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Development of an Online Resource Manual and Online Protocol to Facilitate Care Coordination

Leonore Bingham
Walden University

Walden University

College of Health Sciences

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Leonore Bingham-Porter

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Dr. Joan Moon, Committee Chairperson, Nursing Faculty
Dr. Susan Hayden, Committee Member, Nursing Faculty
Dr. Anne Vitale, University Reviewer, Nursing Faculty

Chief Academic Officer
Eric Riedel, Ph.D.

Walden University
2019

Abstract

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MSN, Thomas Jefferson University, 2012

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

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Abstract

Persons with disabilities tend to be in poorer health compared to those without disabilities, and timely coordination of care is essential for maintaining optimal health and wellness. The problem addressed in the Care Coordination Referral Project was the lack of timely access to health care and preventive care services for clients with disabilities in the organization for which this project was developed. Using the appraisal of guidelines research and evaluation II model, the purpose of this DNP project was to analyze and synthesize the evidence-based literature to support the project and develop an online health care resource manual and protocol. The practice- focused question focused on evidence from literature that supported the development of a resource manual and protocol to provide care coordination to patients with disabilities. The literature indicated that timely access to care was essential to a patient's overall health and well-being. The manual and protocol were approved by an organizational team and included in the patient care plan. Results of a summative evaluation showed that team members agreed that the project objectives were met, the project was appropriate to the setting, and that strong leadership was demonstrated throughout the project. The findings of this project show that providing the resource manual for the nurses might improve the overall health and well- being of patients with disabilities through access to health care and preventive care services access.

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Dedication

This project is dedicated to all those nurses who wear many hats and work in various settings often challenging them to come up with innovative ways to care for those that they serve. You are always ready to take on the challenge but ever so mindful of why you became a nurse. You are the ones that are imbedded in the minds and hearts of those patients that need you the most.

Acknowledgments

I would like to take the time to thank Dr. Charles Intenzo my preceptor and Dr. Joan Moon for always encouraging me and lending their guidance and expertise. Because of the guidance that you have both provided, I am where I stand today.

My family, friends, and colleagues, you all have given so much of your time and encouragement that I don’t know what I would have done without you. To my mother and my grandmother, I know that you are smiling down upon me from heaven; you never gave up on me.

Finally, to my husband Kevin, you are the glue that binds. Whenever, wherever, or whatever I needed, without fail you were there. You have been with me through every step of this journey and I sincerely thank you.

Table of Contents

Section 1: Overview of the Evidence-Based Project

Introduction

The National Institutes of Health (2018) defines *care* as the intentional alignment of health care activities involving both the patient and providers of care to promote the delivery of services that complement health and well-being. Care coordination is an aspect of professional nursing practice that can significantly influence health outcomes for all patients (American Nurses Association [ANA], 2012). In the key role of championing for the patient, nursing care coordination is essential to acquiring, preserving, and sustaining an optimal level of health (Ajani & Moez, 2011).

The U.S. Census Bureau reports that one in five adults who live with a disability often equating to poorer health (Centers for Disease Control [CDC], 2017). Timely coordination of care plays an essential role in maintaining optimal health and wellness for persons with disabilities who tend to be in poorer health compared to those without disabilities (National Council on Disability [NCD], 2009). Persons with disabilities have increased difficulty in accessing basic health care services that are normally accessible to all others (World Health Organization [WHO], 2015). This lack of resources can negatively affect one’s health and well-being.

I developed this doctor of nursing practice (DNP) Care Coordination Referral Project (CCRP) for an urban outpatient community program on the East Coast of the United States. Nurses in the organization assist those with disabilities in acquiring preventive care services and gaining access to various community resources with the primary goal of helping the targeted group maintain an optimal level of health and wellness.

Nurses in the organization assist those with disabilities in connecting with various providers of resources to promote the health and well-being of their clients. The nurses in the outreach program experienced a significant lag between the time taken for them to procure resources (set up appointments, find available providers) and the time that clients were able to connect with providers to receive those services (personal communication, January 25, 2018). Leadership in the organization voiced their concerns about the increasing number of complaints from clients serviced by the organization; during the last fiscal year, nurses in the outreach program received 132 complaints from clients referencing untimely access to services. The CCRP was created to support the nurses in helping clients gain timely access to health care and preventive care services in a judicious manner. An anticipated positive social change was a decreased use of emergency rooms and urgent care settings with a more positive fiscal outcome for health care dollars (Moses et al., 2013). In this section, I will explain the problem, purpose, nature, and significance of the doctoral project.

