care professional(s) and patient(s), that allowed for shared responsibility with decision making and enabled the patients to become active participants with their medical and health care needs (Carman et al., 2013).

The Lewin's Force Field Analysis (LFFA)

The health care system has been going through changes across all levels to improve quality of care and patient care (White &Dudley-Brown, 2012). Hence, the ability to facilitate and manage change (applying appropriate theories, framework, models, or concepts) within clinical settings is very relevant and applicable to nursing, the nursing profession, as well as health care (White & Dudley-Brown, 2012). Leadership’s involvement to changing practice would require the skills and ability to produce positive changes that would improve patient care, clinical practices, as well as the delivery of health care (Baulcomb, 2003; Bozak, 2003; White &Dudley-Brown, 2012). The LFFA provided support for change within an organizational setting and relevant data to the development of projects and programs for improving quality of care as well as patient care (Baulcomb, 2003; Bozak, 2003; VBM, 2016; White &Dudley-Brown, 2012; W. K. Kellogg Foundation [WKKF], 2004).

When making change to health practices, it is a planned action that involves taking effort in facilitating individuals from one frame of reference to another (Bozak, 2003). Changing behavior or actions can occur if forces (positive and negative) in a particular environment are aligned and the summation of the forces drives for change (Bozak, 2003). The force field analysis (FFA) derived from the field theory within physical science (Bozak, 2003). It was Kurt Lewin who expanded the concept to the area of social psychology (Bozak, 2003). Within the field of social psychology, Kurt Lewin developed LFFA (Value Based Management.net [VBM], 2016). LFFA model identified two opposing forces (i.e. driving and restraining forces) that have an impact on change processes within an environment (Bozak, 2003). The driving forces moves and encourages change to occur and the restraining forces maintains status quo within that environment, creating barriers and preventing change (Bozak, 2003). The forces could be the result of external forces or internal forces (Bozak, 2003). The application of the FFA occurs with an analysis of a situation (or problem) and the context within its environment (Bozak, 2003). With an analysis of the environment, one is able to identify the driving and restraining forces and can then facilitate the process of implementing strategies that can support the driving forces and mitigate the restraining forces (Bozak, 2003). Applying LFFA can provide the framework for planning and implement change within health care practices and policies (Baulcomb, 2003; Bozak, 2003; VBM, 2016; White & Dudley-Brown, 2012).

The LFFA is widely used across various disciplines and health fields, related to management practices, such as program planning, business management, change management, and project management (Baulcomb, 2003; Bozak, 2003; VBM, 2016; White & Dudley-Brown, 2012). The LFFA model provided opportunities to implement strategies that will help develop programs or policies that will change and improve health practices, services or policies (White & Dudley-Brown, 2012). Therefore, for this DNP project the LFFA supported the development and use program planning and quality improvement strategies that helped to develop an e-learning module. It is the application of the LFFA to program planning and quality improvement strategies that facilitated the development of the goals, action plans, and outcomes for this DNP project (Hallinan, 2011; Hodges & Videto, 2011).

Relevance to Nursing Practice

The Problem of Chronic Kidney Disease

CKD, also known as chronic renal failure, is a chronic illness associated with progressive kidney damage and loss of renal function over time (Arora et al., 2013; Levin et al., 2008). CKD is associated with kidney damage and a glomerular filtration rate

(GFR) less than 60ml/min/1.73m^2 for three months and longer (Jha et al., 2013). The identification of CKD can be determined by pathological abnormalities or abnormalities in the blood, urine, or image testing (Murphy, Jenkins, Chamney, McCann, & Sedgewick, 2008). There are five stages of CKD that are based upon the GFR value (El Nahas & Bello, 2005; Registered Nurses' Association of Ontario [RNAO], 2009).When the GFR is less than 15ml/min/1.73m^2 that individual is considered to have end stage renal failure (ESRF) (RNAO, 2009). End stage renal failure (ESRF) is the fifth and last CKD stage and in this stage the kidneys are no longer working (El Nahas & Bello, 2005; Haynes & Winearls, 2010).

Chronic kidney disease affects all age groups but the older adult age group (i.e. age 65 years and older) has the most increasing numbers in prevalence and incidence of the disease (Arora et al., 2013; National Institute of Diabetes and Digestive and Kidney Diseases [NIDDKD], n.d.). Furthermore, there are increasing numbers of mortality associated with end stage renal disease (ESRD) (NIDDKD, n.d.). The cost associated with the disease is over forty billion dollars in public and private funds (NIDDKD, n.d.). Unfortunately, for those without health insurance, the high cost associated with care of the disease can be unaffordable (NIDDKD, n.d.). The implications for those affected by the disease included a decline in quality of life, function, psychosocial well-being, as well as increased risk for morbidity, poverty, and premature death (Anand, Johansen, & Tamura, 2014; Davison, 2007; Jha et al., 2013).

Implications for Nurses and Other Health Care Professionals

Nurses and other health care professionals have contributed to reducing the progression of the disease (Costantini, 2005; Coulter et al., 2015; Levin et al., 2008; Novak et al., 2013; RNAO, 2009). For the CKD stage one to stage three, nurses and clinicians monitored and controlled for risk factors such as diabetes, obesity, dyslipidemia, smoking, diet, and low physical activity (Costantini, 2005; Coulter et al., 2015; Levin et al., 2008; Novak et al., 2013; RNAO, 2009). The nurses and clinicians worked with their patients in patient education and promoting self-management strategies (Costantini, 2005; Coulter et al., 2015; Levin et al., 2008; Novak et al., 2013; RNAO, 2009). For CKD stages four to stage five (i.e. late and end stage of the disease), the approach used is that clinician supported patients with managing the associated symptoms of the disease as well as helped their patients come to a decision regarding the type of treatment for their kidney failure (Costantini, 2005; Coulter et al., 2015; Levin et al., 2008; Novak et al., 2013; RNAO, 2009).

The daily management of CKD is complex and can also present with many challenges for patients living in the community (Bonner et al., 2014; (Ong, Jassal, Porter, Logan, & Miller, 2013). The appropriate supports and proactive management of CKD could lead to delaying the progression of the disease (Chen et al., 2011; Grady & Gough, 2014; Johnston et al., 2008; Levin et al., 2008). Therefore, nurses and other health care professionals play an important role to helping those affected by the disease, to understand CKD as well as the treatment and management strategies (Chen et al., 2011; Grady & Gough, 2014; Johnston et al., 2008; Novak et al., 2013). For example, health care professionals can provide education and support for individuals and families experiencing stress and anxiety in coping with the illness. Multidisciplinary teams are also encouraged to review current practices and identify areas that can be improved to improve the care of their patients (Bonner et al., 2014; Filler & Lipshultz, 2012; Ong et al., 2013). Furthermore, there is a focus for health care professionals to improve self-management strategies for their CKD patients (Bonner et al., 2014; Ong et al., 2013).

The health care movement towards patient engagement supported nurses and other health care professionals to actively engaging their patients (Bonner et al., 2014; Carman et al., 2013; Ong et al., 2013; RNAO, 2009). With patient engagement, nurses and other clinicians would also learn to better apply and incorporate knowledge about their patients' beliefs, past experiences, health literacy, psychosocial factors, and attitudes relating to understanding their patients' health care decision making and facilitate in supporting their patients taking an active role in their health decisions (Carman et al., 2013; CCO, n.d., 2015; ORN, n.d.). Therefore, this DNP project supported the health care movement for patient engagement into the delivery of health care and provided an approach that would facilitate nurses and other clinicians in becoming familiar with the term and concept of patient engagement, within the health care system (CCO, n.d., 2015; ORN, n.d.).

Local Background and Context

For over a decade, CKD has remained a global challenge and there are on-going efforts to reduce the negative outcomes associated with the disease (Coresh et al., 2007; James, Hemmelgarn, & Tonelli, 2010). CKD was ranked eighteenth for the cause of death globally (Jha et al., 2013). Over 19 million people in United States and about two million people in Canada have the disease (Arora et al., 2013; Davison, 2007). Researchers have found that up to 35% of older adults meet the criteria of having CKD (James et al., 2010). In Ontario, it was estimated that about 12,000 people require pre dialysis care and about 10,000 and 500 people require dialysis (ORN, n.d.). It is also estimated within Ontario that about 25% of new CKD patients went straight to dialysis without prior care (ORN, n.d.). Unfortunately, the need for dialysis is continuing to rise, which has been associated with increasing prevalence of CKD's associated risk factors such as high blood pressure, diabetes, and aging (ORN, n.d.). Therefore, it has become imperative for health care organizations to contribute to decreasing the effects that CKD has on society and the health care system.

For this doctoral quality initiative project, a community hospital in Ontario, Canada, has been involved and actively participating in strategies that would improve patient engagement within the CKD/Nephrology program (ORN, n.d.). The strategies that they incorporated are both at systems level (policies and practices) but also at clinical practices. Hence, the drive to improve patient care and incorporate patient engagement into clinical practice has led to the development of a quality improvement initiative that can be beneficial to clinicians involved in caring for patients who have CKD.

Role of the DNP Student

As a student at Walden University, the role I had as a DNP student for this doctoral project was to apply clinical scholarship and leadership to improve clinical practice and address the health problems (Zaccagnini & White, 2013). I had the opportunity to use systematic inquiry and participate in clinical scholarship, that would also facilitate my growth as a scholarly practitioner (Zaccagnini & White, 2013). My role was to work with this writer's practicum preceptor and her project team to develop and implement a quality improvement plan for clinical staff within the CKD/Nephrology clinic department. I applied quality improvement planning strategies, and also incorporated a systematic process, that led to the desired outcome for the quality initiative (i.e. development of an e-learning module for clinical staff) (Ridenour & Trautman, 2009; White & Dudley-Brown, 2012). The motivation for participating in this DNP project was to have a positive impact and contribute to social change of improving clinical practice among clinicians working with patients who have CKD.

A potential bias that I may have possessed was the assumption that the clinical staff lack any knowledge about patient engagement. Hence, a needs assessment was conducted, and I also engaged with key stakeholder, to ensure that baseline information regarding the clinical staff's knowledge would not be based on personal biases (Kelly, 2011; Kettner et al., 2013). Furthermore, this project was limited to one clinical department within one hospital, so the outcome from the data collection cannot be generalized to all health care facilities within the region of Canada (Kelly, 2011; Kettner et al., 2013; White & Dudley-Brown, 2012). Hence, the methods, results, and outcomes of this DNP project were based upon the data obtained within the CKD/Nephrology program at the community hospital within the province of Ontario (Kelly, 2011; Kettner et al., 2013; White & Dudley-Brown, 2012; Zaccagnini & White, 2013).

Summary

To summarize this section of the DNP project, the purpose of the DNP project was to increase knowledge and awareness of patient engagement among clinicians within a community hospital. The SMT and LFFA guided and contributed to the development of the DNP project and facilitated in implementing quality improvement strategies to meet the objectives of the DNP project (Hodges & Videto, 2011; Kettner et al., 2013). Nurses engaged in evidence-based practice, such as SMT, can help to support patients with CKD (Grady & Gough, 2014; James et al., 2010). However, patient engagement is an opportunity where nurses and other clinicians can further improve the care they provide to their patients (ORN, n.d.). However, nurses and clinicians must obtain the knowledge for change in practice to occur (Graham et al., 2006; Kent et al., 2009; Straus & Graham, 2009). Within the province of Ontario, there are increasing numbers of patients with CKD (ORN, n.d.). Hence, health care facilities are implementing strategies to reduce the burden of CKD (CCO, n.d., 2015; ORN, n.d.). Furthermore, with patient engagement as a movement within the health care system, hospitals within Ontario are implementing strategies to improve patient engagement within their facilities. Improvement to patient and health outcomes enables DNP students to participate in clinical scholarship (Zaccagnini & White, 2013). Furthermore, DNP students’ role in advancing practice and improving patient outcomes would also contribute to becoming a DNP prepared scholarly practitioner (Zaccagnini & White, 2013).

Section 3: Collection and Analysis of Evidence

Introduction

CKD is a national and global health issue (Eckardt et al., 2013; El Nahas & Bello, 2005; Levey & Coresh, 2012; Levey et al., 2007; Jha et al., 2013). There are increasing numbers of individuals affected by CKD and therefore there are health strategies being created and implemented worldwide to combat the disease and reduce the burden of the disease (Levey et al., 2007; ORN, n.d.). Patient engagement has become a fairly new term or concept within the renal programs of Ontario (ORN, n.d.) and renal programs are beginning to implement policies and practices that help to improve patient engagement within their facilities (CCO, 2015; ORN, n.d.; Verma et al., 2013). Hence, the purpose of this DNP project was to develop a quality improvement initiative that would help to improve patient engagement into clinical practice among clinicians. The focus of this DNP project was to increase the knowledge and awareness of patient engagement among clinicians, such that clinicians could use and apply that knowledge and awareness towards improving patient engagement practices within their own clinical practices. Therefore this section of this paper will discuss the description of this quality improvement initiative, discussing in particular, the collection and analysis of the data involved within this quality improvement project.

Practice-focused Questions

Currently, there appears to be limited quality improvement initiatives and research around patient engagement within the renal programs of Ontario (Carman et al., 2013; Ryan & Sawin, 2009). With the provincial mandate for renal programs within

Ontario to improve patient engagement, the overall goal of this doctoral project was to contribute to quality improvement initiatives within Ontario that addressed patient engagement. Therefore, the practice-focused questions for this doctoral project were:

1. What is the CKD staff knowledge, understanding or perceptions about patient engagement?
2. Can the knowledge of the SHERPA-DM tool for CKD patients improve staff knowledge of patient engagement?
3. Can the educational presentation about patient engagement increase knowledge about patient engagement?
4. What are the clinicians' perceptions of the educational presentation and its relationship to patient engagement in clinical practice?

The practice-focused questions aligned with the purpose of the project because one of the first stages to changing clinical practice is ensuring that staff has the knowledge and understanding about current and new concepts, terms, or practices (Graham et al., 2006; Kent et al., 2009; Straus & Graham, 2009). With knowledge relating to a health concept, term, or practice, that knowledge should contribute and lead to research and projects in the development of evidence-based clinical practices that contribute to positive patient and health outcomes (Graham et al., 2006; Kent et al., 2009; Straus & Graham, 2009).

Sources of Evidence

The sources of evidence used to address the practice questions mentioned in the previous section included literature related to patient engagement and chronic kidney disease, obtained from literature search using databases OVID, PubMed, and CINAHL. Other sources of evidence will be obtained from organizations from ORN, NKF, (NIDDKD), CCO, RNAO best practice guidelines, CIHI, and AHRQ, as well as data and/or information from nephrology nurses, advance practice nurses, and physicians currently practicing within the renal program of Ontario. The evidence obtained by the various sources was used to develop the power point presentation relating to CKD and patient engagement that would incorporate evidence-based knowledge and best practices for CKD management. The completed power point presentation was reviewed by experts and clinicians within the CKD department, prior to doing a trial presentation to a few clinicians within the CKD/nephrology program. The final draft of the power point presentation would eventually be developed into an e-learning module, and made available and accessible to clinicians and students within the CKD/nephrology program, and even staff within the hospital.

DNP Project Methods

The DNP project is a quality improvement project that applied a quantitative pretest and post test design.

Participants

The site of the DNP project was at the practicum placement site, a community hospital in Ontario. The participants in the DNP project included clinicians and staff (e.g. nurses, registered dietician, social worker, physicians, students, clerks, administrative assistants, and etc.) working within the nephrology program at the practicum placement site at the community hospital. The number chosen for individuals within the program to participate in the project was a maximum of 20 participants; the selection of participants was based upon availability of the clinicians working within the nephrology department who agreed to participate in the project and would attend the educational presentation, as well as the complexity and time constraints of clinicians who work within the department.

Procedures

Step 1: Quality improvement plan. A quality improvement plan was established that outlined the mission, goals, and objective of the DNP project. The quality improvement plan identified and analyzed, using LFFA, barriers and facilitators to implement this quality improvement project. The quality improvement plan was reviewed by the clinical preceptor at the clinical practicum site. Discussion with the clinical preceptor and leaders within the program also occurred to discuss the implementation of the project.

Step 2: Chronic kidney disease patient engagement presentation. The educational presentation was developed and adapted from previous CKD/nephrology educational materials, articles and journals from literature search, and support from experts within the CKD/nephrology program within the community hospital. The educational presentation was presented in a didactic style with multiple check point choice questions throughout the presentation. The presentation also included reference to information relating to the SHERPA-DM tool. The educational presentation was a 30 presentation, with a five minute questionnaire pre survey prior to the beginning of the presentation and a five minute questionnaire post survey at the end of the presentation.

Participants completed the pre survey prior to the presentation and then complete the post survey at the end of the presentation.

Survey. The pre and post questionnaires were adapted from the program or hospital's previous educational evaluation surveys, and also based on resource(s) that taught how to develop survey questions (Taylor-Powell & Renner, 2009). The survey was then reviewed and validated by clinical experts within the CKD/Nephrology department. The questionnaire also included demographic information relating to participants' age, occupation, and years of experience within the occupation/profession. The participants' names were not included on the questionnaire, to maintain privacy and confidentiality of the participants who participated in the project. Each questionnaire survey had a corresponding numerical code.

Step 3: Data collection. The results of the survey was collected immediately at the end of the presentation and placed in a sealed envelope remained in a locked drawer within the CKD/nephrology department at the practicum site. The results from the pre and post questionnaires papers were electronically entered into excel spread sheet and saved in an encrypted USB; once each paper questionnaire has been entered into the excel spread sheet, the paper questionnaire surveys were destroyed, by placing them in a confidentiality shredder container at the practicum placement site.

Protection of Human Participants

Walden University institutional review board (IRB) reviewed and approved this DNP project, approval number for this DNP project study was 05-05-17-0554736. Walden IRB reviewed the DNP project to ensure that the DNP project complied with

Walden University policies and federally regulated ethical standards for research. Once the DNP project was approved, the clinical preceptor and department manager was informed and notified that the DNP project received approval.

During the implementation phase of the quality improvement project, an announcement at CKD/nephrology team huddles, email message, and meetings occurred to inform the CKD or nephrology staff about the DNP project. The CKD or nephrology staff were also informed that the DNP project was looking for volunteers to participate in the DNP project, including the date and time of the educational session. Interested clinicians were to inform the DNP project's clinical preceptor, and/ or department manager. An email message was also sent out to the CKD/nephrology team with an information consent letter attached in the email.

An information consent letter regarding this project was provided to the participants through both a paper format and email, which provided information regarding the project as well as contact information should they require further information. All participants were notified that participation in the project is voluntary and he or she can withdraw to participate in the project by notifying myself or the writer's practicum clinical preceptor. Contact information (telephone number and email) was provided in the information letter. The information consent letter also notified participants that their consent was implied by clinicians and staff who attended the educational session, completed the power point presentation and completed the surveys.

Privacy and confidentiality of participants in the study were maintained by not including personal identifying information on the questionnaire surveys and use of numerical codes for each participant who completed the questionnaires.

Data were saved in an encrypted USB and writer's personal home computer. Access to the data was only available to the writer; other individuals who had access to the data were the clinical preceptor who supported this project and a member from hospital site's decision support team or health informatics or learning organization support team that supported the data collection and analysis process portion of the project; the names of the members involved in the data collection and data analysis were updated and added to the quality improvement plan document. At the end of the project, the data on the encrypted USB were transferred onto a password protected computer at the hospital facility site where it will be stored for five years. The data in the encrypted USB and home computer will be stored for five years and then it will be deleted from the encrypted USB and home computer.

Analysis and Synthesis

The data from the electronic Microsoft excel spread sheet (including the Excel Analysis Toolpak) was used for the analysis. For each completed survey, no responses (i.e. questions left blank) was also captured and collected during the data collection phase of the project in the excel spread sheet. The mean pretest score was compared to the mean post test score, to determine if there was a statistical difference ($p < 0.05$) between the pretest scores and post test scores. The results from data analysis were used to answer the practice-focused questions and facilitate discussion about the outcome of the DNP project.

Summary

To summarize, upon IRB approval, the DNP project implemented the quality improvement plan, for the development of the e-learning module. Hospital staff were notified about the DNP project and the project’s request for volunteers to participate in this project. For each clinician who attended the educational session, a pretest and post test questionnaire survey was provided to the staff to complete. The clinicians were expected to complete the questionnaires and submit them at the end of each session. The data from the questionnaires was entered into Microsoft excel spread sheet for data analysis. Privacy and confidentiality of individuals who participated in the educational session were maintained by removing personal identifying information from the project and use of an encrypted USB. Statistical analysis was conducted to determine if there was statistical difference between the mean pretest score and mean post test score. The results from the data analysis were then used to answer the practice-focused question and to facilitate discussion about the results from the data analysis.

Section 4: Findings and Recommendations

Introduction

There is a provincial mandate for renal programs within Ontario to improve patient engagement (Carman, et al., 2013; ORN, n.d.; Ryan & Sawin, 2009). The renal programs of Ontario are beginning to implement practices and policies to help improve patient engagement (CCO, 2015; ORN, n.d.; Verma et al., 2013). However, there is limited research and quality improvement initiatives around patient engagement within the renal programs of Ontario (Carman, et al., 2013; Ryan & Sawin, 2009). Therefore, the focus of this DNP project was to develop a quality improvement initiative to help improve the use of patient engagement into clinician's clinical practice within a hospital setting. The purpose of the DNP project was to increase clinicians' knowledge and awareness about patient engagement so that the clinicians can apply that knowledge of patient engagment to their own clinical practices. Hence, the doctoral project practice-focused questions included:

1. What is the CKD staff knowledge, understanding or perceptions about patient engagement?
2. Can the knowledge of the SHERPA-DM tool for CKD patients improve staff knowledge of patient engagement?
3. Can the educational presentation about patient engagement increase knowledge about patient engagement?
4. What are the clinicians' perceptions of the educational presentation and its relationship to patient engagement in clinical practice?

The sources of evidence used for this doctoral project included literature related to chronic kidney disease and patient engagement obtained from electronic OVID, PubMED and CINAHL databases as well as literature and resources from organizations such as (NKF, AHRQ, CIHI, ORN, CCO, and the RNAO BPG. Other sources of evidence, relating to information, literature, and data, were also obtained from clinicians such as nephrology advanced practice nurses, nurses, and physicians currently practicing within the renal program of Ontario. These sources of evidence were used to help address the practice questions and to develop an educational Microsoft powerpoint presentation, and then for that power-point presentation to eventually become an e-learning module (Appendix A).

The educational presentation was adapted from the sources of evidences. The educational presentation also included resources that provided information relating to the SHERPA-DM tool. Participants in the project completed a paper-format survey, that included both pre and post questionnaires (Appendix B). The results form the surveys were collected and then transferred to an electronic microsoft excel spreadsheet (Appendix C, D, F G). Data analysis, using the Microsoft Excel Analysis Toolpak, was completed to see if there was an increase from the mean pretest score to the mean post test score, and to determine if there was statistical difference ($p < 0.05$) between the mean scores (Appendix E). The results from data were used to answer the doctoral project's practice-focused questions.

Findings and Implications

There were a total of nine participants who participated in the DNP project. All participants were female. The ages of the participants ranged from 21 - 69 year of age, with majority of the participants being in the age range of 50 - 59 years of age.