Problem Statement

The problem that I addressed in the CCRP was the lack of timely access to health care and preventive care services for clients with disabilities in the organization for which I developed this DNP project. This program is a not for profit, with its mission being to improve the health outcomes of people living with disabilities; they had 132 complaints filed related to inadequate access to needed services and resources in the course of 3 years. Presently, nurses in the organization spend a significant amount of time and effort focused on coordinating care and helping the targeted population obtain access to various resources. For each client, resource attainment is done on a case-by-case basis with no formal record of the resources that are used. There are delays in access to health care and preventive care as expressed by clients when they come in to appointments with their outreach coordinator nurse and nurse educator. The current system is by use of pen and paper with updates and revisions completed periodically as opposed to the use of technology with a resource manual online that can have just-in-time revisions and updates. According to the outreach coordinator, acquiring resources for the targeted population can sometimes take up to 3 months, thereby placing an urgent need to focus on ways that will decrease times for obtaining services for those with disabilities, in particular health care and preventive care services.

The CCRP can be significant to nursing practice by providing tools for the nurses to use to coordinate care of their patients in a timely and efficient manner. The CCRP workflow for the nurses in the organization would also be streamlined, thereby saving valuable time.

Purpose Statement

The gap in practice that I addressed in this project is the evidence-based literature that speaks to the importance of adequate access to care for patients with disabilities (Popplewell, Rechel, & Abel, 2014) and the identified lack of access to care by patients in the organization for which the CCRP was developed. My purpose for the CCRP was to analyze and synthesize the evidence-based literature to support the project and to develop an online health care resource manual and protocol to guide nurses in the outreach program who provide care coordination for patients with disabilities. The literature shows that accessing services in a timely manner is essential to overall health and well-being of patients (Koh et al., 2012). The role of the nurse dictates care coordination as a means to facilitate the needs of each patient (ANA, 2012). Baxter and Glendinning (2011) concluded that by providing access to pertinent information and resources for the disabled, identification of timely health care services could be obtained. The WHO (2015) claimed that inadequate access to preventive health and other health promotion accommodations among people with disabilities compared with the general population is a public health concern.

In this project, my practice-focused question was: What best practice evidence from the literature supports the development of a resource manual and protocol to provide care coordination to patients with disabilities?

Nature of the Project

Sources of Evidence

Sources of evidence that I collected included journal articles, systematic reviews, evidence-based textbooks, and evidence-based guidelines. I obtained evidence by using search engines such as Google, the CDC, and the World Wide Web. For peer-reviewed nursing articles and journals, nursing databases that I used were Medline and the

Cumulative Index of Nursing and Allied Health (CINAHL). I also used the Walden University Database and the Cochrane Library for evidence-based research articles.

Approach

The **A**ppraisal of **G**uidelines **Re**search and **E**valuation (AGREE) II (Brouwers et al., 2010) was used to frame the CCRP (see Appendix E). Beginning with the problem statement and the practice-focused question, the approach included the grading of the evidence and involvement of a stakeholder team. For health care organizations to survive in a complex system, changes in practice will need to take place with multidisciplinary teams being formed that will take the lead and have these changes come to fruition (Megson, 2011). A team approach was used with me as the leader, the physician of the organization, the community outreach coordinator, and the community nurse educator. As the leader of the CCRP, my responsibility was to bring an analysis and synthesis of the evidence-based literature to the team in support of the project.

I performed an in-depth literature review identifying common barriers experienced by those with disabilities, targeted interventions, and community resources. After the committee identified best practices, I developed the project outcome products. Ongoing meetings were held where the team provided formative, ongoing evaluation of each product and an anonymous conclusive final team member’s evaluation. Through the creation of the CCRP, I used the gathered evidence-based literature that spoke to the importance of adequate access to care and created outcome products to support the targeted group as well as provide the nurses in the organization with the most updated information to serve their clients.