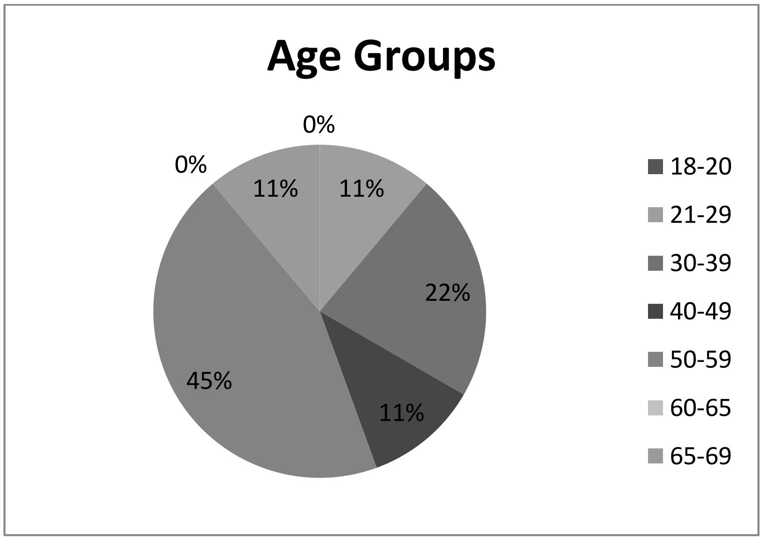

Figure 1. Age groups of participants.

Most participants were registered nurses who participated in the project and most participants have 0-4 years of experience and 15-29 years of experience in their current job.

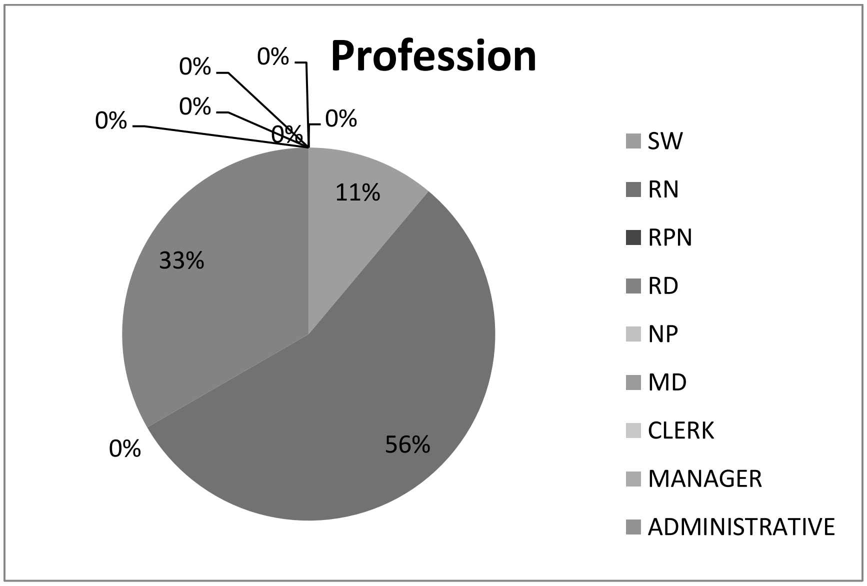

Figure 2. Participants' profession.

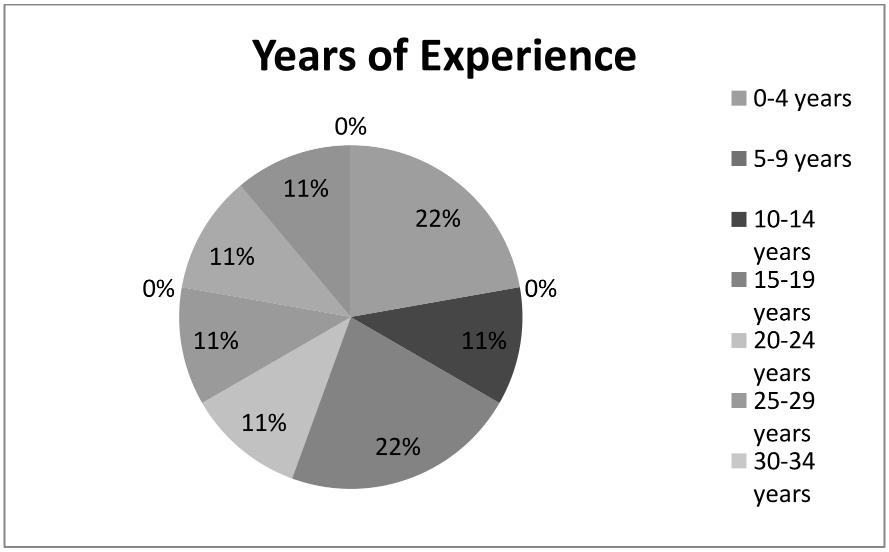

Figure 3. Participants' years of experience in their current job.

Result Findings

Practice-Focused Question 1. Practice Question 1 was: What is the CKD staff knowledge, understanding or perceptions about patient engagement? A 5-point Likert scale (ranging from poor to excellent) was used to help answer question one; the question was for participants to rate their perceptions of their knowledge and awareness about patient engagement, and also their perception on the relevancy of patient engagement to their clinical practice. The pre survey scores with a rating of participants' perceptions of themselves as "very good and excellent" resulted in knowledge, awareness, and its relevancy to clinical practice as 33%, 67%, and 78% of participants.

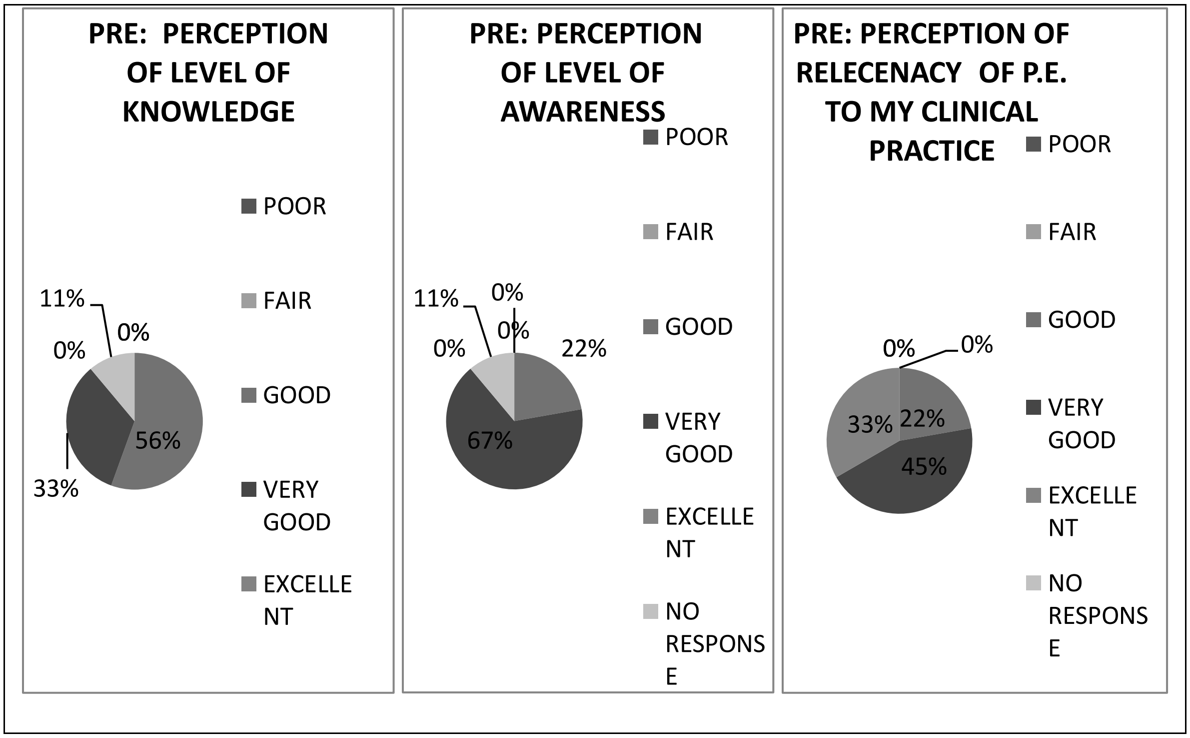

Figure 4. Pre survey results for participants' perception of their knowledge, awareness, and relevancy to clinical practice relating to patient engagement, prior to the educational presentation.

Prior to completing the educational power-point presentation, the results appeared to imply that most clinicians did not perceive themselves as having knowledge about patient engagement even though over 60% felt they had very good and excellent awareness about patient engagement. The clinician responses to this question coincide with their previous experience relating to patient engagement within the hospital setting. Prior to the DNP project, the clinicians previously learned about patient engagement and hence which could explain the high ratings in awareness and relevance to their clinical practice. It could be assumed that the low ratings in knowledge could be related to their historical context about the use of patient engagement practices in their hospital; they potentially had some learning about patient engagement, or they heard about patient engagement practices occurring within their program such as in committees and councils, or also perhaps clinicians were unaware that themselves as clinicians could practice patient engagement in their own clinical practice and with their patients (Health Quality Ontario, 2017).

Practice-Focused Question 2. Practice question two was, 'Can the knowledge of the SHERPA-DM tool for CKD patients improve staff knowledge of patient engagement?' A 5-point Likert scale (ranging from strongly disagree to strongly agree) was used on the post questionnaire survey to rate participants' extent of agreement to statement, "learning about the SHERPA-DM tool increased my knowledge about patient engagement". On the post survey relating to the SHERPA-DM tool, only 33% of participants agreed and 22% strongly agreed that learning about the SHERPA-DM tool increased their knowledge and awareness about patient engagement (Appendix F). Hence, most clinicians within the CKD/nephrology department felt that learning about the tool did not improve their knowledge about patient engagement. The clinicians' responses were appropriate because the development of the SHERPA-DM tool is based on the foundation on the concept of self-management and shared decision making (Barry & Edgman-Levitan, 2012; Murray, Bissonnette, Kryworuchko, Gifford, & Calverley, 2013); for these reasons their responses would contribute to their disconnect to understand that the use of the SHERPA-DM tool can be used in their clinical practice, supporting patient engagement practices (Barry & Edgman-Levitan, 2012; Murray et al., 2013). Hence, future projects or research will need to provide clarification and explain that the use of the use of this tool in clinical practice facilitates evidence based practice within a clinical setting and the tool can also be applied to support patient engagement practices, which is to actively involve patients in decision making (of which the SHERPA-DM tool enables clinician to actively participate in treatment decisions related to end-stage renal disease) (Barry & Edgman-Levitan, 2012; Carman et al., 2013; Cancer Care Ontario Ontario Renal Network, 2015; Murray et al., 2013).

Practice-Focused Question 3. The third practice question was, ‘Can the educational presentation about patient engagement increase knowledge about patient engagement?’ The knowledge testing questions from the educational presentation was used to help address this question. There were a total of eight knowledge test questions in the educational presentation that were used in both the pretest survey and post test survey. The correct scores were calculated and the mean scores were obtained for the pretest survey and post test survey. The mean score knowledge pretest questions was 5.22 (65%) and the survey mean knowledge post test question was 6.22 (78%) (Appendix D). Statistical analysis to compare the mean pretest and post test scores, using the Microsoft Excel Analysis Toolkit, resulted in a non-statistical difference ($p > 0.05$) between the mean pretest score and the mean post test scores (Appendix E). Furthermore, from the results of the post survey, 78% of the clinicians agreed with the statement, that the educational presentation increased their knowledge about patient engagement. There was also an increase in response scores of ‘very good and excellent’ in the participants perception about their own knowledge about patient engagement, from 33% in the pre survey to 67% in the post survey. The results indicate that the educational presentation can increase knowledge about patient engagements to clinicians. Despite the difference in mean scores not being statistically significant, there was a 10% increase from the mean pretest to post test scores as well as an increase in their impression of how well they rated themselves in knowing about patient engagement, which could potentially suggest clinical significance especially for clinicians learning how patient engagement strategies can be applied with their patients in their clinical practice settings (Cancer Care Ontario Ontario Renal Network, 2015; Fortnum, Smolonogov, Walker, Kairaitis, & Pugh, 2015; Goovaerts et al., 2015; Nursing Alliance For Quality Care, n.d.; Prey, et al., 2014). The results of this study support other health teaching initiatives in increasing knowledge about concepts or practices geared towards improving care (Fortnum et al., 2015; Goovaerts et al., 2015; Nursing Alliance For Quality Care, n.d.; Prey et al., 2014). However, further research is warranted to determine what is considered clinical significance in learning opportunities related to patient engagement teachings within a CKD management clinical practice setting.

Practice-Focused Question 4. The fourth practice question was, ‘What are the clinicians’ perceptions of the educational presentation and its relationship to patient engagement in clinical practice'. A 5-point likert scale was used in the post survey, looking at the extent of an agreement to a sentence ranging from strongly disagree to strongly agree) to help evaluate the practice question. After completing the educational presentation, 78% of the participants agreed with the statement that the presentation increased their knowledge about patient engagement. Forty-four percent of the participants agreed and another 44% strongly agreed with the statement that learning about patient engagement would be helpful to their clinical practice. Seventy-eight percent of the participants agreed that the presentation will be helpful to other clinicians to learn about patient engagement.

Based on the results, 78% of participants rated their impression of the content of the educational presentation as good and above, 55% of the participants rated their impression of the power-point presentation as good and above, and 67% of the participants rated the organization of the presentation as good and above. Therefore, there is an opportunity to make more improvements to the educational presentation itself prior to converting to an e-learning format and also provide more or enhance learning opportunities about patient engagement and the SHERPA-DM tool to future e-learning modules.

Implications

The outcome from the project study demonstrated that the CKD staff's perception or understanding about patient engagement can improve after completing an educational power-point presentation; The outcome from the project study also demonstrated that the educational presentation about patient engagement can increase knowledge about patient engagement and improve CKD staff's perception about patient engagement and its relevancy to their clinical practice.

Shared decision making is a familiar concept for those who worked in the CKD/nephrology clinic. Also, the clinicians in the CKD/nephrology clinic previously learned about the SHERPA - DM tool, prior to the initiation of the DNP proposal and hence it was expected that there would be little increase or improvement relating to their perception or impression about the SHERPA-DM tool in relation to shared decision making in comparison to patient engagement. On the other hand, patient engagement is a newer concept for clinicians in the hospital setting and hence it was expected that there would be a greater increase or change in score relating to patient engagement in comparison to shared decision making. I would also recommend that clinicians practice how to use the SHERPA-DM tool before using the tool in their clinical practice because practicing how to use the tool may be useful in preparing clinicians to better understand the purpose of the tool and how to use the tool appropriately and effectively with their patients in their clinical practice (Cancer Care Ontario Ontario Renal Network, 2015; Fortnum et al., 2015; Goovaerts, et al., 2015). Therefore, organizations should seek permission to use the SHERMA-DM tool within their organization, with permission to use the tool, then leadership within the organizations can work towards providing learning opportunities for their staff to learn how to properly use the tool in real life (e.g. video demonstration and/or hands on practice) (Cancer Care Ontario Ontario Renal Network, 2015; Fortnum et al., 2015; Goovaerts, et al., 2015; Health Quality Ontario, 2017).

Overall, the results from this doctoral study project has shown that an educational presentation about patient engagement can increase clinicians' knowledge and awareness about patient engagement and that an educational presentation can be helpful to clinicians' clinical practice (Bonner et al., 2014; Carman et al., 2013; CCO, n.d., 2015; Ong et al., 2013; ORN, n.d.; RNAO, 2009). The implications from this doctoral project study is that the e-learning module can be developed from the power-point presentation and used in a hospital setting for clinicians to use to learn about patient engagement. This doctoral study also provided support for use of an e-learning module for other potential research or quality improvement initiatives that are looking at developing an e-learning module for their hospital staff. Furthermore, there can be the possibility of improving or enhancing current content and layout of the presentation before converting it to an e-learning module format. A positive feature of using an e-learning module is that the e-learning module can be an alternative way for teaching staff, instead of having in-services or formal education class days (Ball et al., 2011). Clinicians have the ability to select own their times and dates to view the module; clinicians can review the module on their own time and pace, and can even choose to review the module outside of work hours. The challenge that may occur with the use of an e-learning module is that the clinicians have to be familiar with using computers and software technology (Ball et al., 2011). If clinicians are not familiar with how to use computers, then the e-learning module will not be beneficial for those individuals (Ball et al., 2011). Hospital settings will have to ensure that they have the resources (i.e. supplies such as computers, resources, and information technology or health informatics support) to ensure that their staff will have adequate and appropriate access and ability to use computers so that they can use the e-learning module (Ball et al., 2011). In a hospital setting that does not have computers or does not have the resources or accessibility to computers, then the e-learning module may not be beneficial to that hospital and those hospital staff (Ball et al., 2011).

Based on the outcome of the DNP project, this e-learning module can be developed for new staff and students within CKD management program within the community hospital, to learn about patient engagement. The potential implication for the use of the e-learning module is that the e-learning module can be made available for other clinicians and staff and thereby providing the opportunity for clinicians and staff, and even students, to learn about patient engagement (Carman et al., 2013; CCO, n.d., 2015; ORN, n.d.). Therefore, this DNP project was able to support patient engagement and its use and application into the delivery of health care; the DNP project provides an approach that can help health care professionals become familiar with the concept and term of patient engagement (CCO, n.d., 2015; ORN, n.d.). With the patient engagement being used in practices and policies, the health care system is able to take a more active role in empowering patients to become active participants in health care decisions, whether their own individual decisions or facilitate the decisions of other patients and consumers of the health care system (CCO, n.d., 2015; ORN, n.d.).

Recommendations

The proposed recommendation is the use of an e-learning module within a health care setting to increase knowledge and awareness of patient engagement, and also to support use of evidence based practice in clinical setting. This doctoral study may be used as an example of a use of quality improvement strategies that other health care teams or departments can adapt and apply to their clinical setting. Furthermore, it is hoped that further research and quality improvement projects relating to patient engagement are developed and contribute to increasing the amount of resources that health care professionals can use as resource as how to implement patient engagement practices and policies into a health care setting. The key factor will be for departments or organizations to do their own need assessment to identify and address both the facilitators and resistances to help ensure that the initiative or research can become successful. Every clinical setting is different and there will be strategies that work better or worse in different clinical settings (Hodges & Videto, 2011).

Strengths and Limitation of the Project

The strength of the DNP project was the use of quality improvement strategies that enabled the ability to do thorough needs assessment within the clinic; by doing the needs assessment, the project was able to develop a plan that would address the facilitators and barriers within the CKD/nephrology clinic department. Another strength of the DNP project was that the participants in the project, as well as staff within the clinic department, had some knowledge relating to self-management, shared decision making, and the SHERPA-tool, that helped to develop an educational presentation focus on patient engagement and also reduce the length and time of the education presentation. The limitation of the project is that it is not a research study and hence a true cause and effect cannot be established and it cannot be assumed. The DNP project had a very small number of participants and therefore the outcome of the DNP project cannot be generalized to other departments and health organization within Ontario and outside Ontario; it is recommended that health care organizations or departments complete their individual needs assessment so that an appropriate educational strategy can be developed to meet the needs of that department or organization. Another limitation for the project was the limited amount of resources and literature, on patient engagement initiatives within CKD management, which was available to review to adapt to the DNP project. Therefore, it is recommended that future initiatives for this similar project do another literature review as well as to talk to organization programs or associations to find out about most recent resources and activities that may be available and published, or being published. It is also recommended that further quality improvement strategies and research about patient engagement be conducted to contribute to the body of knowledge relating to patient engagement.

Section 5: Dissemination Plan

The plans for dissemination related to this doctoral project included a thirty minute power-point presentation for the various stakeholders within the CKD/nephrology department at the community hospital. The various stakeholders who attended the doctoral project presentation, included health care providers, managers, leaders, would learn about the doctoral project and the doctoral project outcomes (Laureate Education, 2012; Oermann & Hays, 2016; Zaccagnini & White, 2014). The internal stakeholders had the opportunity to ask questions and offer discussions during the question period (Oermann & Hays, 2016; Zaccagnini & White, 2014). This dissemination plan also provided an opportunity for the internal stakeholders to also gain a greater understanding about the project; the discussions about the project can contribute to suggestions and feedback for further dissemination plans of the doctoral study at a poster presentation at a conference or a journal publication. After completing the power-point presentation, then the work of this doctoral project will then be presented as a poster presentation at a conference or published in a journal article. The opportunity to do a poster presentation at a conference or a journal publication will provide an opportunity to show case and discuss the work, with external stakeholders such as other health care professionals practicing in CKD management, nurse leaders, and even administrators), and also contribute to other similar educational initiatives related to patient engagement at other health care organizations (Oermann & Hays, 2016; Zaccagnini & White, 2014).

Analysis of Self

The dissemination of quality initiatives, research, and projects provides a means of distribution and sharing of knowledge so that fellow health care professionals, academic professionals, researchers, health administrators and policy makers can learn from each other and develop or adapt research or projects or even contribute to further research, which will contribute to advancing the knowledge, and evidence-based practice to improving patient outcomes and health outcomes (Oermann & Hays, 2016; Walsh, 2010; White & Dudley-Brown, 2012; Zaccagnini & White, 2014). As a scholarly practitioner and nurse leader, I will be practicing within the realms of scholarly practitioner, nurse leader, and program manager that would enable me to contribute to leading and collaborating with other health care professionals to improving patient care, health outcomes, delivery of the health care system, health practices, policies, and procedures (Kelly, 2011; Kettner et al., 2013; Walsh, 2010; White & Dudley-Brown, 2012). As a nursing leader and scholarly practitioner, I am able to contribute to making a difference by incorporating evidence-based practice into clinical practices and organizational policies to support the optimization of improving the delivery of the health care system and ensure that patients and their families receive better health outcomes as well as a better quality of life (Kelly, 2011; Kettner et al., 2013; Walsh, 2010; White & Dudley-Brown, 2012).

Scholar and Practitioner

Prior to completing the doctorate of nursing practice (DNP) program and completing the DNP project, I used to believe that the two entities of scholar and practitioner were mutually exclusive, with minimal overlap in clinical practice. However since completing the DNP program and DNP project, I have a greater understanding and appreciation for the term scholarly practitioner. I have come to appreciate and understand how these roles are not mutually exclusive but the two terms can overlap, merge, and both be used and applied in clinical practice (Zaccagnini & White, 2014). As a scholarly practitioner, I am using and applying science, science theories, evidence-based practice, advanced nursing practice, and leadership to translate evidence into practice to improve patient and health outcomes (Zaccagnini & White, 2014). As a scholarly practitioner, I am critically looking at current practices to ensure that it is evidenced based; if there are concerns regarding practice and policies, I have the ability to frame a question, complete a literature review, develop a project, program, or research initiative to address the question and then support implementation and evaluation of the project, program or research initaitive within a health care setting (Kelly, 2011; Kettner et al., 2013; Laureate Education, 2011a; Walsh, 2010; White & Dudley-Brown, 2012; Zaccagnini & White, 2014). As a scholarly practitioner, I am also able to be a nursing leader collaborating with other health care professionals to improve patient and health outcomes (Walsh, 2010; White & Dudley-Brown, 2012; Zaccagnini & White, 2014). The skills and knowledge that I have aquired through this project developed and expanded my competencies as a DNP prepared nurse (AACN, 2006; Zaccagnini & White, 2014). I have developed the skills on how to utilize and apply the DNP essentials within my nursing practice to improve patient outcomes and health outcomes and can apply these essential skills in my practice as a DNP prepared nurse.