Significance of the Project

Stakeholders who have an interest and influence on the outcomes of the project were the community outreach staff, persons with disabilities and their families, and the communities of which the targeted population is a part. Community outreach staff will have resources to better perform their jobs; those with disabilities and their families will benefit through more timely access to needed resources; and the community will benefit through the improved health and quality of life of its members. The CCRP has the potential to contribute to nursing practice because the initiative increases the nurse's knowledge related to the evidence found in the literature thereby enhancing nursing practice for those with disabilities. By highlighting the significance of care coordination for those with disabilities, suitable interventions can be created and transferred into other areas of nursing practice. Ridenour and Trautman (2009) asserted that the nursing profession garners the ability to influence access to care, cost, and quality. As informed health care professionals, nurses see firsthand the toll that illness takes on a community and must be conscious of directing efforts that focus on maintaining and improving the health status of all (Bodenheimer & Grumbach, 2012). In support of a positive culture of change, improved care coordination will be pivotal in supporting the disabled in gaining access to health care and preventive care services with resulting stewardship of health care dollars. By ensuring standardization and consistency of patient care across the continuum of care, the outcomes of the CCRP can positively influence those with disabilities, caregivers, the community, and society.

Summary

In Section 1, I identified the problem as those with disabilities not having timely access to health care and preventive care services. The problem addressed in the CCRP was the lack of timely access to health care and preventive care services for clients with disabilities in the organization for which I developed this DNP project. Following the problem identification, I presented the purpose of the project, which would address the gap in practice by bringing the evidence-based literature on care coordination to practice in support of the development of the resource manual and protocol, thus providing patients with timely access to care. I identified the sources of evidence and I summarized the approach for the project. In Section 2, I describe the Appraisal of Guidelines Research and Evaluation (AGREE) II framework, speak to the relevance of the project to nursing practice, summarize the local background and context, and, finally, describe my role and the role of the team in the project.

Section 2: Background and Context

Introduction

The problem that I addressed in the CCRP was the lack of timely access to health care and preventive care services for clients with disabilities in the organization for which I developed this DNP project. In this project, I explored the question: What best practice evidence from the literature supports the development of a resource manual and protocol to provide care coordination to patients with disabilities? My purpose in the CCRP was to analyze and synthesize the evidence-based literature to support the project and to develop an online health care resource manual and protocol to guide nurses in the outreach program who provide care coordination for patients with disabilities. The areas covered in this section are models, relevance of the project to nursing practice, local background and context, my role as leader, and role of the project team.

Appraisal of Guidelines Research and Evaluation (AGREE) II

For the CCRP, the AGREE II (Brouwers et al., 2010) was the framework (Appendix E). The AGREE II framework was developed by a group of internationally renowned researchers and developers to assist providers of health care with guideline development based upon evidence generated (AGREE Next Steps Consortium, 2009). The AGREE II model was used for the development of the new resources created to support the nurses and the outreach team in the organization in use of evidence-based practice. Having the framework as a foundation, the nurses were better informed with pertinent information as they assist those with disabilities about appropriate care decisions and the significance with health promotion (AGREE Next Steps Consortium, 2009). The AGREE II framework also highlighted the importance of considering the entire health care system from the provider to the patient and to the infrastructure, using research within these contexts to guide practice decisions with the intention of promoting quality care (Dontje, 2007). I chose this model because the AGREE II is a framework that prompts nurses to solicit knowledge by asking questions about current practice and whether that practice is the best practice based upon research and the evidence (Brown, 2014). Further, the model helped move the team through the process of problem identification to resolution. The five domains of the AGREE II model that I used were as follows:

1. Scope and purpose.
2. Stakeholder involvement.
3. Rigor of development.
4. Clarity of presentation.
5. Applicability.

Using AGREE II as a framework, Barceló, Jawed, Qiang, and the Pan American Health Organization (PAHO; 2017) conducted research to evaluate current clinical practice guidelines for diabetes mellitus Type 2. The authors evaluated 17 guidelines and concluded that further improvements must be made to guideline development with a focus on stakeholder involvement and ongoing efforts toward the improvement of high quality management of Type 2 diabetes requires continued efforts to update and create quality guidelines. For patients with chronic heart failure, there have been a number of international guidelines developed to support clinicians with the goal of improving the quality of care for end-of-life patients (Irving et al., 2013).

Conducting a systematic literature search, Irving et al. (2013) used AGREE II to assess 19 heart failure guidelines to discern whether or not those guidelines were in support of primary care being patient centered. The authors of the study concluded that of the guidelines analyzed all lacked adequate stakeholder involvement and applicability, a theme noted by many other researchers. Going forward, the authors suggested that future guidelines for those with end of life heart failure should be individually tailored and attention be focused on care continuity. Having been used across the health care spectrum, the AGREE II has been instrumental in guideline development projects such as diabetes, heart failure, health policy formation, and public health.

In the organization for which I developed the CCRP, there are many disciplines involved in the care of those with disabilities. To support interprofessional collaboration within the organization, use of the AGREE II was an effective approach highlighting a multidisciplinary method of initiating a change that incorporates evidence-based practice. The current focus of modern medicine is primarily the treatment of disease. Nurses are able to help expand that focus to include health promotion and disease prevention. Through educational resources tailored to the needs of persons with disabilities, nurses possess the knowledge to collaborate across the continuum to prevent disease before the start, enable early detection for improved outcomes, and provide effective strategies to empower those who are already chronically ill to play an active role in the management of their disease. Using these interventions in the targeted population in the context of an outpatient setting will not only help to achieve these goals, but will also increase patient satisfaction with primary care, perceived health status, and self-efficacy, thereby increasing access to adequate health care and preventive care services by this group (National Quality Forum, 2010).

Definition of Terms

Care coordination: Facilitation of the delivery of health care services involving the patient and other providers of care/services in a coordinated manner (Agency for Healthcare and Research Quality, 2014).

Disability: Any impairment of the mind or body making it difficult to engage and participate in certain activities for the person with the condition (CDC, 2017).

Manual: Reference marker providing guidelines or instructions (*Dorland's Medical Dictionary for Health Consumers*, 2007).

Protocol: Implementable actions created in the management of a patient's clinical condition (Medical Dictionary for the Health Professions and Nursing, 2012).

Relevance to Nursing Practice

When individuals with disabilities face barriers, the likelihood of them receiving preventive care as opposed to those who are fully functional is null (Couser, 2011). Nurses in the community outreach program for which the CCRP was designed assist adults with disabilities in procuring services that include counseling, advocacy, and education. The nurses in this setting serve as liaisons to other service providers in the community. Importance lies with the need to ensure that access to adequate health care and preventive care services received by this population enable them to flourish in accordance with their daily participation in their communities. As pointed out by Megson (2011), responsibility lies with nurses and other providers of care to ensure that those with disabilities are assessed properly and rendered equal, quality care.

In the United States, health care is one of the most important industries and has a direct effect on everyone (Menaker, 2010). Iezzoni (2011) asserted that with the United States having such a diverse population, health interventions designed for those with disabilities often come at a disadvantage as accommodations for one specific group may not be conducible for another group. However, timely access to resources that are inclusive of health care and preventive care services for this population will be key to lessening the chances of experiencing problems that can have a direct correlation to a decreased quality of life. Nurses can be the driving force as they play a central role in patient care and have a direct influence on health outcomes and patient safety (Savitz, Jones, & Shulamit, 2005).

In practice, when persons with disabilities face untimely accessibility issues this potentially leads to decreased preventive tests, care that is delayed, and potentially missed diagnoses—all leading to further debilitation and continued rising costs of health care (Mahmoudi & Meade, 2015). Optimal care for the targeted population entails coordination of services from various entities and is measured by using outcomes related to those with disabilities' integration into society (Zheng et al., 2014). Through the use of care coordination, nurses can directly influence health, cost outcomes, and functional abilities for those with disabilities (Popejoy et al., 2015). Central to the role of nursing, nurses are engaging more in care coordination and can take the lead in creating positive outcomes that could potentially influence the way in which care is delivered (Bower, 2016). According to the ANA (2012), care coordination is essential to all nurses and is identified as a primary professional standard as well as being a critical component in improving outcomes for all populations across the continuum. The CCRP has the potential to advance nursing practice by adding emphasis to expanding health promotion, thus positively affecting the health of people with disabilities and signifying the need for the nursing profession to collaborate across disciplines to create interventions that support the disabled in gaining access to health promoting behaviors. In the last several decades, there have been an array of methods used to address the issue of access to health care and preventive services for those with disabilities. Being deemed a public health concern (WHO, 2015) signifies that previous attempts to target the problem were unsuccessful. In their landmark study, "The Current State of Healthcare for People with Disabilities," the NCD (2009) contended that slow progress has been shown when meeting the needs of those with disabilities. In a retrospective cohort study, Liu, Bryson, Burgess, Sharp, Perkins, and Maciejewski (2012) examined the difference in outpatient use in Veterans Administration (VA) and Medicare between disability-eligible and age-eligible veterans who used VA primary care services and found that for VA care, there is greater outpatient care needs among disability-eligible veterans than age-eligible veterans. With these findings, the study implicates that care coordination plays an essential role in ensuring the efficient use of resources and high quality care. Mahmoudi and Meade (2015) used logistic regression analysis of the 2002-2011 Medical Expenditure Panel Survey to examine the effect of physical disability on access to care in the areas of medical care, dental care, and prescription drugs and found that those with disabilities have 1.75 times greater odds of unmet medical care, 1.57 times greater odds of unmet dental care, and 1.85 times greater odds of not getting medications when needed. The results of these findings would suggest that changes in community programs and policy could potentially reduce the gap in health care access when tailored to the needs of the disabled. On the other hand, a study by Maart and Jelsma (2014), using the conceptual framework of the International Classification of Functioning Disability and Health, hypothesized that a combination of environmental factors and functional limitations had the greatest impact on access to services. The descriptive study used random clustering sampling in Cape Town to interview 152 people with disabilities from a community-based survey and determined an urgency to improve access to rehabilitation services that are inclusive of assistive devices in order for those with disabilities to gain access to appropriate overall care. Despite many studies and the various approaches, there has yet to be one solution to the many attributions of access for the disabled. Although research has identified some interventions to reduce barriers associated with access to health care and preventive services for the disabled, there are still remaining gaps in the literature that need further research.