Project Director/Project Manager

Developing, implementing, and evaluating the DNP project provided the opportunity to apply project management skills to facilitate the accomplishment of completing the DNP project. The DNP program and completion of the DNP project have provided the foundation for me to develop and advance in project and program planning. The skills involved in program management have been applied to this DNP project to facilitate in creating and developing an initiative to improve practice within a clinical setting (AACN, 2006). Furthermore, the ability to incorporate a quality improvement lens within the DNP project facilitated my ability to appropriately address the needs of the staff and leadership within the community hospital. Throughout the DNP project, I have learned how to apply the skills and roles of a program director and manager to help complete the DNP project which will also help me to develop my skills as a DNP prepared nurse. I believe that the skills of project management are very relevant and applicable to the role of DNP prepared nurses and provide the foundation for DNP prepared nurses to work within organizational systems to lead initiatives to improve health outcomes and patient outcomes (AACN, 2006; Kettner et al., 2013; Zaccagnini & White, 2014). With the knowledge and skills of project management, I am able to work in future formal nursing leadership roles, contributing to changing practices and policies within the health care system (AACN, 2006; Kelly, 2011; Kettner et al., 2013; Zaccagnini & White, 2014).

Overall, my experience while completing the DNP project has been full of growth and learning as a DNP prepared nurse. While completing the DNP project, the most area of growth and learning has been in program and project management that has also positively contributed to the successful completion this project. I learned how to apply program and project management skills as a nurse to support organizational mission and strategy. Also, I learned how to incorporate program and project management in helping to drive change within a health care setting. Through this scholarly journey, I have also come to appreciate the process involved in quality improvement, program or project planning, and research; these three strategies for translating and implementing evidence based practice requires collaboration, team work, and patience, since change to clinical practice cannot be done quickly but rather it takes time, patience, and perseverance.

Summary

To conclude, the focus of this DNP project was the development of a quality improvement initiative to improve the use of patient engagement among clinicians within a community hospital, with the purpose to increase clinicians' knowledge and awareness about patient engagement. An educational Microsoft power point presentation was developed from sources of evidence obtained from literature data bases and organizational resources. A pretest survey and a post test survey were provided to participants to evaluate the presentation. The data from the survey was collected, compiled and transferred to excel spreadsheet. An Excel Analysis Tool Pak was used to determine if there was statistical difference between the mean pre survey score and the mean post survey score. Nine participants participated in the DNP project study. The results showed that there was an increase from the mean pretest score to the mean post test score, but it was not statistically significant ($p > 0.05$). The percentage of participants who rated their level of knowledge and awareness as very good and excellent, relating to patient engagement, increased from of 33% and 67% to post survey results of 67% and 100%. After completion of the presentation, 100% of participants who rated their perception that patient engagement were relevant to their clinical practice while 78% of participants agreed with the statement that the presentation would be helpful to other clinicians to learn about patient engagement.

The results of the doctoral study demonstrated that an educational presentation can increase knowledge and awareness about patient engagement. The results from DNP project study supported the development for an e-learning module. Hence, the outcome of the DNP project was the development of the e-learning module. The dissemination plan for this doctoral project included a thirty minute power-point presentation to various stakeholders within the CKD/nephrology department as well as a poster presentation at a conference or a journal publication. The social impact of this DNP project is that other departments and health care organizations can adapt and use the e-learning module or a similar education strategy to increase staff’s knowledge about patient engagement. It is recommended that other departments or organizations complete their own needs assessments, to determine if an e-learning module is appropriate for their clinical setting. It is also recommended that further quality improvement initiatives and research related to patient engagement to occur, to continue to expand the knowledge base of patient engagement within CKD management and increase availability and accessibility of resources for clinicians working with CKD patients.

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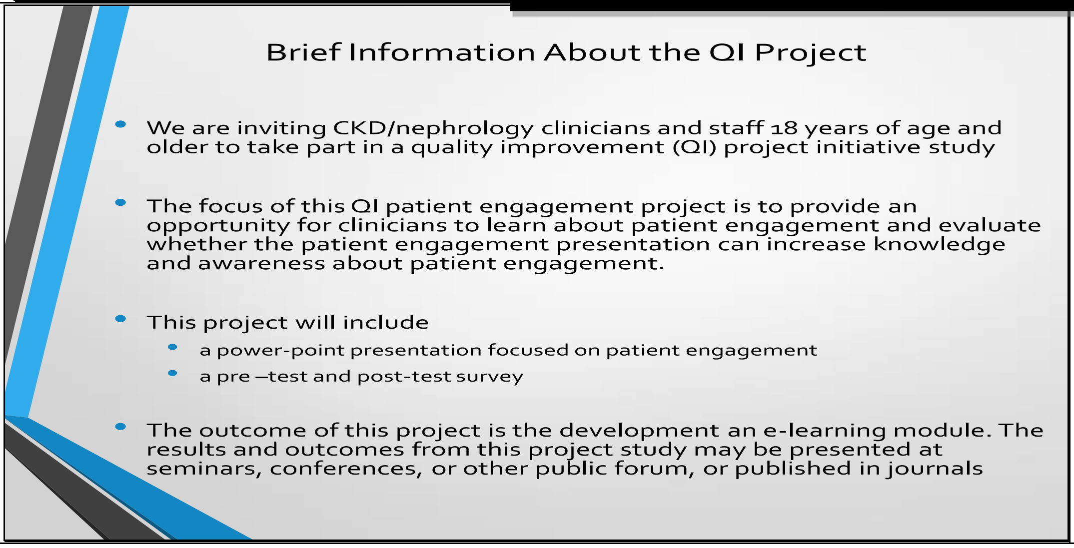
Appendix A: Patient Engagement Education Presentation

Patient Engagement
E-Learning Module
Quality Improvement Project:

CKD/NEPHROLOGY DEPARTMENT
JUNE 2017

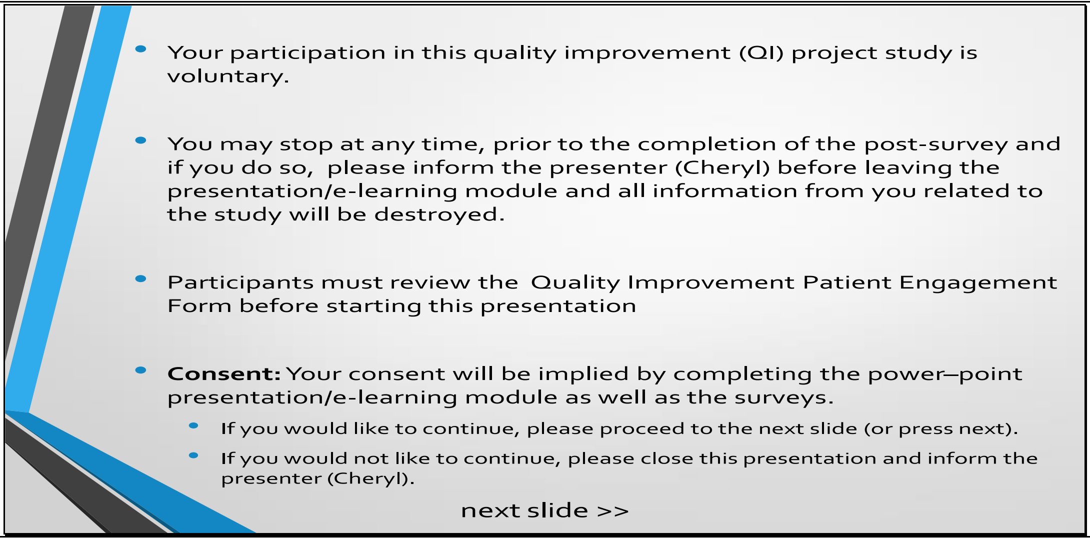
[redacted]

Patient Engagement e-learning [redacted]



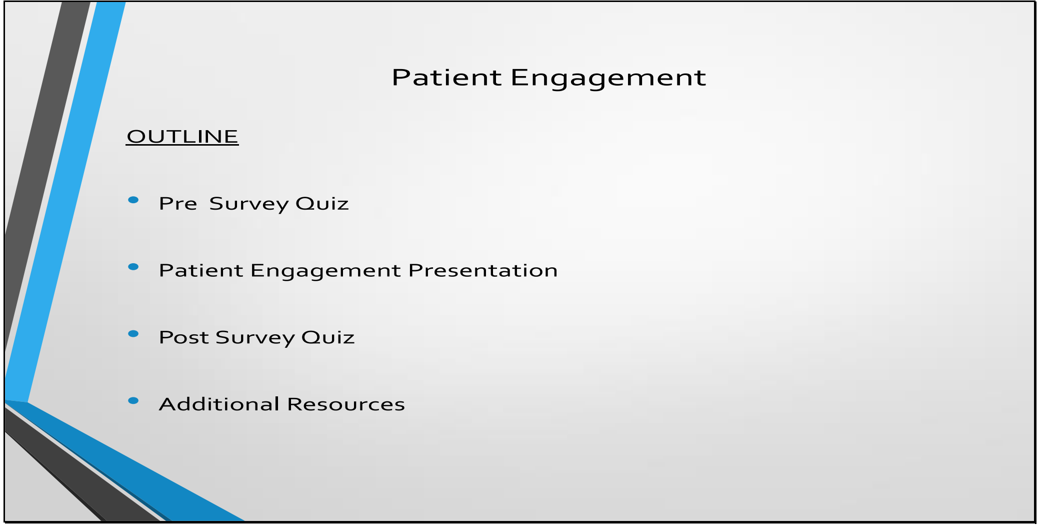
Brief Information About the QI Project

- We are inviting CKD/nephrology clinicians and staff 18 years of age and older to take part in a quality improvement (QI) project initiative study
- The focus of this QI patient engagement project is to provide an opportunity for clinicians to learn about patient engagement and evaluate whether the patient engagement presentation can increase knowledge and awareness about patient engagement.
- This project will include
  - a power-point presentation focused on patient engagement
  - a pre –test and post-test survey
- The outcome of this project is the development an e-learning module. The results and outcomes from this project study may be presented at seminars, conferences, or other public forum, or published in journals



- Your participation in this quality improvement (QI) project study is voluntary.
- You may stop at any time, prior to the completion of the post-survey and if you do so, please inform the presenter (Cheryl) before leaving the presentation/e-learning module and all information from you related to the study will be destroyed.
- Participants must review the Quality Improvement Patient Engagement Form before starting this presentation
- **Consent:** Your consent will be implied by completing the power–point presentation/e-learning module as well as the surveys.
  - If you would like to continue, please proceed to the next slide (or press next).
  - If you would not like to continue, please close this presentation and inform the presenter (Cheryl).

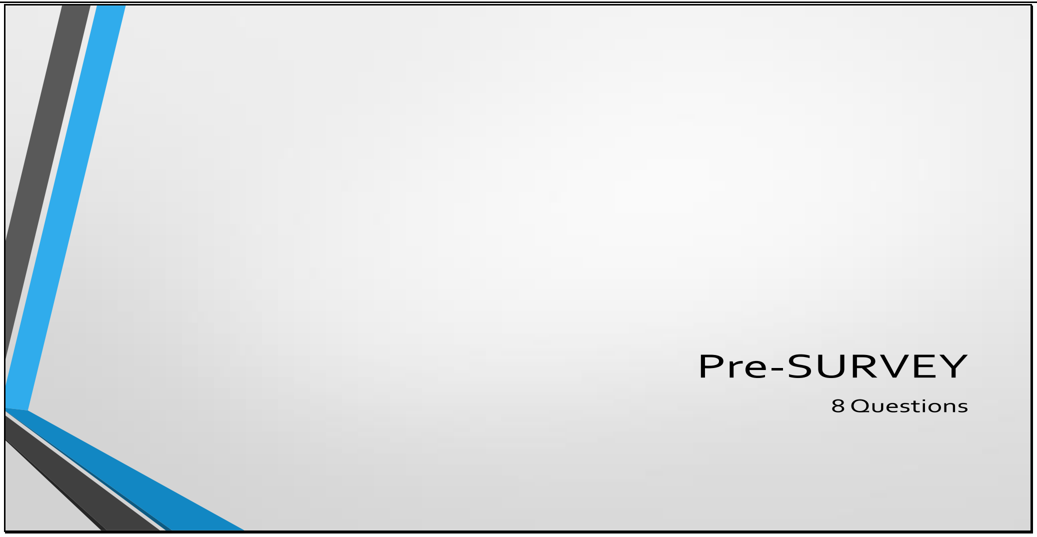
next slide >>



Patient Engagement

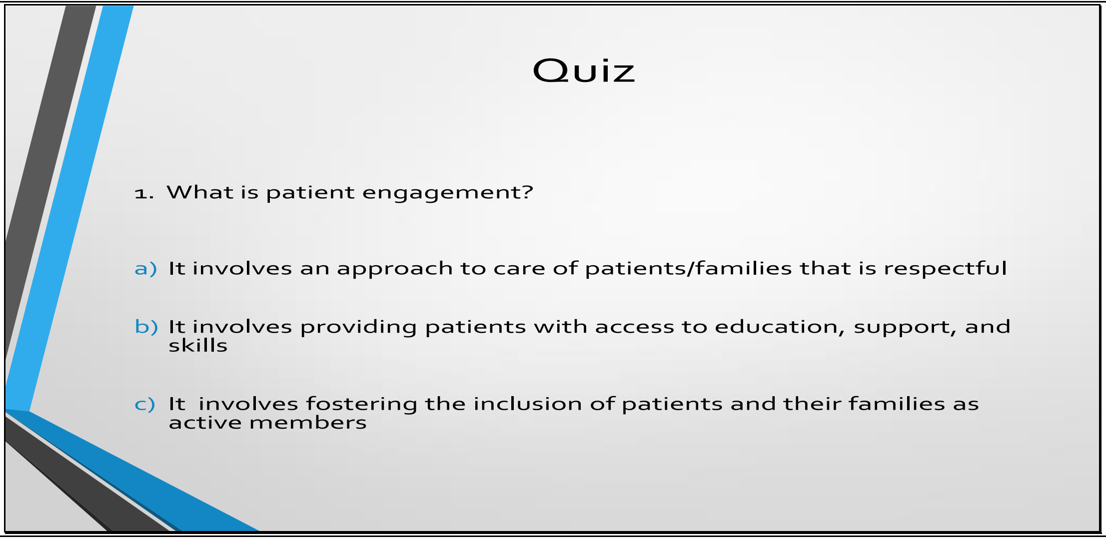
OUTLINE

- Pre Survey Quiz
- Patient Engagement Presentation
- Post Survey Quiz
- Additional Resources



Pre-SURVEY

8 Questions



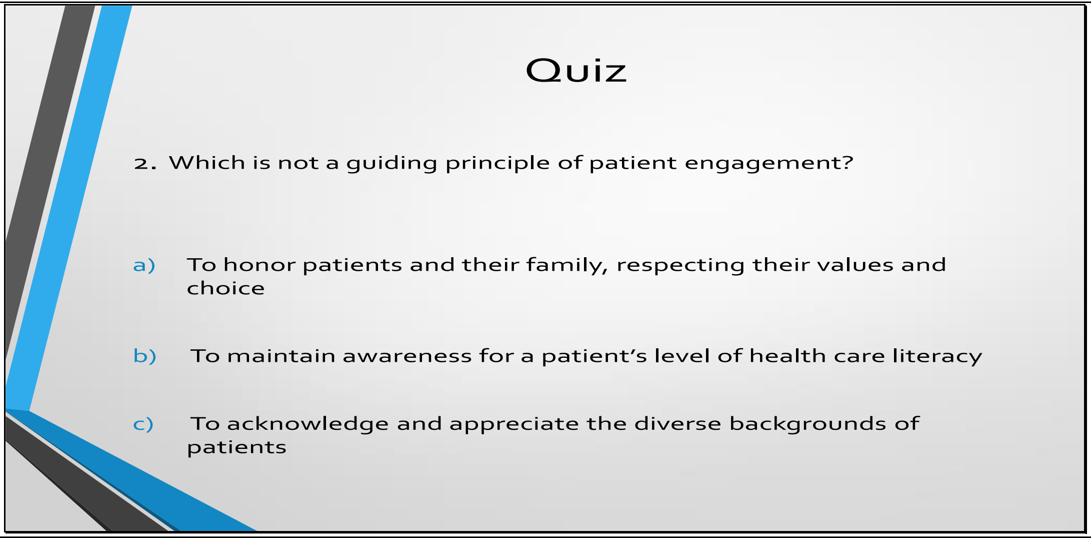
Quiz

1. What is patient engagement?

a) It involves an approach to care of patients/families that is respectful

b) It involves providing patients with access to education, support, and skills

c) It involves fostering the inclusion of patients and their families as active members



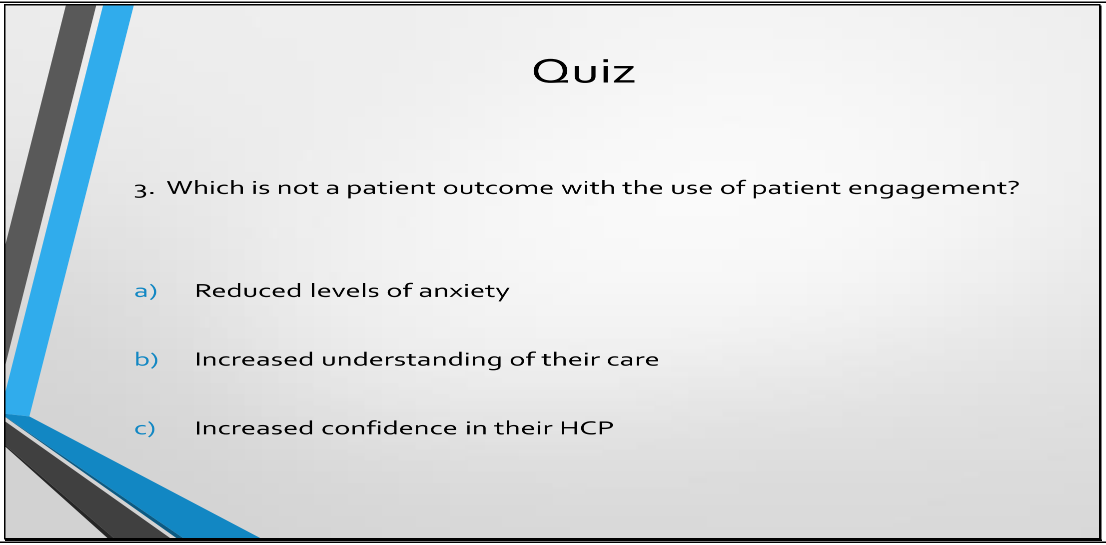
Quiz

2. Which is not a guiding principle of patient engagement?

a) To honor patients and their family, respecting their values and choice

b) To maintain awareness for a patient’s level of health care literacy

c) To acknowledge and appreciate the diverse backgrounds of patients



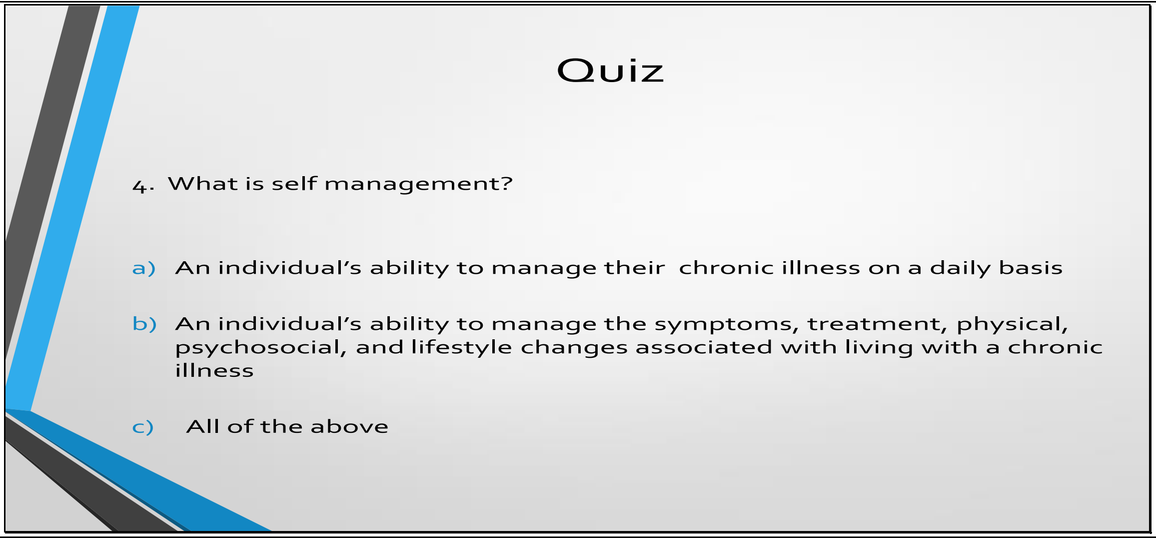
Quiz

3. Which is not a patient outcome with the use of patient engagement?

a) Reduced levels of anxiety

b) Increased understanding of their care

c) Increased confidence in their HCP



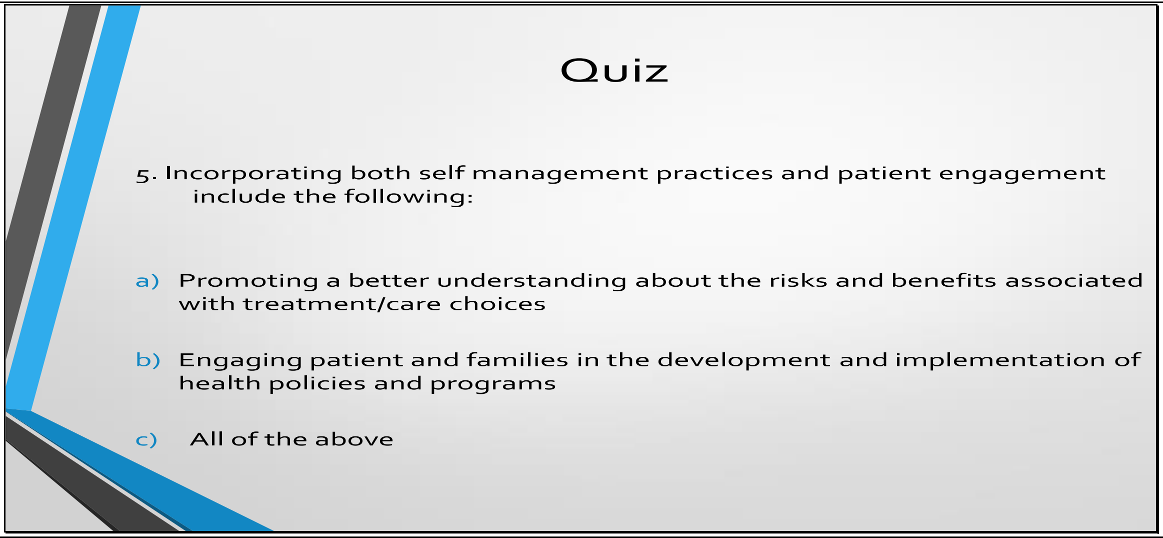
Quiz

4. What is self management?

a) An individual’s ability to manage their chronic illness on a daily basis

b) An individual’s ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes associated with living with a chronic illness

c) All of the above



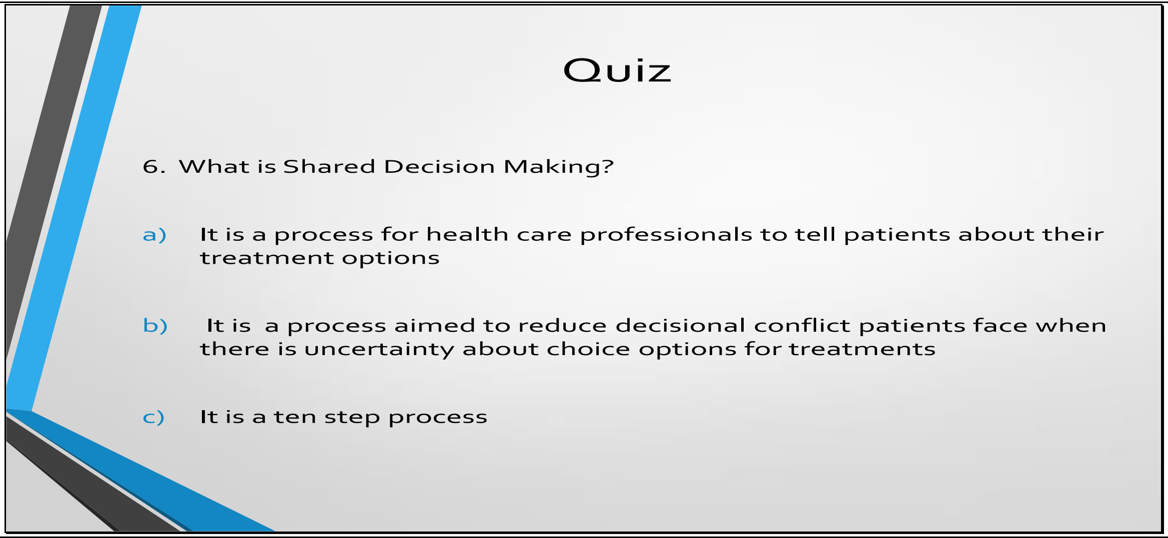
Quiz

5. Incorporating both self management practices and patient engagement include the following:

a) Promoting a better understanding about the risks and benefits associated with treatment/care choices

b) Engaging patient and families in the development and implementation of health policies and programs

c) All of the above



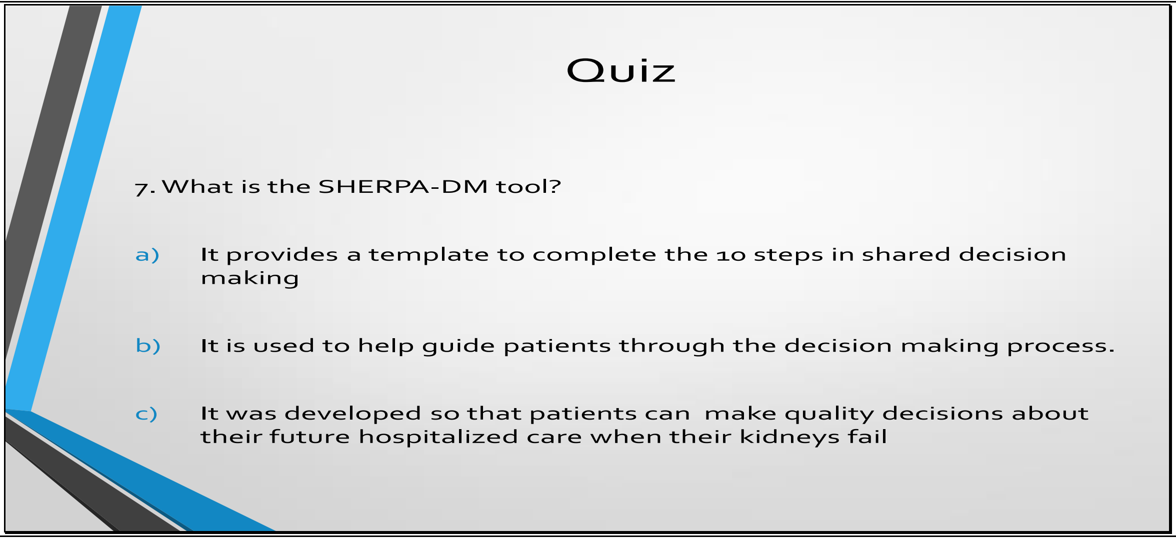
Quiz

6. What is Shared Decision Making?

a) It is a process for health care professionals to tell patients about their treatment options

b) It is a process aimed to reduce decisional conflict patients face when there is uncertainty about choice options for treatments

c) It is a ten step process



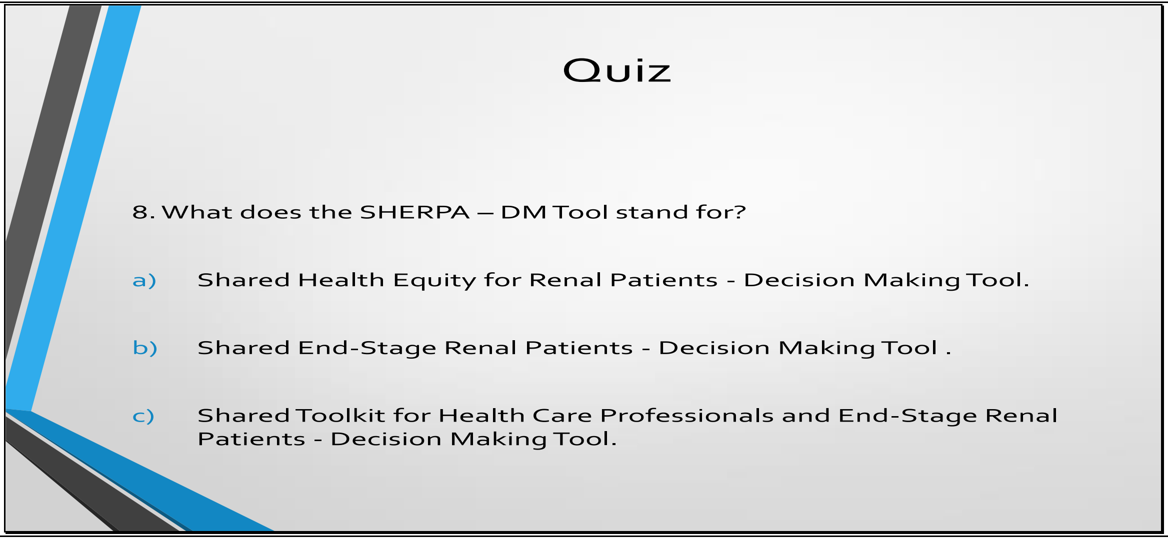
Quiz

7. What is the SHERPA-DM tool?

a) It provides a template to complete the 10 steps in shared decision making

b) It is used to help guide patients through the decision making process.

c) It was developed so that patients can make quality decisions about their future hospitalized care when their kidneys fail



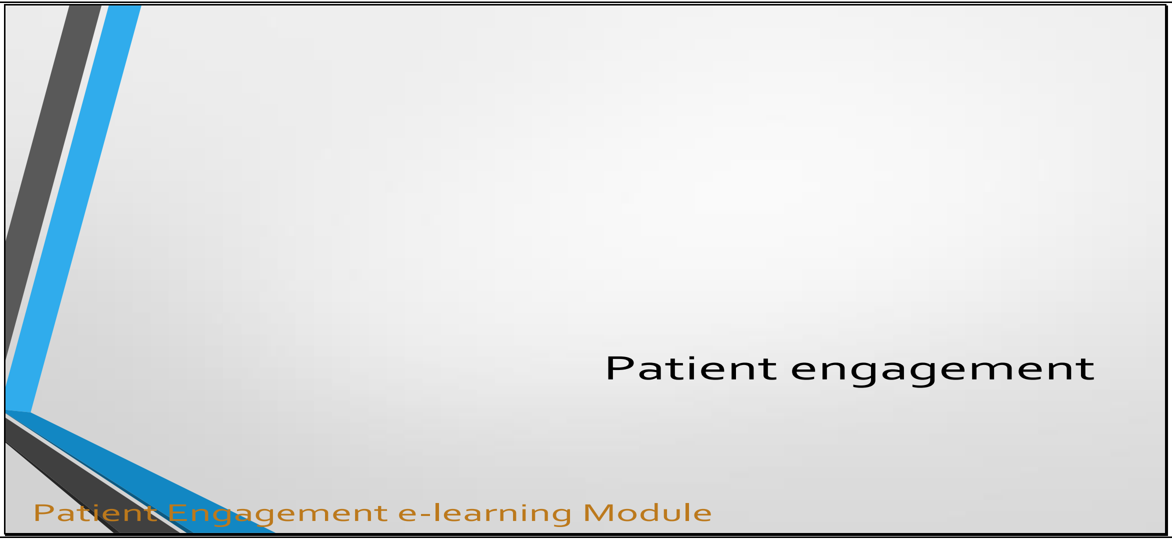
Quiz

8. What does the SHERPA – DM Tool stand for?

a) Shared Health Equity for Renal Patients - Decision Making Tool.

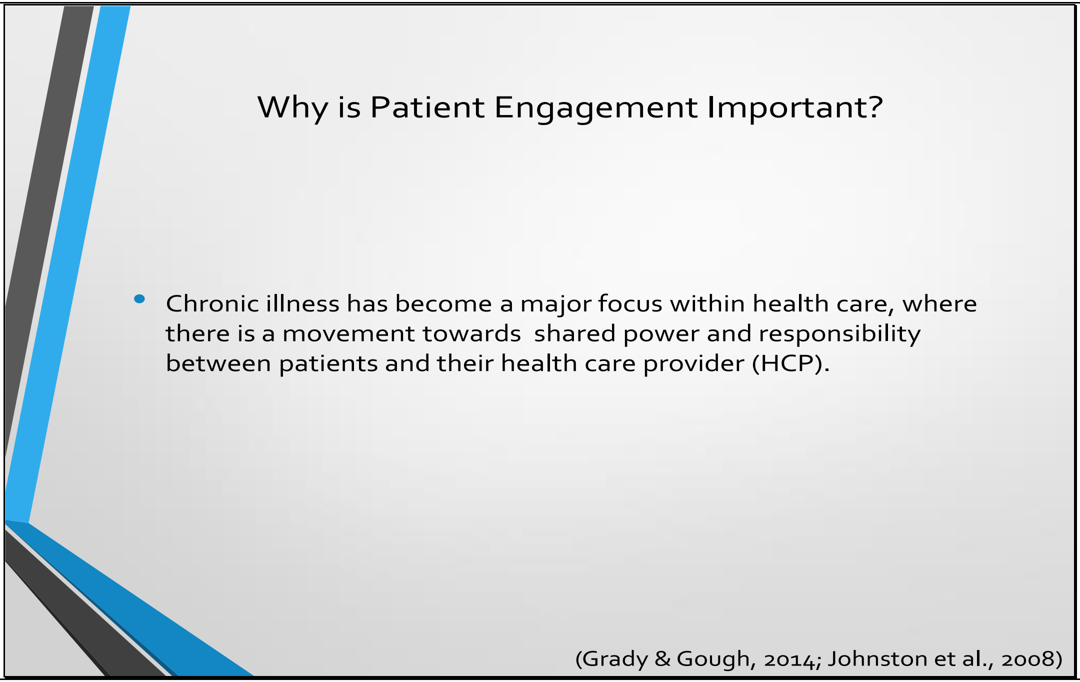
b) Shared End-Stage Renal Patients - Decision Making Tool .

c) Shared Toolkit for Health Care Professionals and End-Stage Renal Patients - Decision Making Tool.



Patient engagement

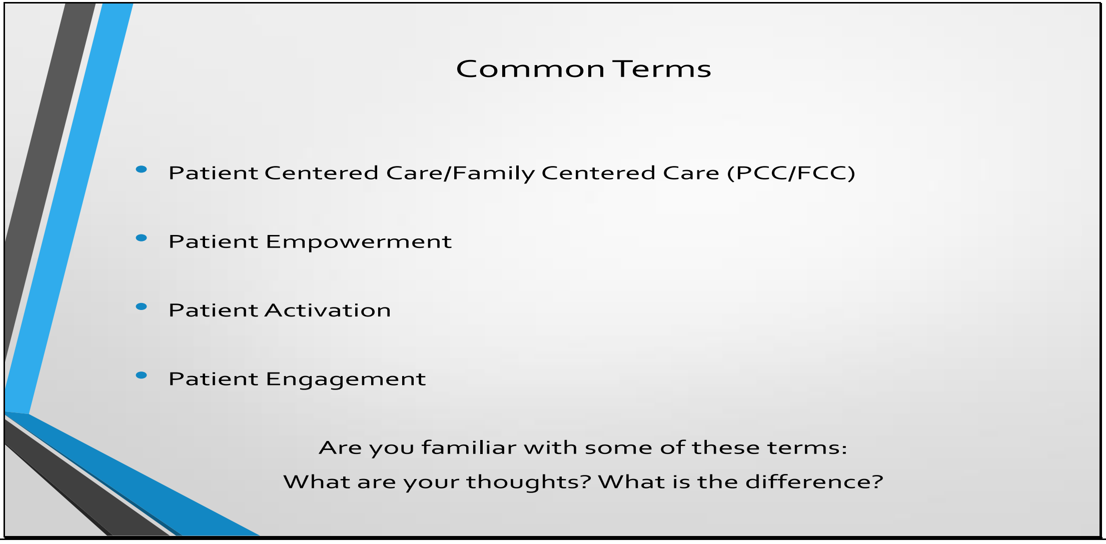
Patient Engagement e-learning Module



Why is Patient Engagement Important?

- Chronic illness has become a major focus within health care, where there is a movement towards shared power and responsibility between patients and their health care provider (HCP).

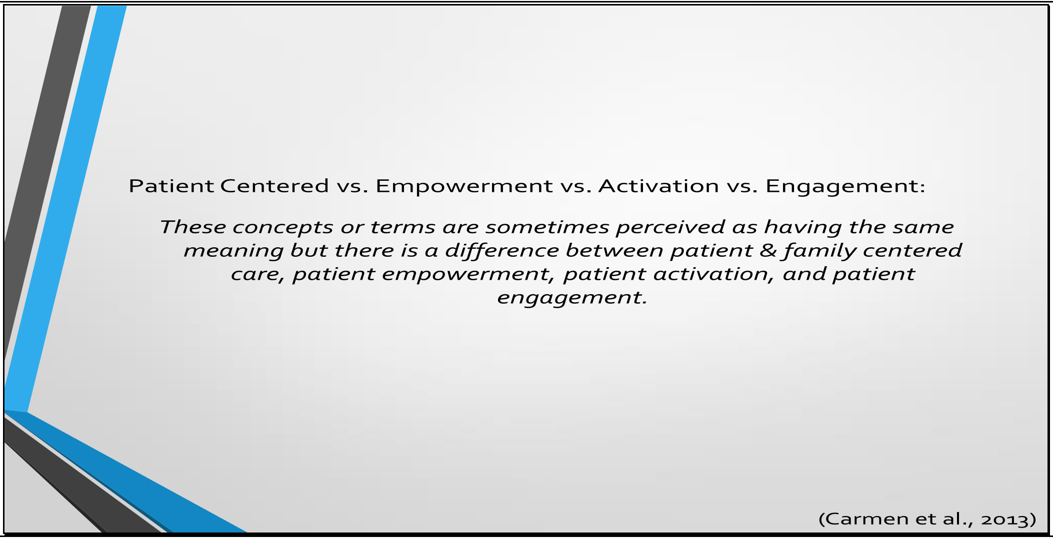
(Grady & Gough, 2014; Johnston et al., 2008)



Common Terms

- Patient Centered Care/Family Centered Care (PCC/FCC)
- Patient Empowerment
- Patient Activation
- Patient Engagement

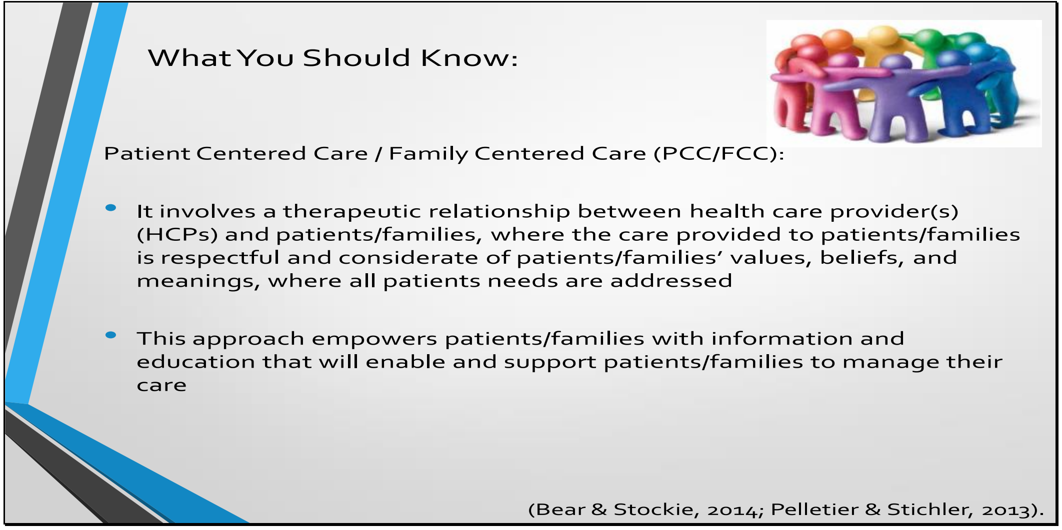
Are you familiar with some of these terms:
What are your thoughts? What is the difference?



Patient Centered vs. Empowerment vs. Activation vs. Engagement:

These concepts or terms are sometimes perceived as having the same meaning but there is a difference between patient & family centered care, patient empowerment, patient activation, and patient engagement.

(Carmen et al., 2013)

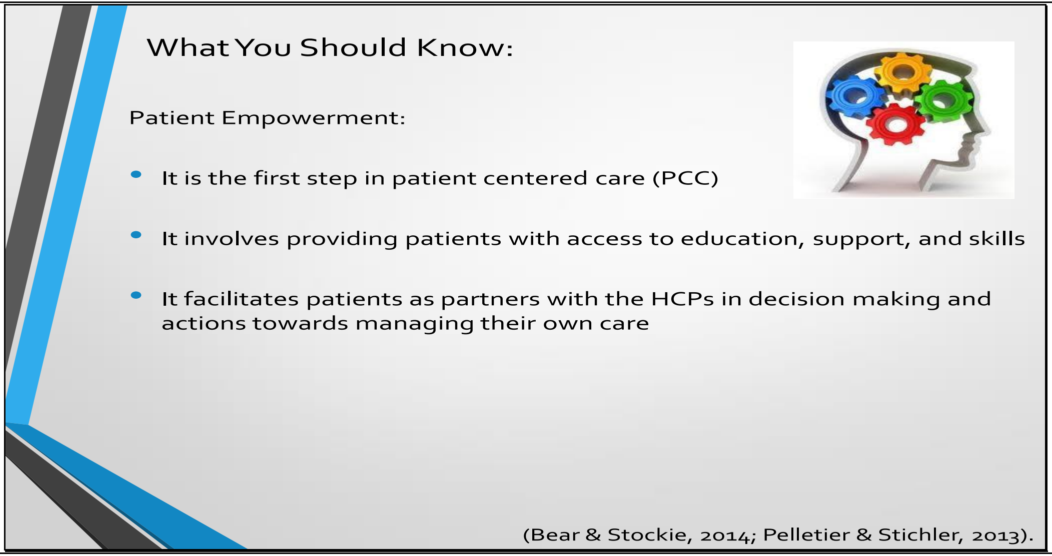


What You Should Know:

Patient Centered Care / Family Centered Care (PCC/FCC):

- It involves a therapeutic relationship between health care provider(s) (HCPs) and patients/families, where the care provided to patients/families is respectful and considerate of patients/families' values, beliefs, and meanings, where all patients needs are addressed
- This approach empowers patients/families with information and education that will enable and support patients/families to manage their care

(Bear & Stockie, 2014; Pelletier & Stichler, 2013).

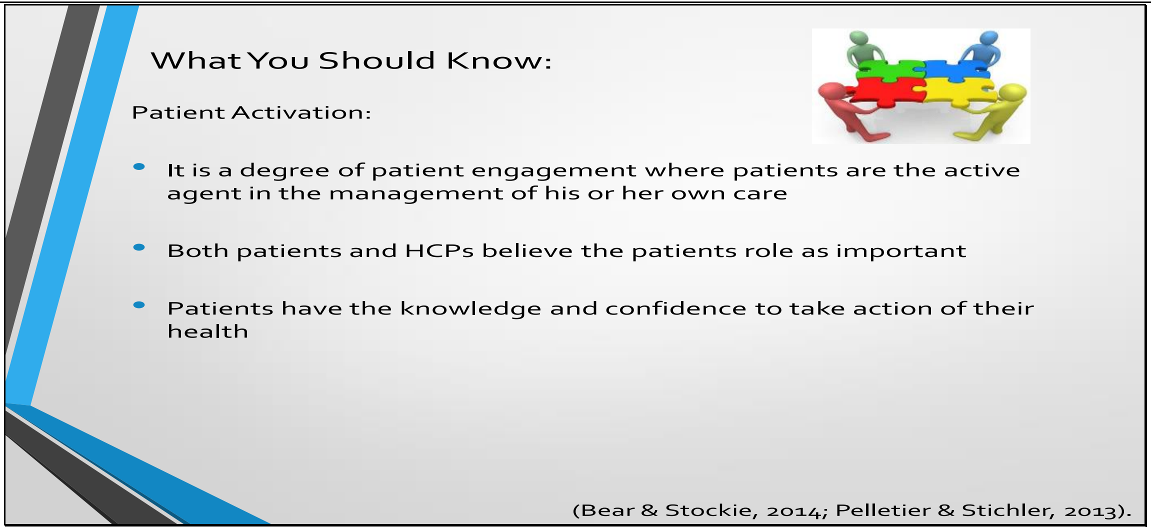


What You Should Know:

Patient Empowerment:

- It is the first step in patient centered care (PCC)
- It involves providing patients with access to education, support, and skills
- It facilitates patients as partners with the HCPs in decision making and actions towards managing their own care

(Bear & Stockie, 2014; Pelletier & Stichler, 2013).



What You Should Know:

Patient Activation:

- It is a degree of patient engagement where patients are the active agent in the management of his or her own care
- Both patients and HCPs believe the patients role as important
- Patients have the knowledge and confidence to take action of their health

(Bear & Stockie, 2014; Pelletier & Stichler, 2013).

What You Should Know:
What is patient engagement & what does it mean?