Local Background and Content

The need to address timely access to resources for the disabled in an urban outpatient community setting adds to the necessity of creating interventions that support the endeavor to promote health and prevent disease. The nurses in the outreach program voiced their concerns about the importance of timely access and significance as applied to those with disabilities. As quality improvement places focus on those processes that are directed toward improving patient outcomes, similarly placing a greater emphasis on access to preventive care may in turn prove to be pivotal in helping to alleviate access barriers and continued rising costs of health care for those with disabilities. In light of the evidence, for those with disabilities, poor health can be attributed to a complex interaction of challenging social, economic, and environmental and behavioral factors, combined with a lack of timely access to care. By addressing limitations in access, one of the root causes of poor health, health promoting services can be acquired thereby supporting reduced morbidity and mortality in the targeted population.

The nurses in the urban outpatient community program situated on the East Coast of the United States were without an online health care resource manual and protocol for the accession of services and without knowledge of updated evidence-based guidelines to safely and efficiently care for and promote healthy behaviors in those with disabilities. Annually, the urban outpatient community program assists about 400 clients with disabilities in acquiring various services and resources in an effort to help maintain an optimal level of health and wellness. As found by the *World Health Survey* (2004), data obtained from 51 countries revealed that those with disabilities were three times more likely to be denied much needed health care, twice as likely to report provider skills as inadequate to serve their needs, and four times more likely to be treated inappropriately and without due respect. The *Healthy People 2020* (2016) initiative addresses health disparities for the disabled and the need to take action to address these disparities. In an effort to decrease health disparities in people with disabilities, providers of care and services must be champions for equitable access to care of the highest quality and continually advocate for ways to promote healthy behaviors in this population (Krahn, Hammond, & Turner, 2006). With persons with disabilities facing disparities in their everyday lives that continue to threaten their quality of life and well-being, most organizations lack knowledge about their needs as well as the resources needed to keep them healthy. Health care providers must further educate themselves and create new approaches when providing services to those with disabilities. In the midst of this service provision, providers must look at those with disabilities as a single population in order for them to be provided better coordination of care (Reichar, Gulley, Rasch, & Chan, 2015).

Role of the DNP Student

The project approach was a team approach with me as the leader and a committee of stakeholders inclusive of the community outreach coordinator, physician liaison, nurse educator, and several members from the various disciplines in the organization all considered to be experts in practice. My relationship to the setting was that of an employee of the physician liaison who often solicits my assistance with helping the nurses in the outreach program. By working closely with the nurses in the organization notice had been taken of the daily struggles that they each faced when assisting those with disabilities to obtain adequate health care and preventive care resources in a timely manner. The paper system utilized for obtaining those resources was antiquated and time consuming. After working with and talking to the nurses, in an effort to streamline the process, I felt as though the CCRP would be a project from which the nurses and the organization could greatly benefit.