Patient Engagement is:

- It is a newer approach to improving the delivery of health care
- It is a framework for actively involving patients to improve patient and health outcomes
- It is the **active collaboration** between patients, families, and HCPs
- Patients/families are actively involved in decision making related to the management of their disease and/or delivery of health care services, to improve the quality and safety of health care
- It includes a set of behaviors by patients and health care providers/health care systems that foster inclusion of patients and their families as **active** members of the health care team

(Health Quality Ontario [HQO], 2017; Pelletier & Stichler, 2013)

Guiding Principles for Patient Engagement

- It is a dynamic partnership and relationship that exist between HCPs and patients/families, which respects the privacy, confidentiality, boundaries, and ethical behavior between those within the partnership and relationship
  - Patients are the ultimate source of information about their health
  - Patients have the right to make their own decision about their care
  - The relationship between patient and HCP are grounded in appreciation for patients' rights and mutuality (which involves sharing of information and shared decision making)

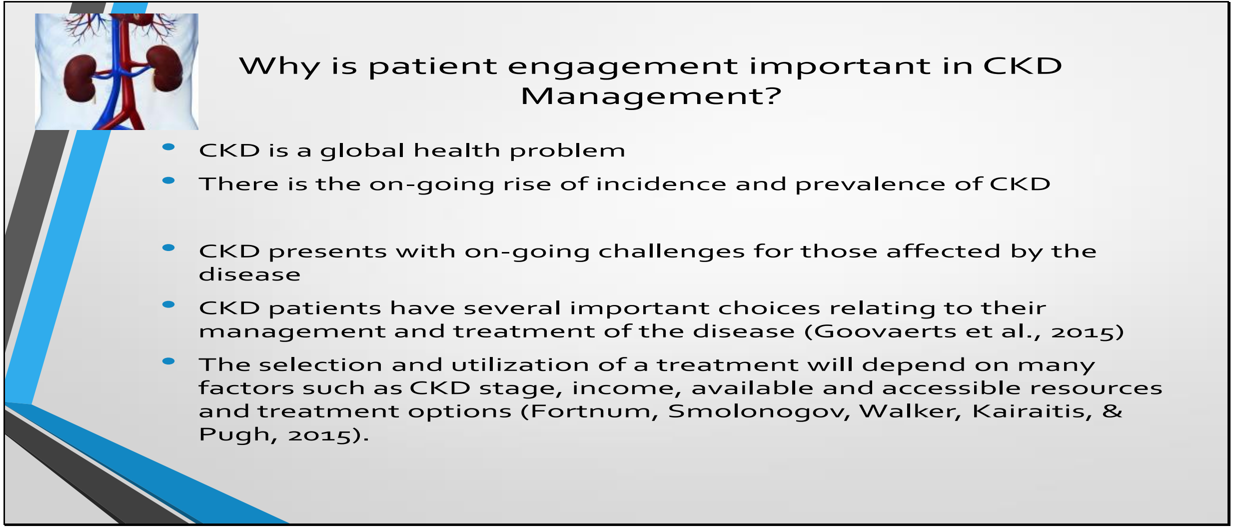
(Nursing Alliance For Quality Care, n.d.)

Guiding Principles for Patient Engagement

- HCPs must maintain awareness for level of health care literacy
- HCPs must acknowledge and appreciate the diverse backgrounds of patients
- HCPs must recognize the extent to which patients/families are able to engage or choose to engage, and the extent of engagement varies based upon each individual's circumstance

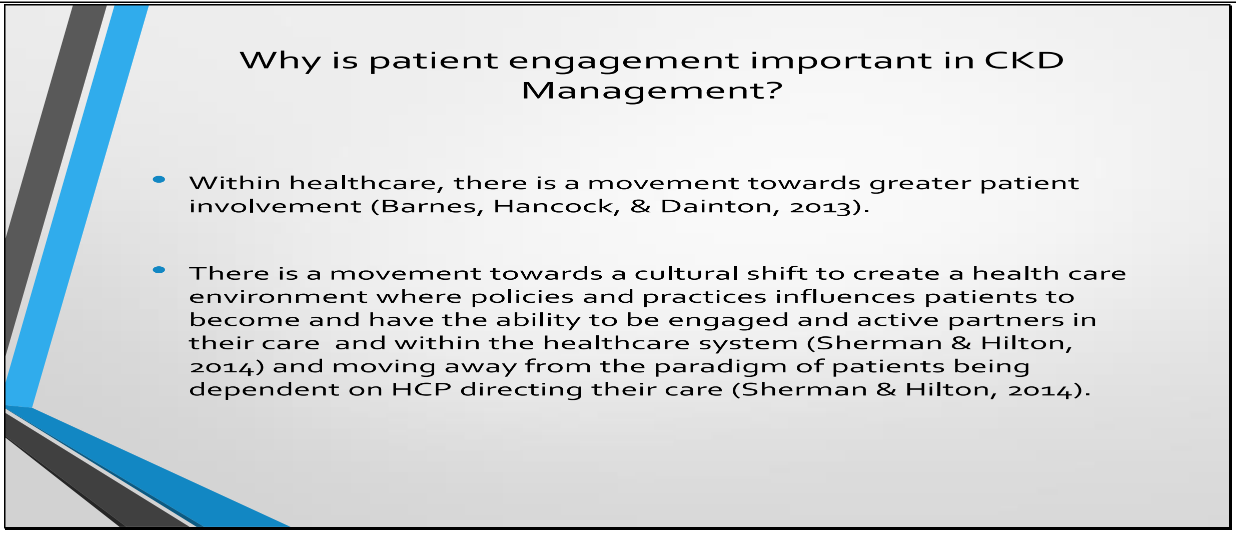
- HCPs adopt behaviors, attitudes, and interventions that encourage patient and their family to be active in decision making and care that will meet the patient's needs

(Nursing Alliance For Quality Care, n.d.)



Why is patient engagement important in CKD Management?

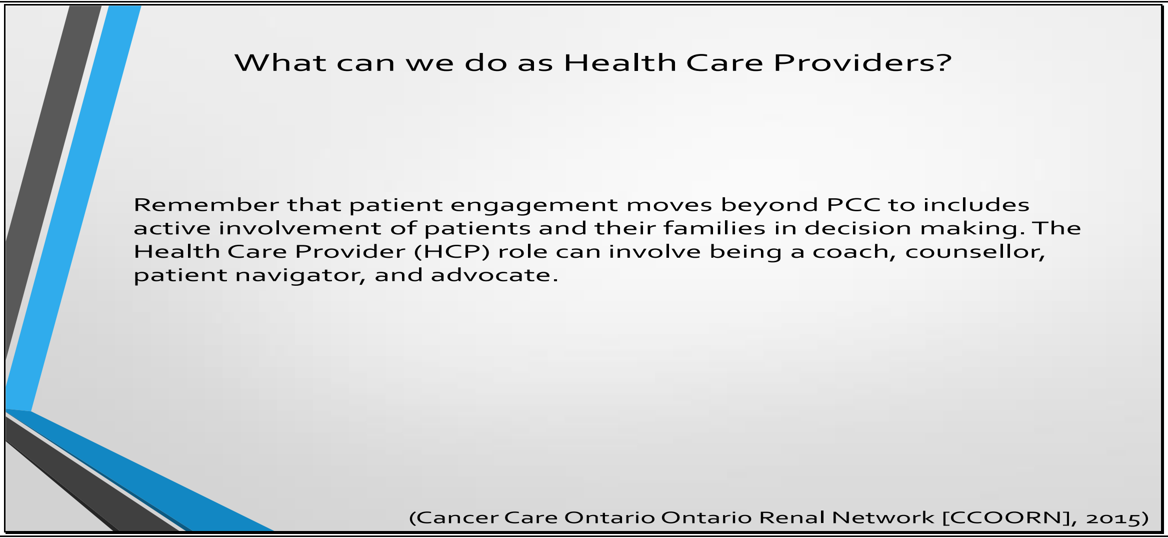
- CKD is a global health problem
- There is the on-going rise of incidence and prevalence of CKD
- CKD presents with on-going challenges for those affected by the disease
- CKD patients have several important choices relating to their management and treatment of the disease (Goovaerts et al., 2015)
- The selection and utilization of a treatment will depend on many factors such as CKD stage, income, available and accessible resources and treatment options (Fortnum, Smolonogov, Walker, Kairaitis, & Pugh, 2015).



Why is patient engagement important in CKD Management?

- Within healthcare, there is a movement towards greater patient involvement (Barnes, Hancock, & Dainton, 2013).

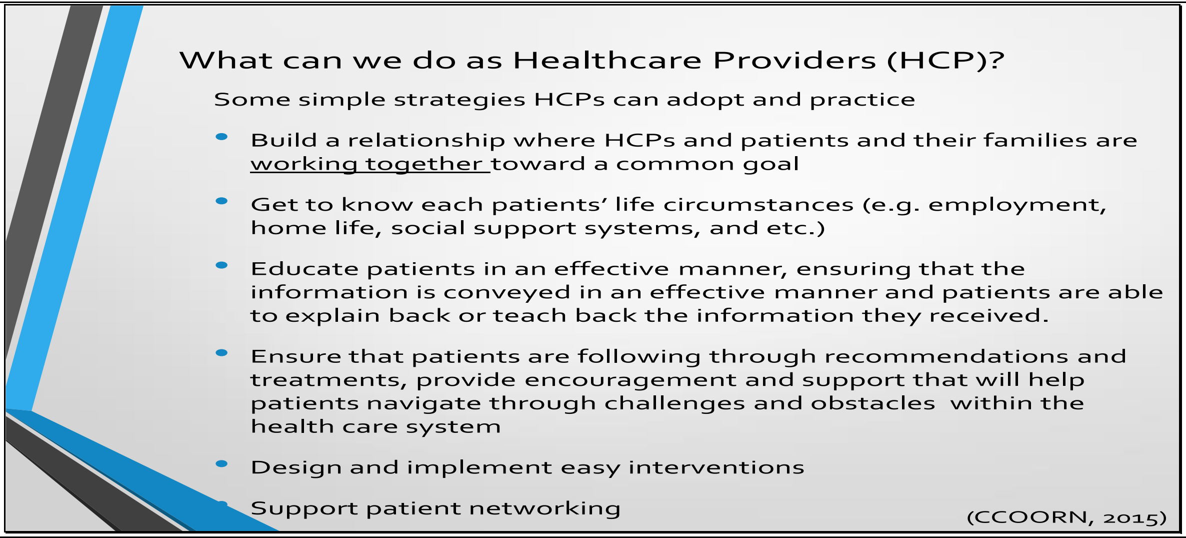
- There is a movement towards a cultural shift to create a health care environment where policies and practices influences patients to become and have the ability to be engaged and active partners in their care and within the healthcare system (Sherman & Hilton, 2014) and moving away from the paradigm of patients being dependent on HCP directing their care (Sherman & Hilton, 2014).



What can we do as Health Care Providers?

Remember that patient engagement moves beyond PCC to includes active involvement of patients and their families in decision making. The Health Care Provider (HCP) role can involve being a coach, counsellor, patient navigator, and advocate.

(Cancer Care Ontario Ontario Renal Network [CCOORN], 2015)

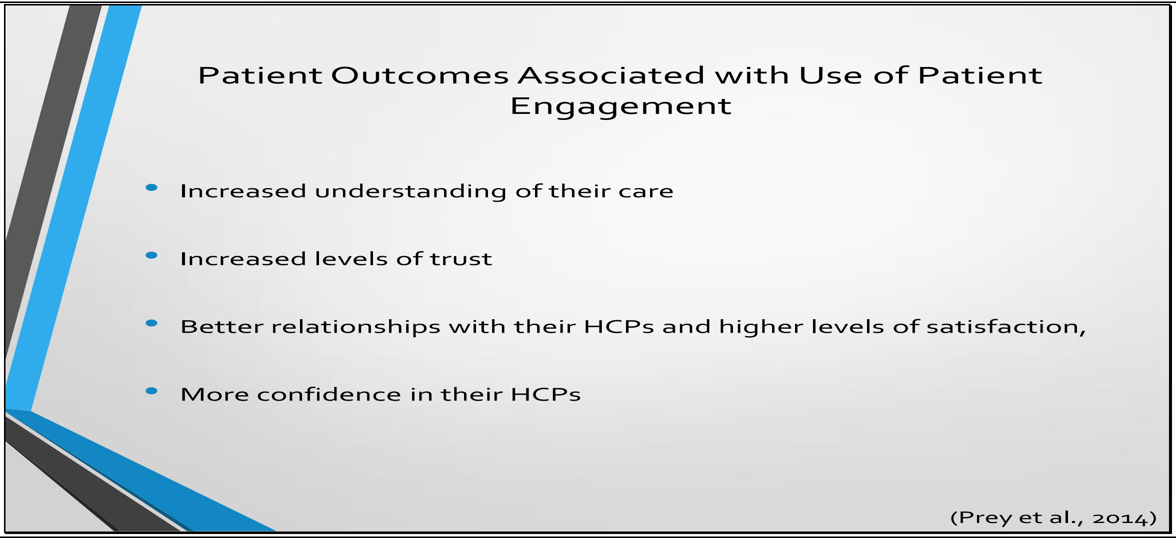


What can we do as Healthcare Providers (HCP)?

Some simple strategies HCPs can adopt and practice

- Build a relationship where HCPs and patients and their families are working together toward a common goal
- Get to know each patients' life circumstances (e.g. employment, home life, social support systems, and etc.)
- Educate patients in an effective manner, ensuring that the information is conveyed in an effective manner and patients are able to explain back or teach back the information they received.
- Ensure that patients are following through recommendations and treatments, provide encouragement and support that will help patients navigate through challenges and obstacles within the health care system
- Design and implement easy interventions
- Support patient networking

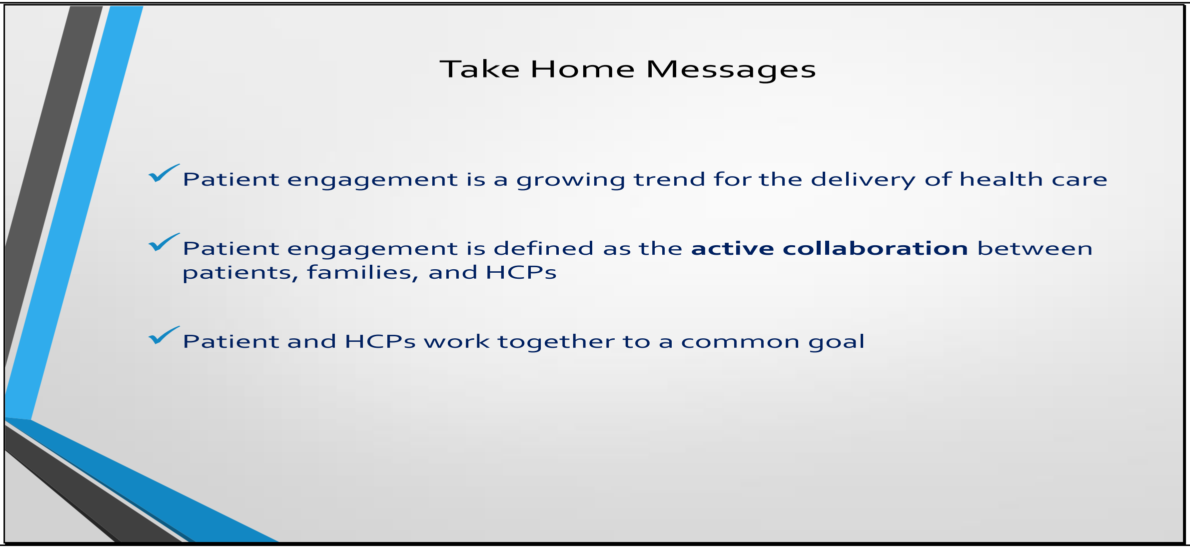
(CCOORN, 2015)



Patient Outcomes Associated with Use of Patient Engagement

- Increased understanding of their care
- Increased levels of trust
- Better relationships with their HCPs and higher levels of satisfaction,
- More confidence in their HCPs

(Prey et al., 2014)



Take Home Messages

- ✓ Patient engagement is a growing trend for the delivery of health care
- ✓ Patient engagement is defined as the **active collaboration** between patients, families, and HCPs
- ✓ Patient and HCPs work together to a common goal

Incorporating patient engagement into chronic illness self management programs

- Through patient engagement, chronic illness self-management provides an opportunity at the individual level for direct care interventions to have a positive impact on patients' health and health behavior as well as to improve the quality of life for those affected by chronic illness, such as CKD.

(Carman et al., 2013; Gough & Grady, 2014)

How we can incorporate both self management (SM) & patient engagement (PE):

Direct Care:

- Integrate patients' values, experiences, risk tolerance, and perspectives into diagnosis, management and treatment and care plans.
- Encourage and support patients to communicate with HCPs about their health situation, to ask questions, to access and help create their medical records, and promote better understanding about the risks and benefits associated with care choices.
- Provide patients with timely, complete, and understandable information.

(Carman et al., 2013)

How we can incorporate both self management (SM) & patient engagement (PE):

Direct Care cont'd:

- Involve family and friends, according to the patient's wishes.
- Allow opportunities to Involve or incorporate other health related resources and services . E.g. patients may seek information about health conditions and treatments and patients may participate in support groups.
- Enable patients to become active partners in the care team, by allowing them to set goals, make decisions, and proactively manage their health.

(Carman et al., 2013)

How we can incorporate both self management (SM) & patient engagement (PE):

Organizational Programs and Departments:

- Integrate patients' values and perspectives into the design of a program or department.
- Have patients and families serve on hospitals' patient and family advisory councils and participate in quality improvement projects.
- Engage patient and families in the development and implementation of policies and programs.

(Carman et al., 2013)

✓ Check Point Questions: True or False?

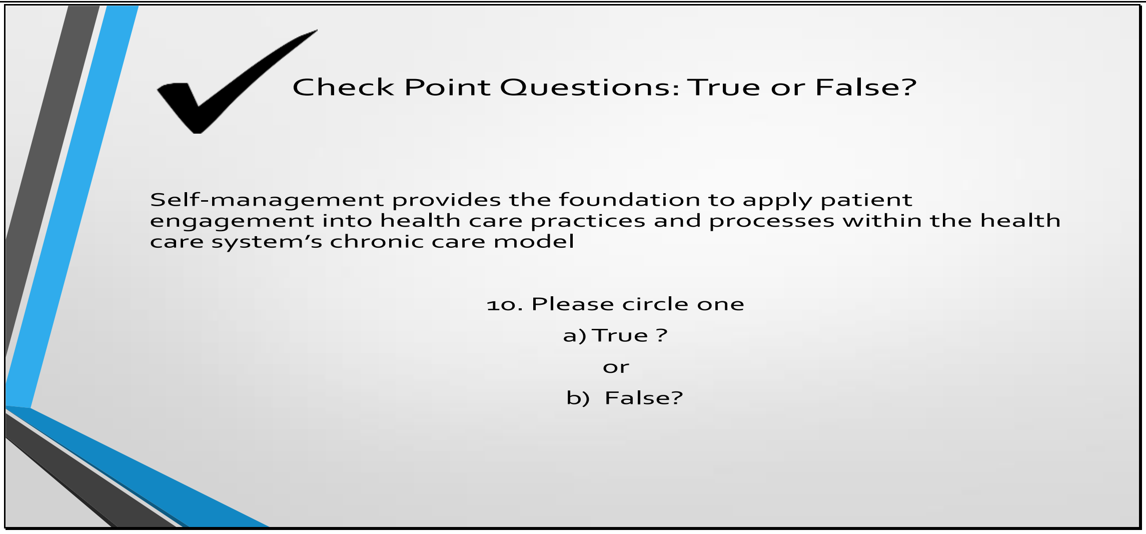
Self management is not defined a person's ability to manage their symptoms, physical, psychosocial, lifestyle, and treatment changes associated with their chronic illness

9. Please circle one

a) True ?

or

b) False?



Check Point Questions: True or False?

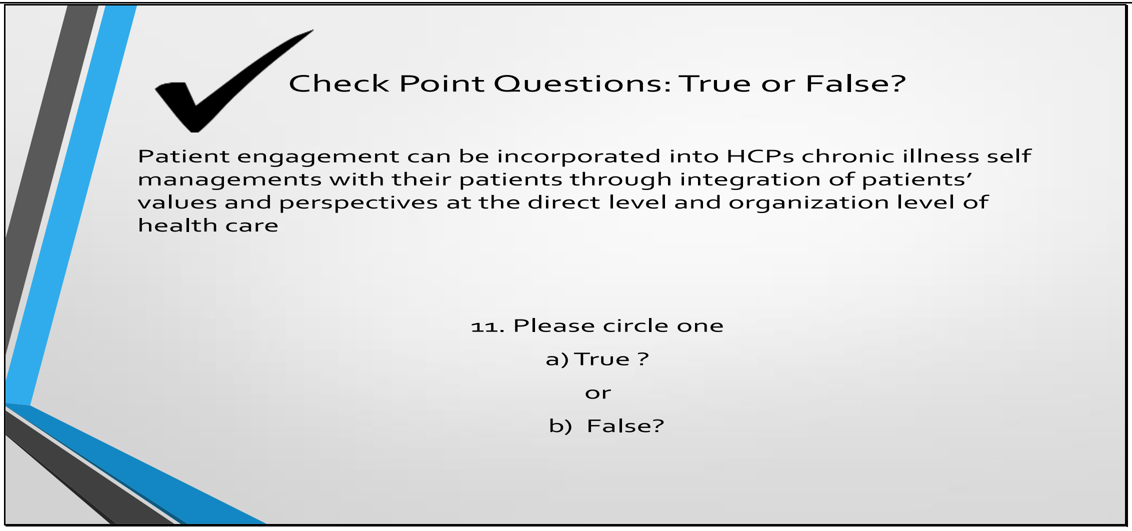
Self-management provides the foundation to apply patient engagement into health care practices and processes within the health care system’s chronic care model

10. Please circle one

a) True ?

or

b) False?



Check Point Questions: True or False?

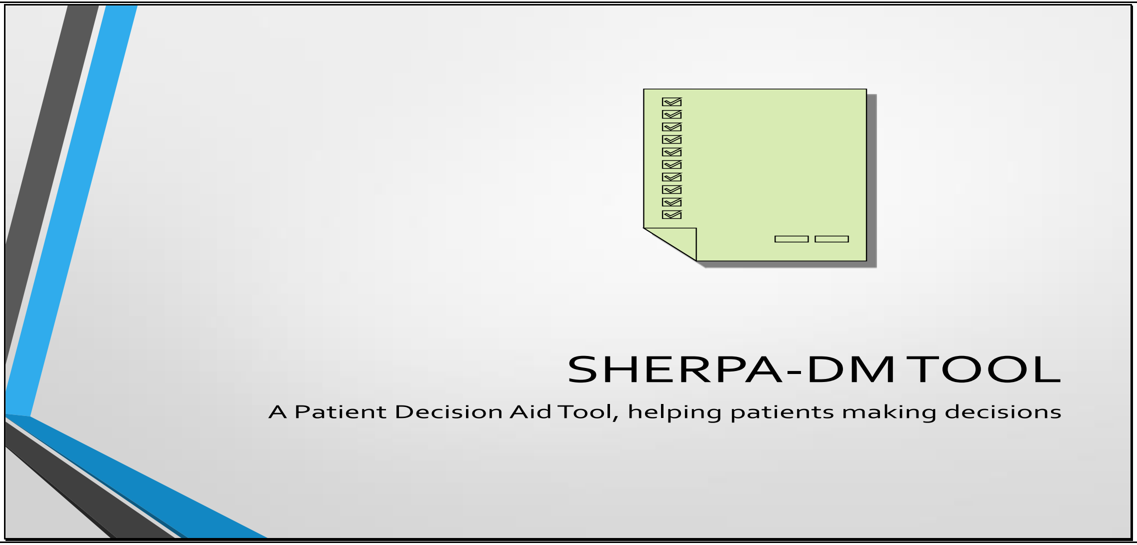
Patient engagement can be incorporated into HCPs chronic illness self managements with their patients through integration of patients’ values and perspectives at the direct level and organization level of health care

11. Please circle one

a) True ?

or

b) False?



SHERPA-DM TOOL

A Patient Decision Aid Tool, helping patients making decisions

SHERPA-DM TOOL

- SHERPA-DM TOOL stands for Shared End-Stage Renal Patients-Decision Making
- A decision aid tool that was developed to help patients reflect and communicate their preferences of what is important to them and helps them make a decision to their treatment option
- It facilitates the ability for HCPs to incorporate patient engagement with their patients through integration of patients' values and perspectives towards their care

(Barry & Edgman-Levitan, 2012; Murray, Bissonnette, & Graham, 2015)

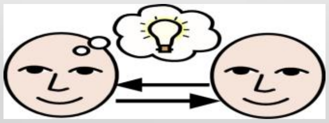
SHERPA-DM TOOL : What is Shared Decision Making?

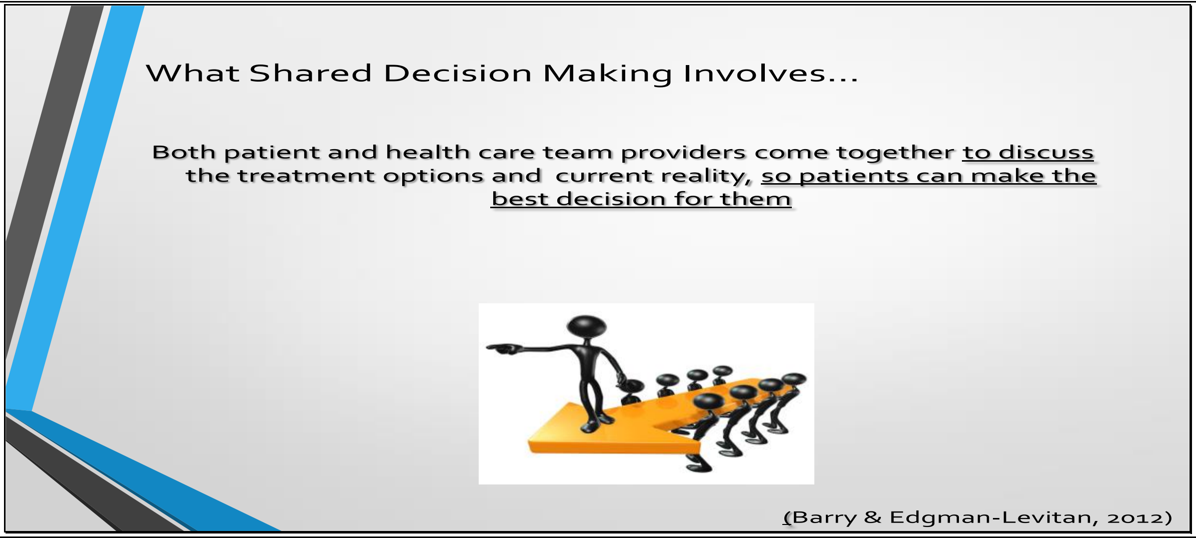
- Shared Decisional Making helps to reduce decisional conflict patients face when there is uncertainty about different treatment options and /or there is no clear best choice of treatment
- Shared Decision Making is a process that involves both health care provider(s) and their patient (which may also include patient's family or friends) sharing information so that the patient can make a decision
- Shared Decision Making enables patients to share the responsibility in making a decision on their treatment and also how to proceed with their treatment choice

(Barry & Edgman-Levitan, 2012)

Shared Decision Making Cont'd

- In Shared Decision Making,
  - HCPs provide their patients with the various treatment options and outcomes, and discuss with their patient the risks and benefits associated with each treatment option (Barry & Edgman-Levitan, 2012)
  - Patients will express their preferences and values of what is important to them in their life, to help them make a decision to a treatment option that is best for them (Barry & Edgman-Levitan, 2012)

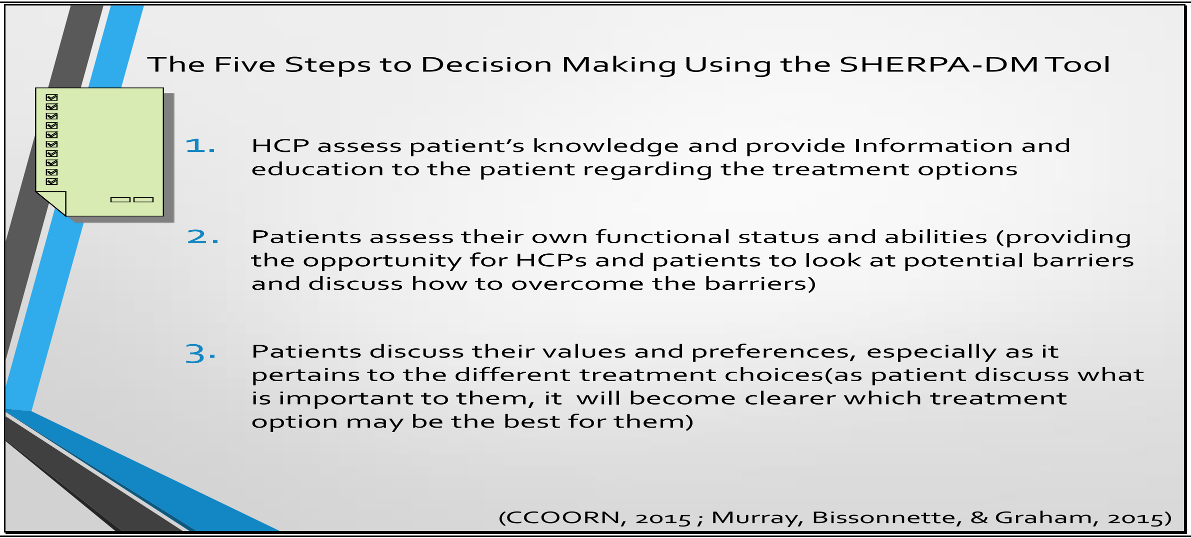




What Shared Decision Making Involves…

Both patient and health care team providers come together to discuss the treatment options and current reality, so patients can make the best decision for them

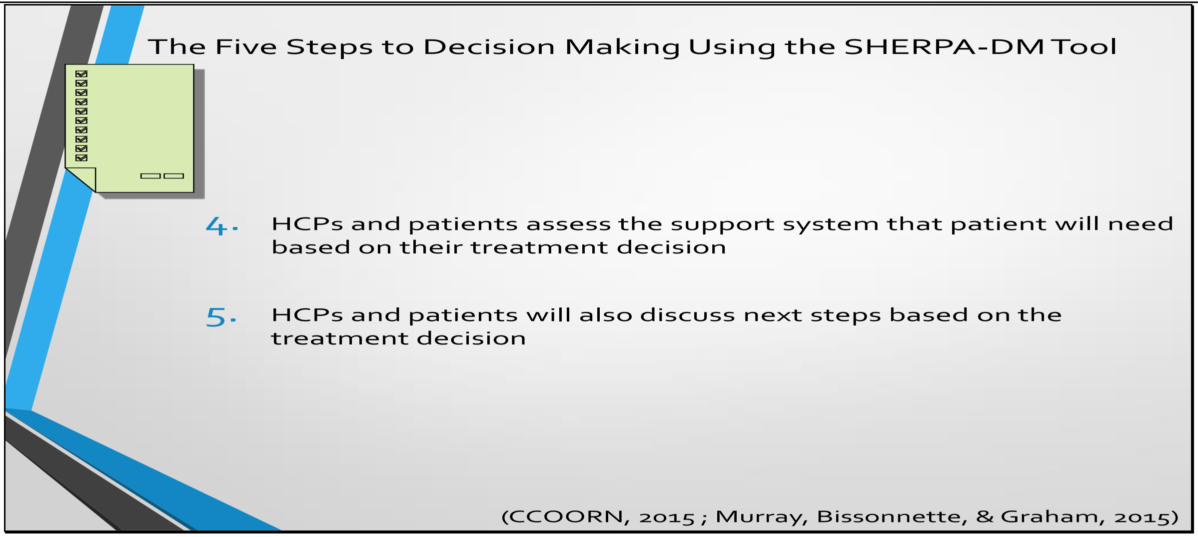
(Barry & Edgman-Levitan, 2012)



The Five Steps to Decision Making Using the SHERPA-DM Tool

1. HCP assess patient's knowledge and provide Information and education to the patient regarding the treatment options
2. Patients assess their own functional status and abilities (providing the opportunity for HCPs and patients to look at potential barriers and discuss how to overcome the barriers)
3. Patients discuss their values and preferences, especially as it pertains to the different treatment choices(as patient discuss what is important to them, it will become clearer which treatment option may be the best for them)

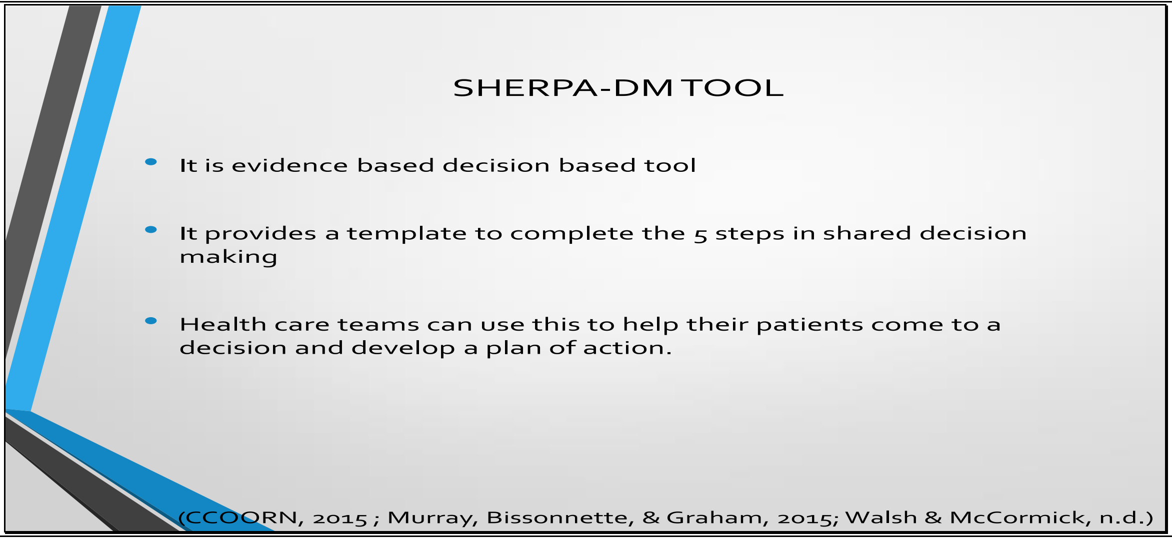
(CCOORN, 2015 ; Murray, Bissonnette, & Graham, 2015)



The Five Steps to Decision Making Using the SHERPA-DM Tool

4. HCPs and patients assess the support system that patient will need based on their treatment decision
5. HCPs and patients will also discuss next steps based on the treatment decision

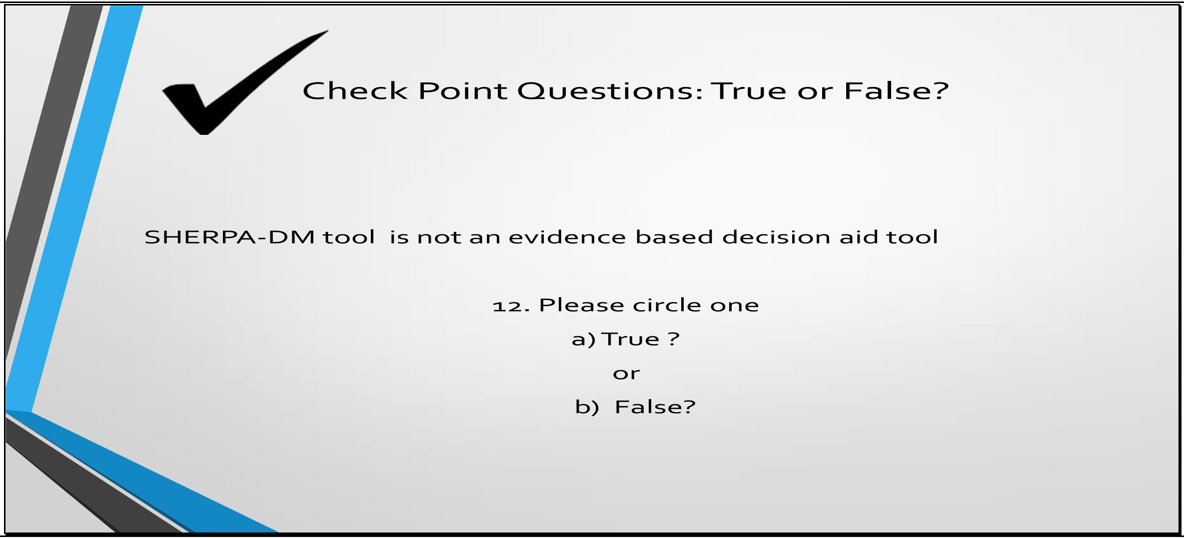
(CCOORN, 2015 ; Murray, Bissonnette, & Graham, 2015)



SHERPA-DM TOOL

- It is evidence based decision based tool
- It provides a template to complete the 5 steps in shared decision making
- Health care teams can use this to help their patients come to a decision and develop a plan of action.

(CCOORN, 2015 ; Murray, Bissonnette, & Graham, 2015; Walsh & McCormick, n.d.)



Check Point Questions: True or False?

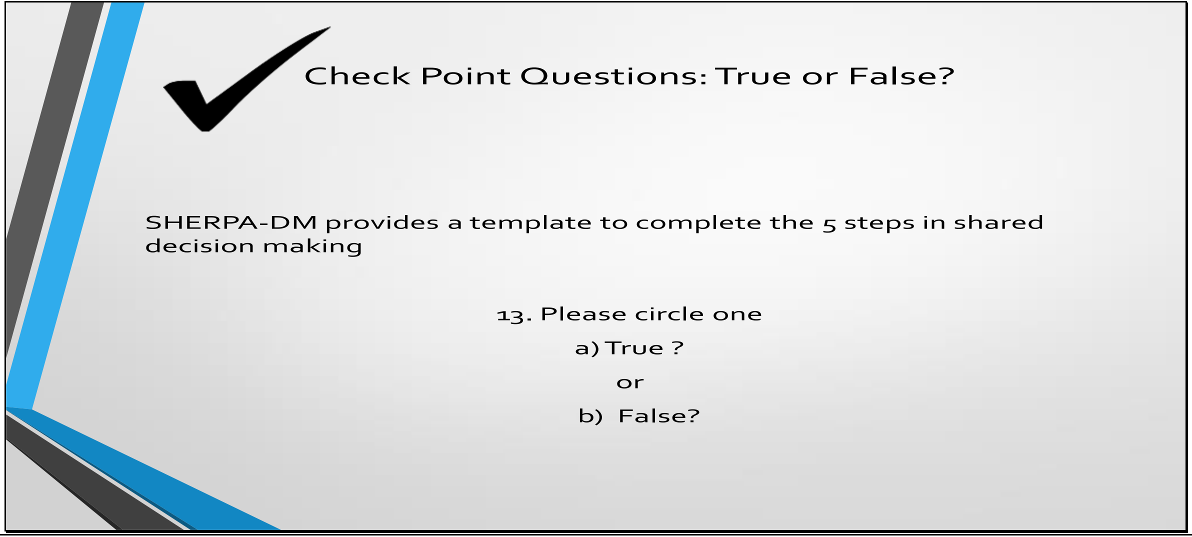
SHERPA-DM tool is not an evidence based decision aid tool

12. Please circle one

a) True ?

or

b) False?



Check Point Questions: True or False?

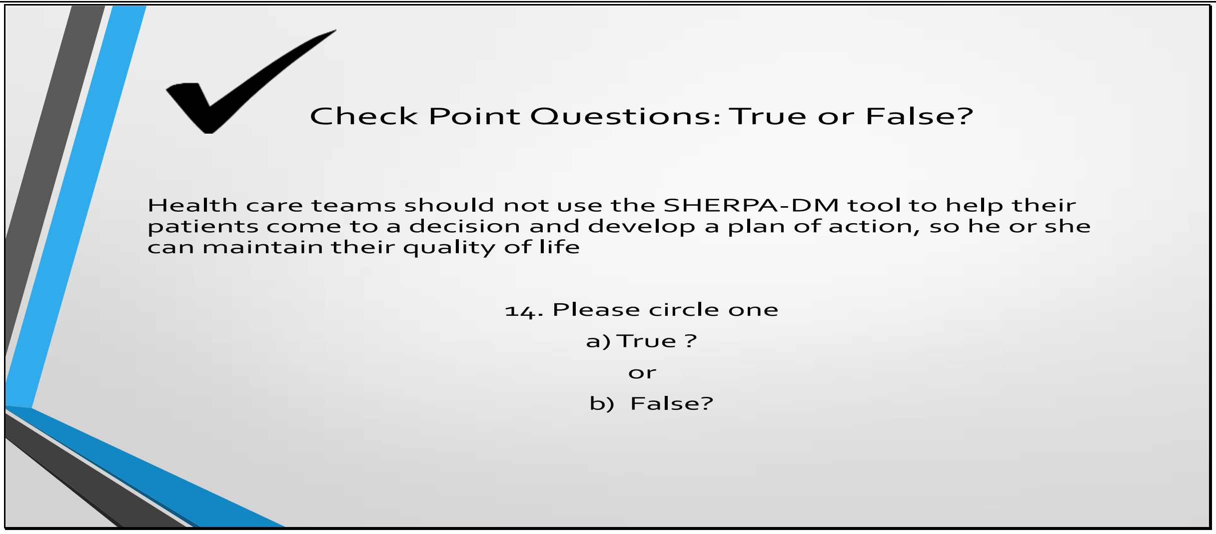
SHERPA-DM provides a template to complete the 5 steps in shared decision making

13. Please circle one

a) True ?

or

b) False?



Check Point Questions: True or False?

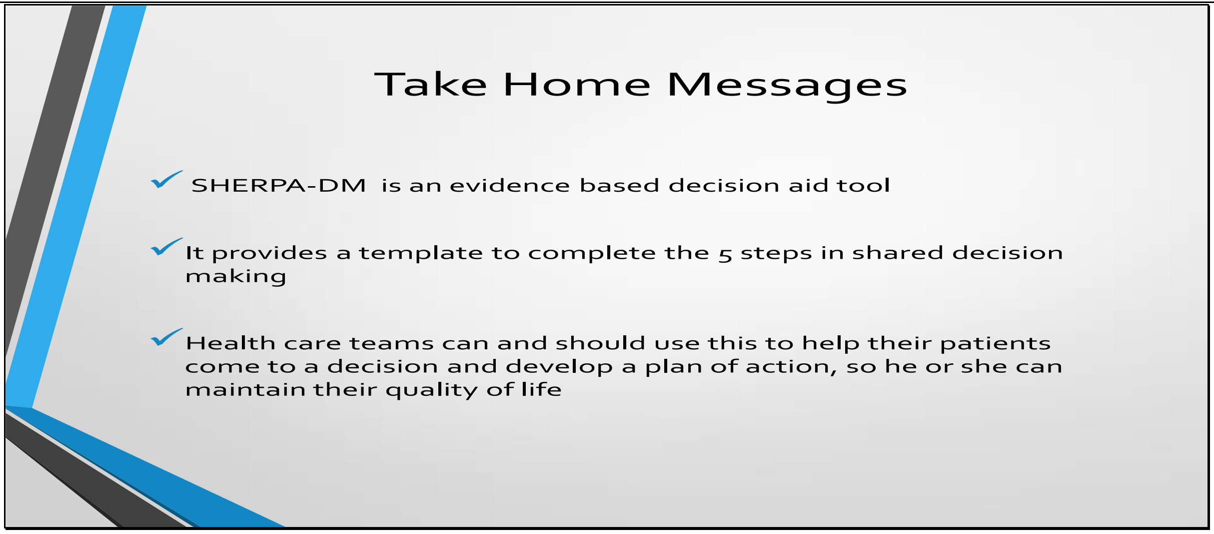
Health care teams should not use the SHERPA-DM tool to help their patients come to a decision and develop a plan of action, so he or she can maintain their quality of life

14. Please circle one

a) True ?

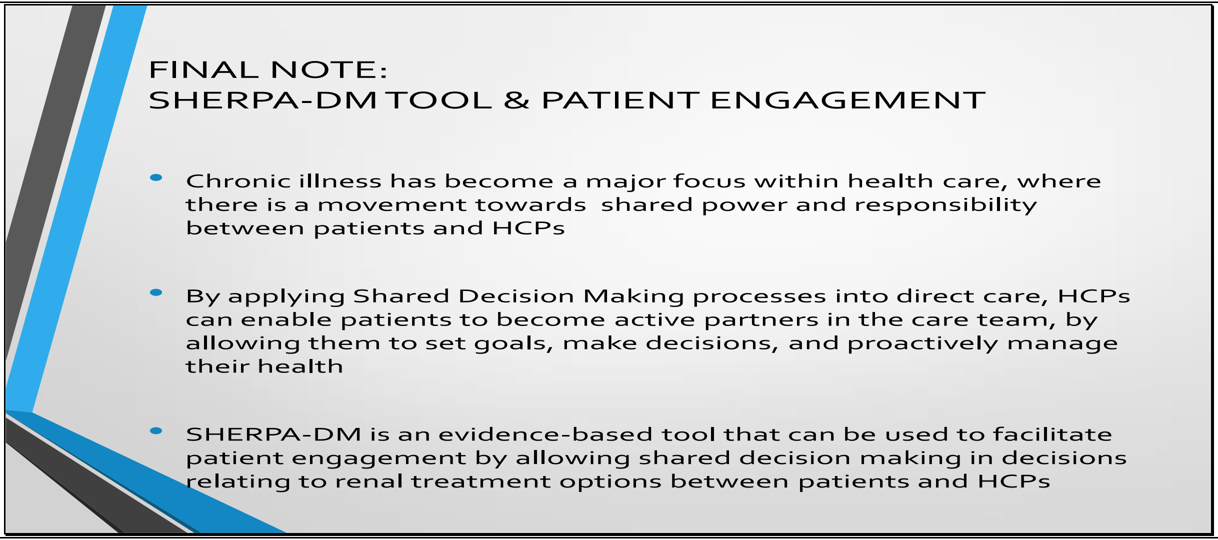
or

b) False?



Take Home Messages

- ✓ SHERPA-DM is an evidence based decision aid tool
- ✓ It provides a template to complete the 5 steps in shared decision making
- ✓ Health care teams can and should use this to help their patients come to a decision and develop a plan of action, so he or she can maintain their quality of life

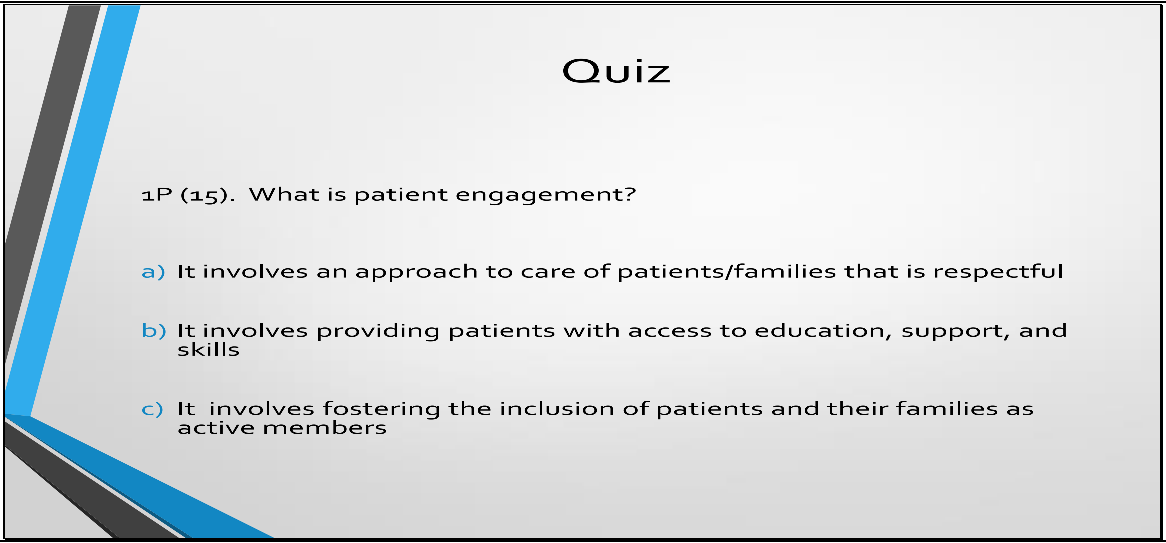


FINAL NOTE:
SHERPA-DM TOOL & PATIENT ENGAGEMENT

- Chronic illness has become a major focus within health care, where there is a movement towards shared power and responsibility between patients and HCPs
- By applying Shared Decision Making processes into direct care, HCPs can enable patients to become active partners in the care team, by allowing them to set goals, make decisions, and proactively manage their health
- SHERPA-DM is an evidence-based tool that can be used to facilitate patient engagement by allowing shared decision making in decisions relating to renal treatment options between patients and HCPs

Post-SURVEY

8 Questions



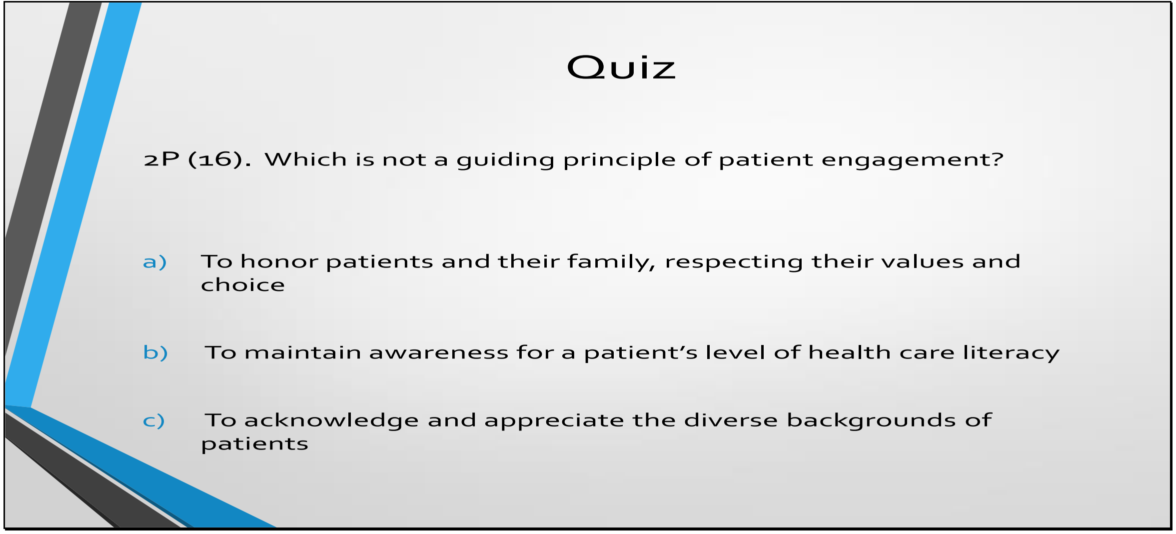
Quiz

1P (15). What is patient engagement?

a) It involves an approach to care of patients/families that is respectful

b) It involves providing patients with access to education, support, and skills

c) It involves fostering the inclusion of patients and their families as active members



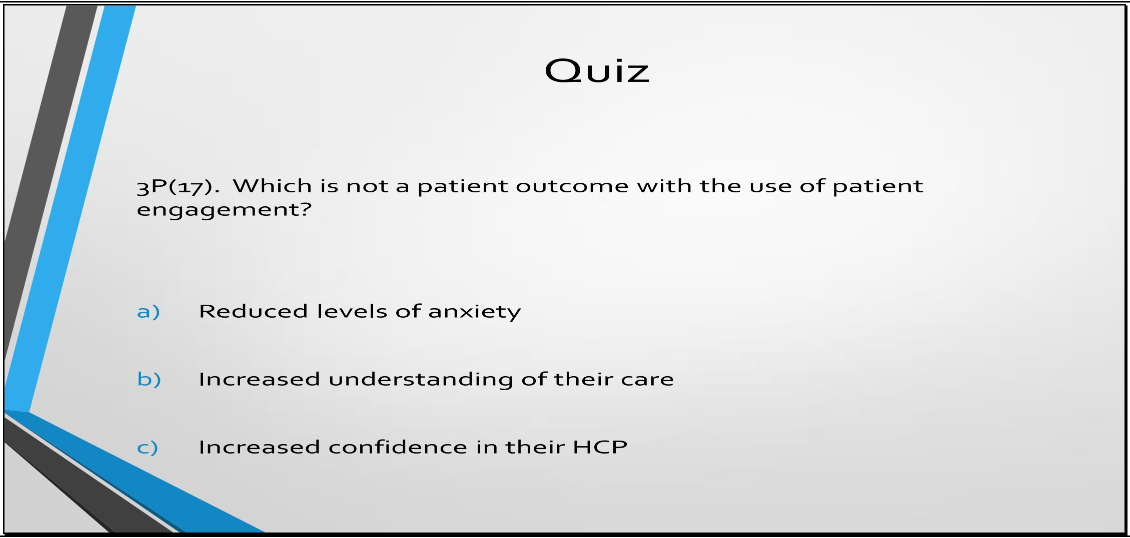
Quiz

2P (16). Which is not a guiding principle of patient engagement?

a) To honor patients and their family, respecting their values and choice

b) To maintain awareness for a patient's level of health care literacy

c) To acknowledge and appreciate the diverse backgrounds of patients



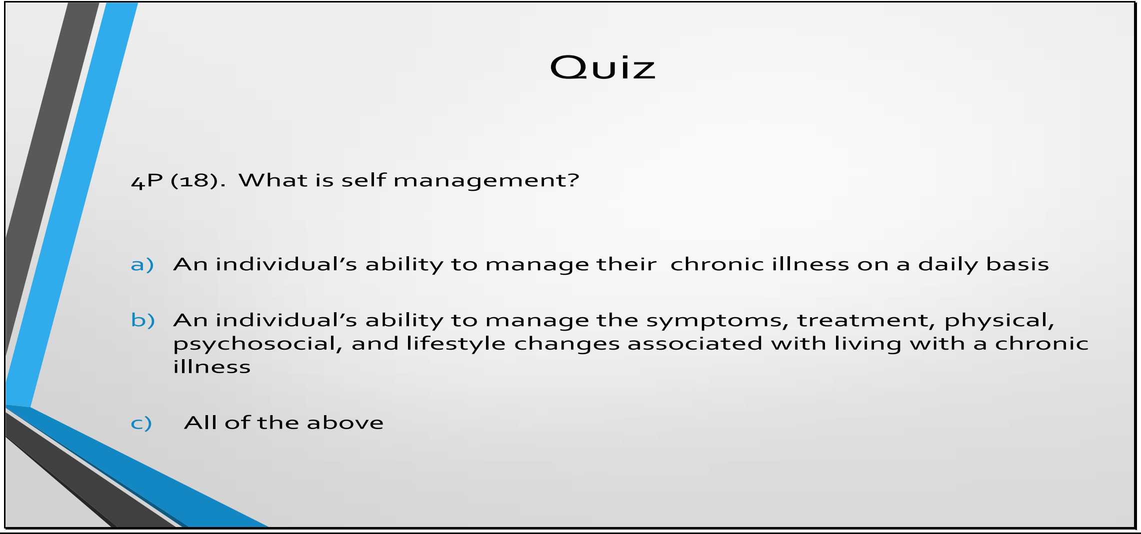
Quiz

3P(17). Which is not a patient outcome with the use of patient engagement?

a) Reduced levels of anxiety

b) Increased understanding of their care

c) Increased confidence in their HCP



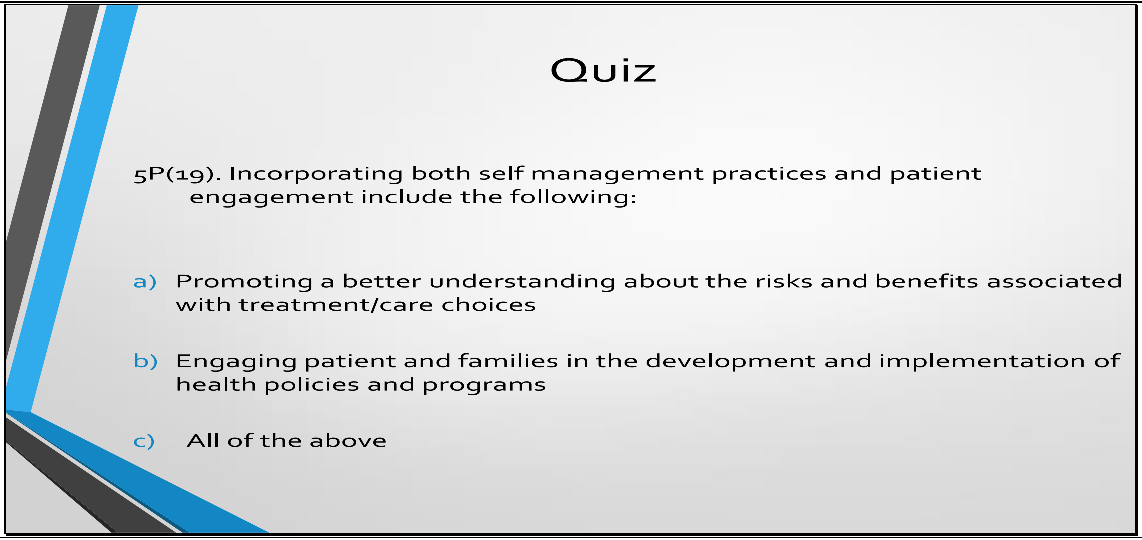
Quiz

4P (18). What is self management?

a) An individual's ability to manage their chronic illness on a daily basis

b) An individual's ability to manage the symptoms, treatment, physical, psychosocial, and lifestyle changes associated with living with a chronic illness

c) All of the above



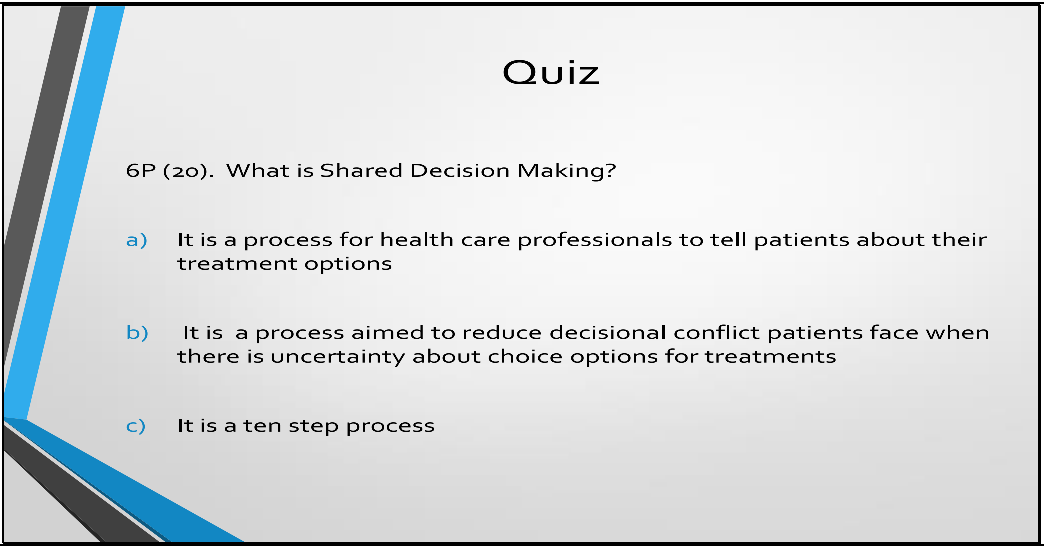
Quiz

5P(19). Incorporating both self management practices and patient engagement include the following:

a) Promoting a better understanding about the risks and benefits associated with treatment/care choices

b) Engaging patient and families in the development and implementation of health policies and programs

c) All of the above



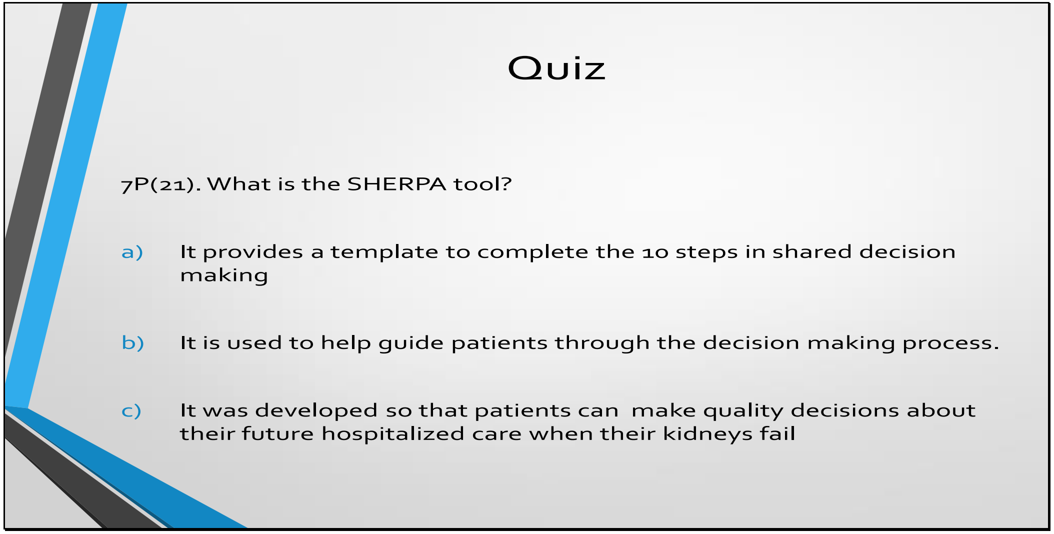
Quiz

6P (20). What is Shared Decision Making?

a) It is a process for health care professionals to tell patients about their treatment options

b) It is a process aimed to reduce decisional conflict patients face when there is uncertainty about choice options for treatments

c) It is a ten step process



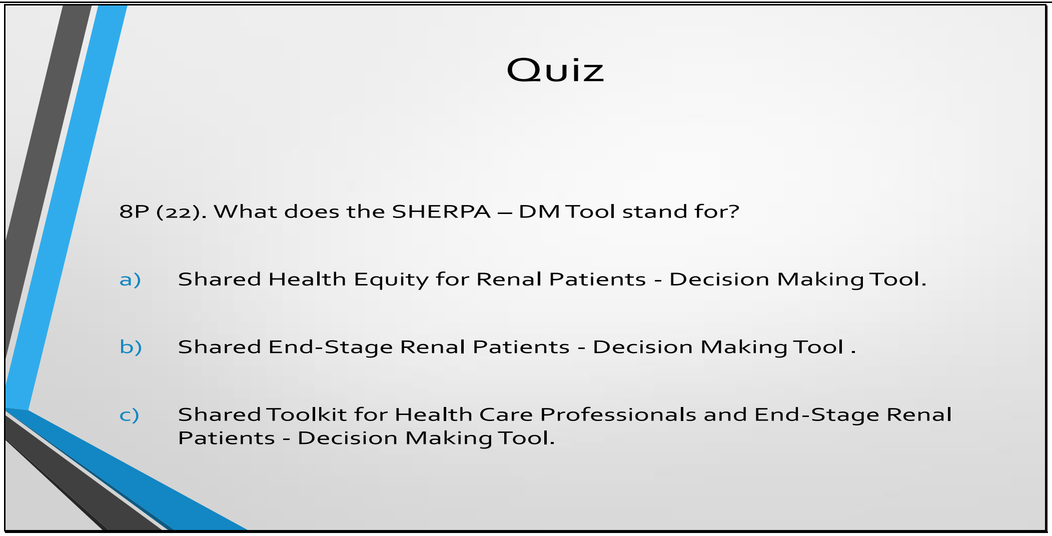
Quiz

7P(21). What is the SHERPA tool?

a) It provides a template to complete the 10 steps in shared decision making

b) It is used to help guide patients through the decision making process.

c) It was developed so that patients can make quality decisions about their future hospitalized care when their kidneys fail



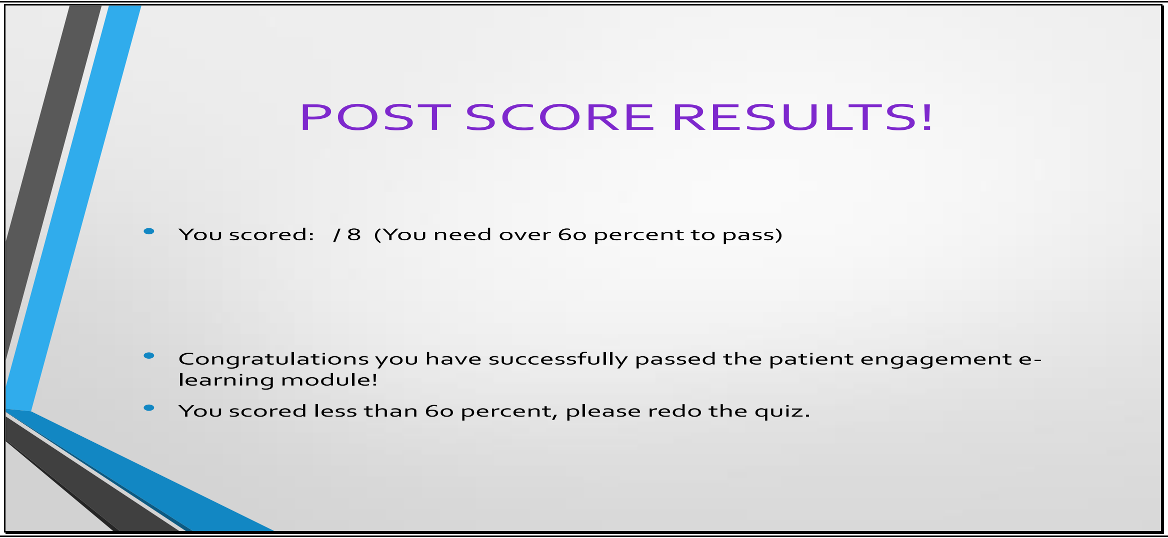
Quiz

8P (22). What does the SHERPA – DM Tool stand for?

a) Shared Health Equity for Renal Patients - Decision Making Tool.

b) Shared End-Stage Renal Patients - Decision Making Tool .

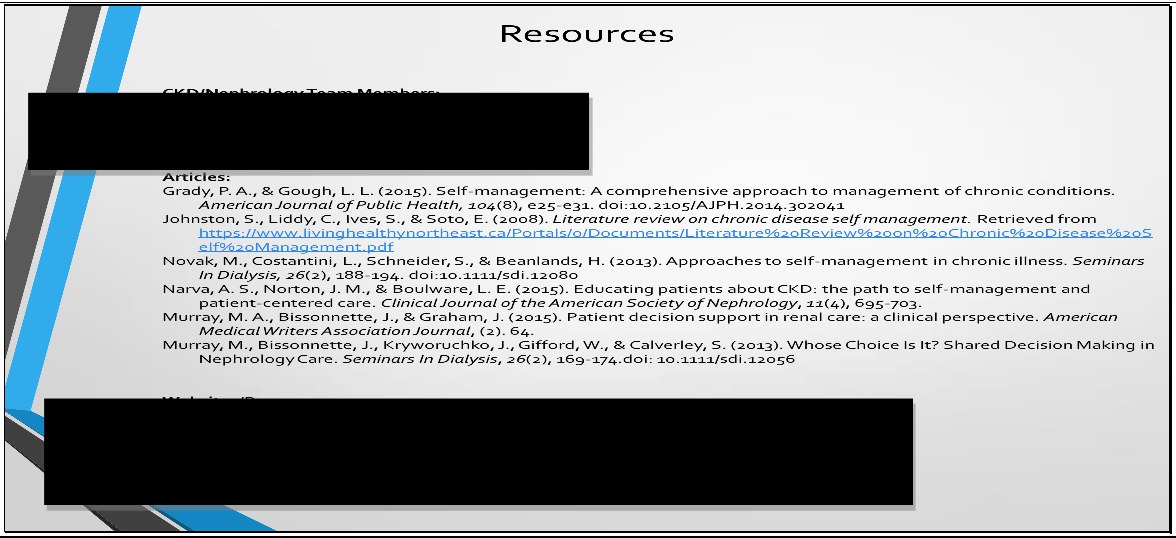
c) Shared Toolkit for Health Care Professionals and End-Stage Renal Patients - Decision Making Tool.



POST SCORE RESULTS!

- You scored: / 8 (You need over 60 percent to pass)

- Congratulations you have successfully passed the patient engagement e-learning module!
- You scored less than 60 percent, please redo the quiz.



Resources

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Articles:

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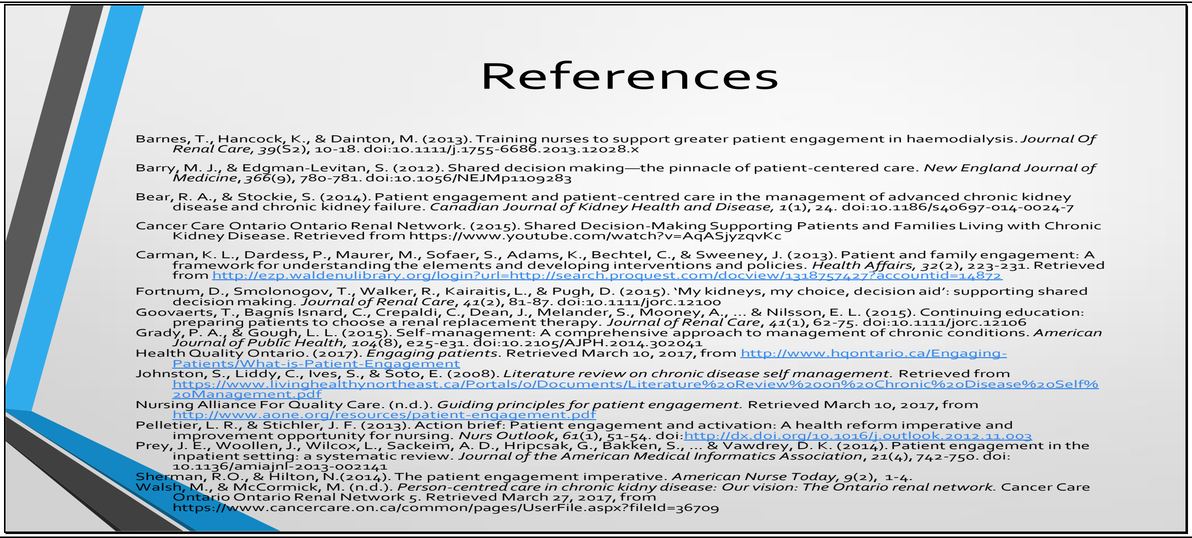

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THANK YOU!

You have completed the Patient Engagement e- learning module

Appendix B: Pre- and Postsurvey

QI PATIENT ENGAGEMENT PRETEST SURVEY

SECTION A: BACKGROUND (CIRCLE ONE ANSWER)

GENDER:	**FEMALE**	**MALE**
AGE GROUP:	18 – 20 21-29 30-39	40-49 50-59 60-65 65-69
PROFESSION:	Social Worker: Registered Nurse: Registered Practical Nurse: Dietician: Nurse Practitioner:	Medical Physician: Clerk (administrative assistant, secretary, etc.): Manager: Administration (director, VP, etc.): Other: Please indicate ____________
NUMBER OF YEARS OF SERVICE IN THIS JOB:	0-4 5-9 10-14 15-19	20-24 25-29 30-34 35+

PLEASE RATE YOUR PRECEPTION OF YOURSELF ON THE FOLLOWING ITEMS BELOW, TO PATIENT ENGAGEMENT

(PLEASE CIRCLE ONE OPTION):

	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT

LEVEL OF AWARENESS ABOUT PATIENT ENGAGEMENT	1	2	3	4	5
LEVEL OF KNOWLEDGE ABOUT PATIENT ENGAGEMENT	1	2	3	4	5
RELEVANCY TO MY CLINICAL PRACTICE	1	2	3	4	5

SECTION B: <u>PRE-TEST</u> QUESTIONS (CIRCLE ONE ANSWER) **PowerPoint/module Questions**			
1	A	B	C
2	A	B	C
3	A	B	C
4	A	B	C
5	A	B	C
6	A	B	C
7	A	B	C
8	A	B	C
9	TRUE	FALSE	
10	TRUE	FALSE	
11	TRUE	FALSE	
12	TRUE	FALSE	

13	TRUE	FALSE	
14	TRUE	FALSE	

SECTION C: POST TEST QUESTIONS (CIRCLE ONE ANSWER) PowerPoint/module Questions			
1P (15)	A	B	C
2P(16)	A	B	C
3P(17)	A	B	C
4P(18)	A	B	C
5P(19)	A	B	C
6P(20)	A	B	C
7P(21)	A	B	C
8P(22)	A	B	C

PATIENT ENGAGEMENT POST –TEST SURVEY

At the end of the presentation/e-learning module, please do the last 3 sections below

PLEASE RATE YOUR PERCEPTION OF YOURSELF ON THE FOLLOWING ITEMS BELOW, RELATING TO PATIENT ENGAGEMENT (PLEASE CIRCLE ONE OPTION):

	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
LEVEL OF AWARENESS ABOUT PATIENT ENGAGEMENT	1	2	3	4	5
LEVEL OF KNOWLEDGE ABOUT PATIENT ENGAGEMENT	1	2	3	4	5
RELEVANCY TO MY CLINICAL PRACTICE	1	2	3	4	5

SECTION D:
TO WHAT EXTENT DO YOU AGREE OR DISAGREE WITH THE STATEMENTS BELOW (CIRCLE ONE ANSWER FOR EACH STATEMENT)

1.
THE PRESENTATION /E-LEARNING MODULE INCREASED MY KNOWLEDGE ABOUT PATIENT ENGAGEMENT:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

2.

THE PRESENTATION/E-LEARNING MODULE INCREASED MY AWARENESS ABOUT PATIENT ENGAGEMENT:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

3.
LEARNING ABOUT PATIENT ENGAGEMENT WILL BE HELPFUL TO MY CLINICAL PRACTICE:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

4.
LEARNING ABOUT THE SHERPA-DM TOOL INCREASED MY KNOWLEDGE ABOUT PATIENT ENGAGEMENT:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

5.
LEARNING ABOUT THE SHERPA-DM TOOL INCREASED MY AWARENESS ABOUT PATIENT ENGAGEMENT:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

6.
LEARNING ABOUT THE SHERPA-DM TOOL INCREASED MY KNOWLEDGE AND AWARENESS ABOUT SHARED DECISION MAKING:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

7.
LEARNING ABOUT SHERPA-DM TOOL HELPFUL TO MY CLINICAL PRACTICE:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

8.
THIS PRESENTATION/E-LEARNING MODULE WILL BE HELPFUL TO OTHER CLINICANS TO LEARN ABOUT PATIENT ENGAGEMENT:

Strongly disagree	Disagree	Neutral	Agree	Strongly agree

9.
THIS PRESENTATION/E-LEARNING MODULE WILL BE HELPFUL TO OTHER CLINICANS TO LEARN ABOUT SHARED DECISION MAKING AND THE SHERPA-DM TOOL:

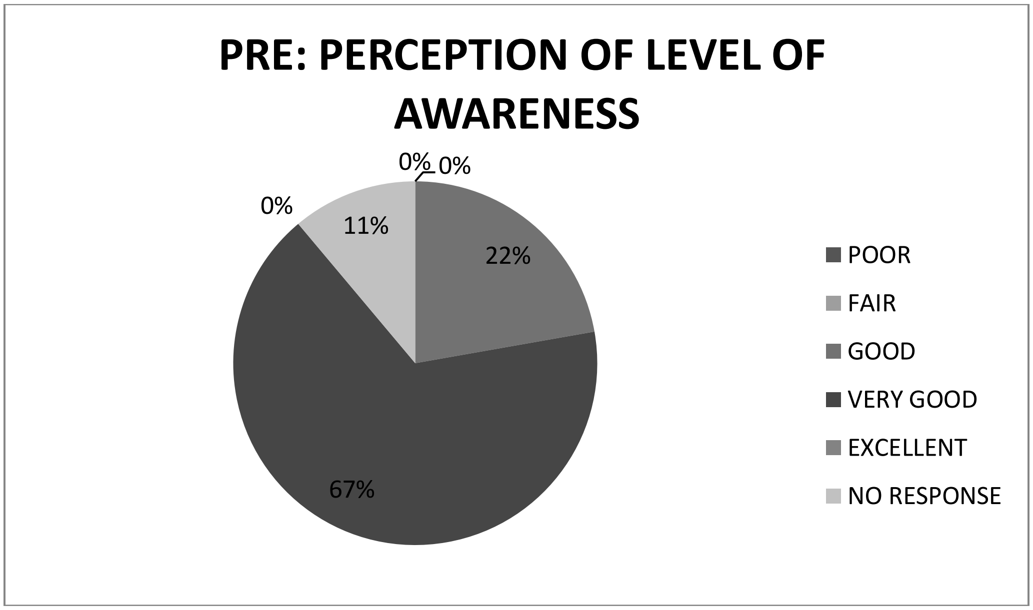
Strongly disagree	Disagree	Neutral	Agree	Strongly agree

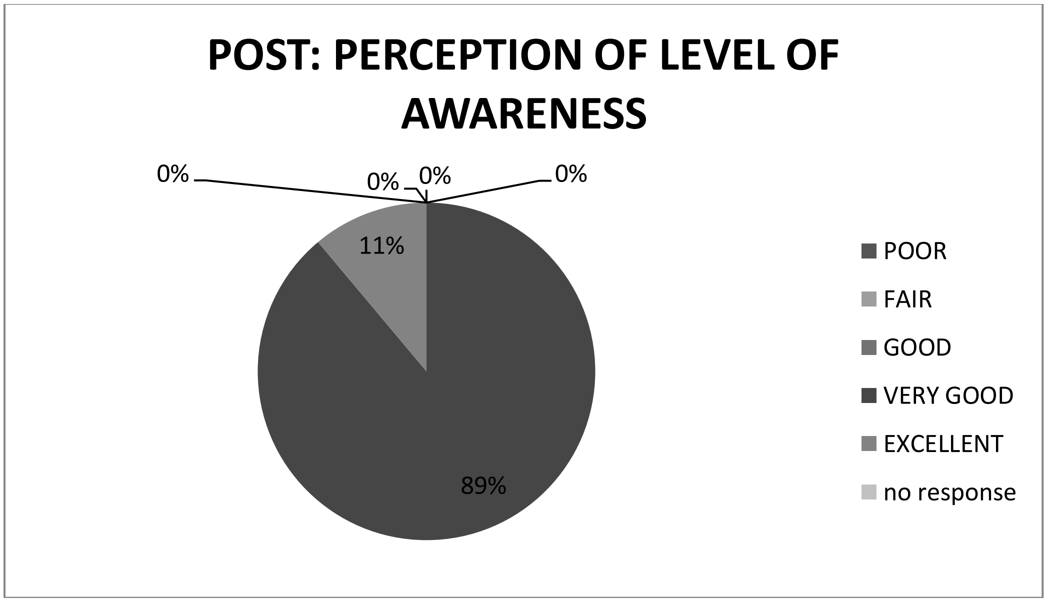
SECTION E:
SELECT A RESPONSE THAT BEST REFLECTS YOUR IMPRESSION OF THE PATIENT ENGAGEMENT POWER-POINT PRESENTATION/E-LEARNING MODULE (CIRCLE ONE ANSWER)

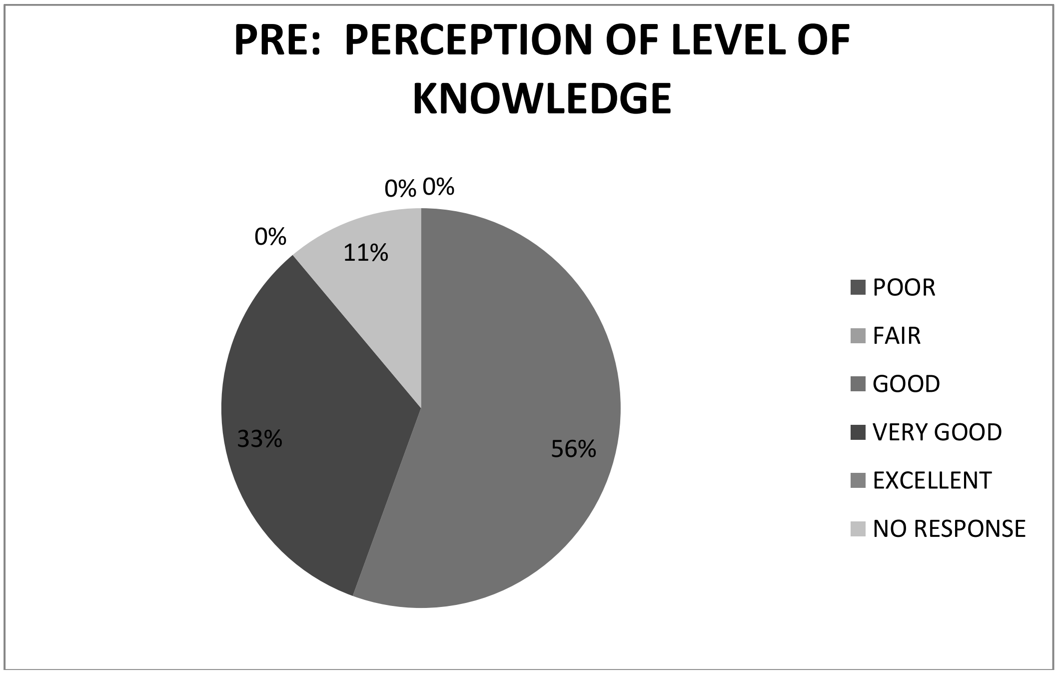
	POOR	FAIR	GOOD	VERY GOOD	EXCELLENT
CONTENT					
ORGANIZATON					
PRESENTATION					
LENGTH					

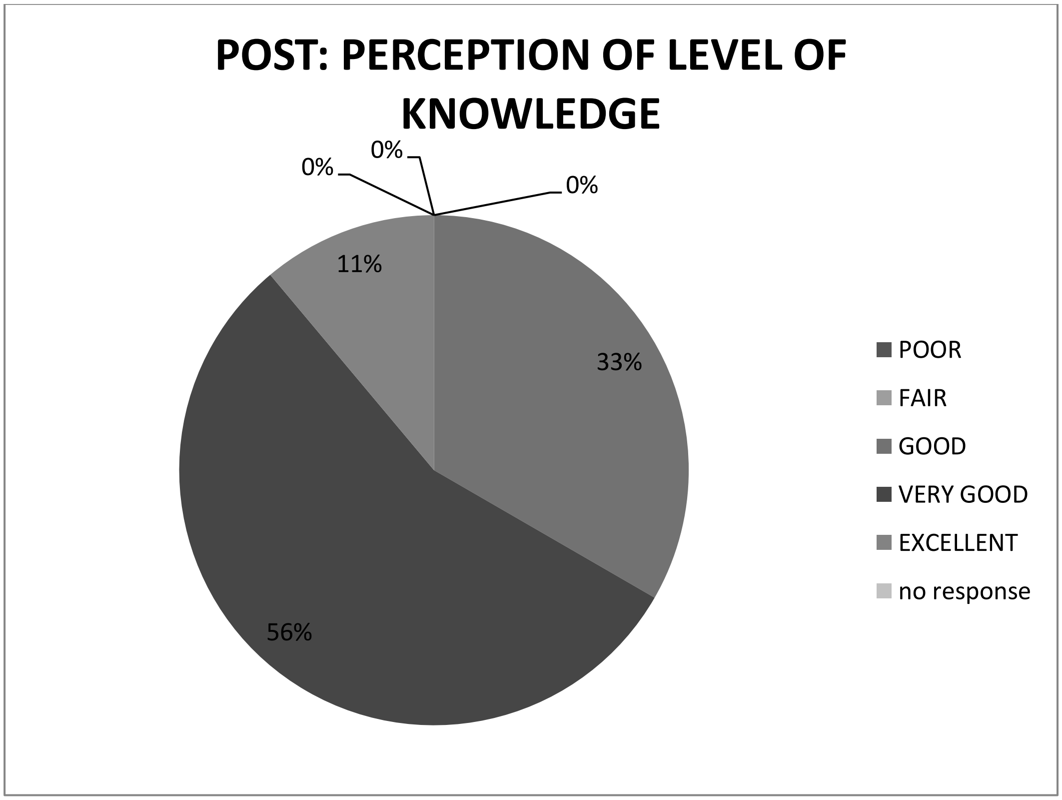
Thank you for completing the survey!

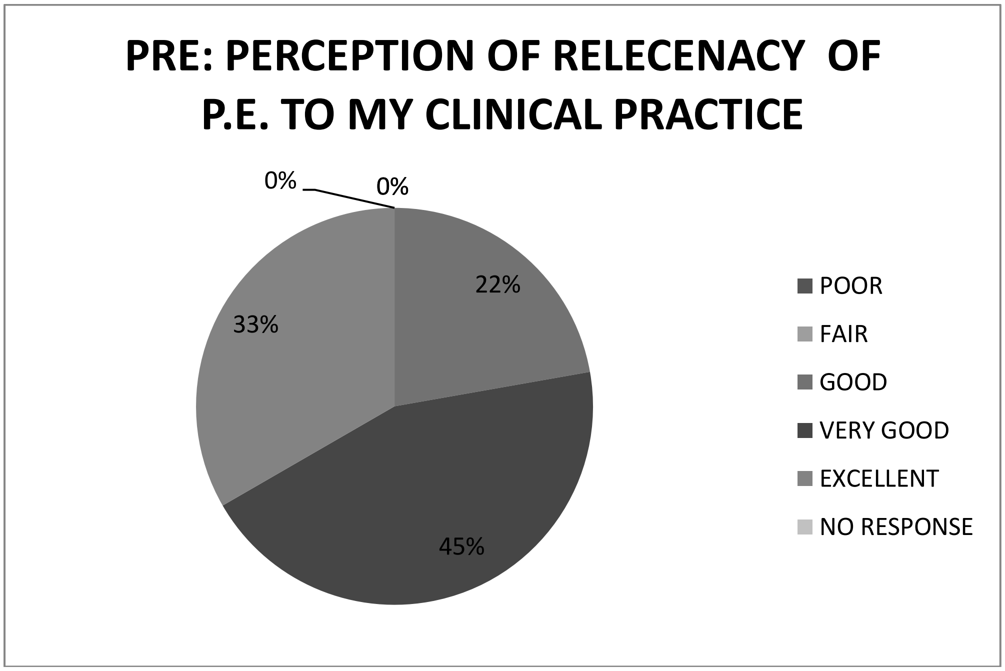
Appendix C: Participants Rating on their Self Perception Relating to Patient Engagement

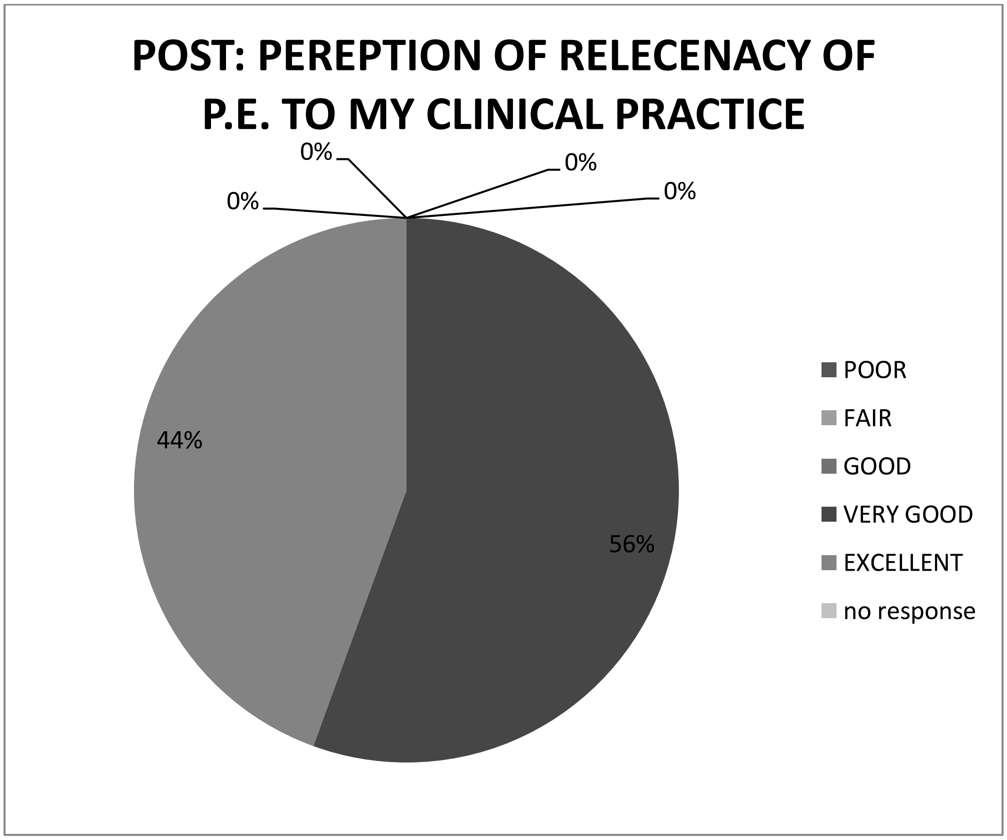





PRE: PERCEPTION OF LEVEL OF KNOWLEDGE
0%
0%
0%
11%
33%
56%
POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
NO RESPONSE


POST: PERCEPTION OF LEVEL OF KNOWLEDGE
0%
0%
0%
11%
33%
56%
POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
no response


PRE: PERCEPTION OF RELECENACY OF P.E. TO MY CLINICAL PRACTICE
0%
0%
22%
33%
45%
POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
NO RESPONSE


POST: PEREPTION OF RELECENACY OF P.E. TO MY CLINICAL PRACTICE
0%
0%
0%
0%
44%
56%
POOR
FAIR
GOOD
VERY GOOD
EXCELLENT
no response

Appendix D: Patient Engagement Knowledge Test

Pre Survey Knowledge Questions	Correct Answer Score	Correct Answer Percentage
1001	7/8	87.50%
1002	5/8	62.50%
1003	1/2	50%
1004	5/8	62.50%
1005	1/2	50%
1006	5/8	62.50%
1007	3/4	75%
1008	3/4	75%
1009	5/8	62.50%
Mean	5.22	
Mean Percentage	65.28%	
Check Point Questions:		
Total Correct Percentage	100%	
Post Survey Knowledge Questions	Correct Answer Post survey score	Correct Answer post survey percentage
1001	3/4	75%
1002	5/8	62.50%
1003	3/4	75%
1004	1/2	50%
1005	3/4	75%
1006	1	100%
1007	7/8	87.50%
1008	3/4	74%
1009	1	100%
mean Score	6.22	
Mean Percentage	77.67%	

Appendix E: *T* Test Two-Sample Assuming Equal Variances (95%)

	Variable 1	Variable 2
Mean	0.65278	0.77667
Variance	0.01476	0.02656
Observations	9	9
Pooled Variance	0.02066	
Hypothesized Mean Difference	0	
Df	16	
t Stat	-1.8286	
P(T<=t) one-tail	0.04308	
t Critical one-tail	1.74588	
P(T<=t) two-tail	0.08617	
t Critical two-tail	2.11991	

Appendix F: Postsurvey Question

	Post module Questions: Extent of agree or disagree with statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	No Response	Unclear
1	Presentation increased my knowledge about patient engagement	0	0	11%	78.00%	0	11%	0
2	Presentation increased my awareness about patient engagement (PE).	0	0	22%	66.67%	0	11%	0
3	Learning about PE will be helpful to my clinical practice	0	0	0	44%	44%	11%	0
4	learning about SHERPA-MD tool increased my knowledge about PE			22%	33%	22%	11%	11%
5	learning about SHERPA-DM tool increased my awareness about PE	0	0	22%	33%	22%	11%	11%
6	Learning about SHERPD-DM tool increased my knowledge and awareness about shared decision making	0	0	11%	56%	22%	11%	0
7	learning about SHERPA-DM tool helpful to my clinical practice	0	0	11%	56%	33%	0	0
8	This presentation will be helpful to other clinicians to learn about PE	0	0	11%	78%	0%	11%	0
9	This presentation will be helpful to other clinicians to learn about shared decision making	0	0	11%	56%	11%	11%	11%

and the SHERPA-DM tool

Table 2.

Appendix G: Postsurvey Questions Relating to the Impression of the Overall Presentaion

Post Module questions: Select a Response that best reflects your impression of the power point/e-module presentation	Poor	Fair	Good	Very Good	Excellent		Total	No Response
Content:	0	0	33.33%	44.44%	0	0	9	22%
Score of excellent	0	0	0	0	0	0	0	0
Percent of excellent	0	0	0	0	0	0%	0	0
Score of very good and above	0	0	0	0	0	0	0	0
Percent of very good and above	0	0	0	0	0	44%	0	0
Percent score of good and above	0	0	0	0	0	77.78%	0	0
Organization:	0	11.11%	22.22%	44.44%	0	0	9	22%
Score of excellent	0	0	0	0	0	0	0	0
Percent of excellent	0	0	0	0	0	0%	0	0
Score of very good and above	0	0	0	0	0	0	0	0
Percent of very good and above	0	0	0	0	0	44%	0	0
Percent of good and above	0	0	0	0	0	66.67%	0	0
Presentation:	11.11%	11.11%	11.11%	44.44%	0	0	9	22.22%
Score of excellent	0	0	0	0	0	0	0	0
Percent of excellent	0	0	0	0	0	0%	0	0
Score of very good and above	0	0	0	0	0	0	0	0
Percent of very good and above	0	0	0	0	0	44%	0	0
Percent of good and above	0	0	0	0	0	55.50%	0	0