In preparation of becoming a DNP prepared scholar and leader, what I brought to this project was reflective of the knowledge that I have gained as laid out by DNP Essential 3 (Clinical Scholarship and Analytical Methods for Evidence-Based Practice; AACN, 2006) and my ability to utilize that knowledge in order to bring the evidence to life. Throughout this journey, one thing that has been learned is that knowledgeable leaders do not accept the “status quo,” but find innovative ways to gather and apply the evidence. In order to add to my development as scholar-practitioner and a nurse leader this project provided a means for me to actively showcase efforts put forth that promote enhanced patient care and meaningful quality improvement based upon the evidence gathered. Evidence-based practice provides us with a method that allows us to use the current (or scholarly) evidence to deliver care that is of high quality and leads to better patient outcomes (Compas, Hopkins, & Townsley, 2008). The project brings to light the need to find ways to decrease those health threatening barriers and ensure those with disabilities be afforded the same liberties to health promoting resources as those who are not disabled.

Role of the Project Team

According to Hodges and Videto (2011), identification of team members firsthand is an essential element of success for change. Kettner, Moroney, and Martin (2012) pointed out, in order for programs to be effective there must be a careful understanding of the social problem.

For the project, weekly meetings were set up for 8 weeks and conducted via conference call with e-mails sent out prior to the meetings and agendas provided. In preparation for the meetings all needed documents for discussion were included in the notification email. Minutes of the meetings were recorded following the meetings with meetings lasting 45 minutes in length. Between meetings, one on one discussions were conducted with both the nurse educator and preceptor about the overall findings of the meetings and next steps for the project identified. The following layout was the content of the meetings:

- Stakeholders identification.
- Analysis and synthesis of the literature.
- Recommendations on development of online resource manual and online protocol.

The online health care resource manual and protocol were developed for the project and presented by me to the stakeholder team for approval. Evaluation of the products was conducted by the stakeholder team and a final summative evaluation was conducted with all team members.

Summary

Section 2 provided a background and content of the lack of timely access to health care and preventive care services for clients with disabilities and the need to address the problem in an efficient manner. The discussion identified the AGREE II framework that was used for the project, what significance timely access to health care and preventive services has on nursing practice, a glimpse of the evidence, and what the roles of the DNP student and project team was for the project. In Section 3, a discussion spoke to sources of evidence which addressed the practice focused question as well as provided an analysis and synthesis of systems and procedures that were used for the project.

Section 3: Collection and Analysis of Evidence

Introduction

The problem that I addressed in this CCRP was the lack of timely access to health care and preventive care services for clients with disabilities in the organization for which I developed this DNP project. My purpose in the CCRP was to analyze and synthesize the evidence-based literature to support the project and to develop an online health care resource manual and protocol to guide nurses in the outreach program who are providing care coordination for patients with disabilities. In Section 2, the eminent need to address timely access to health care and preventive care services at an urban outpatient setting utilizing a multidisciplinary approach was identified. In light of the evidence, for those with disabilities poor health can be attributed to a complex interaction of challenging social, economic, environmental, and behavioral factors, combined with a lack of timely access to care (Popplewell et al., 2014). The literature supports a central theme of those with disabilities receiving inadequate and poorly coordinated care.

Findings suggest that by improving access to timely care, health status improves (Howieson & Clarke, 2013). Liebel, Powers, Friedman, and Watson (2012) found that through care coordination those with disabilities were able to access community and health care resources. In turn, this aided them with maintaining an adequate level of health. According to Kailes (2011), disability should be thought about in a broader sense with close attention being paid to this population acquiring services that promote an increased quality of life. In Section 2, I covered the AGREE II model and the purpose for use in the CCRP. The model guided the creation of the protocol for the CCRP. In section 3, the retrieved evidence is reported on and highlighted as well as graded.

Practice-Focused Question

In the urban community setting for which I developed this project, nurses in the outreach program encounter many barriers and spend a significant amount of time trying to pair those with disabilities to various resources that foster health and well-being in this population. There is a correlation between the gap in knowledge and professional practice on behalf of practitioners, which points to a lack of knowledge about the significance of timely access to resources for those with disabilities (Reichard, 2015). In this project, I sought to explore the question: What evidence from the literature supports the development of a resource manual and protocol to support nurses in the outreach program who are providing care coordination to patients with disabilities? In alignment with the practice-focused question, my purpose in the CCRP was to develop a literature review matrix to support the project, an online health care resource manual, and a protocol to guide nurses in the outreach program who are providing care coordination for patients with disabilities.

Sources of Evidence

To address timely access and care coordination, evidence extrapolated was inclusive of evidence-based guidelines, original published research from peer-reviewed journals, published systematic reviews, and published peer-reviewed journal articles. Search engines such as Google, the CDC, and the World Wide Web were used to obtain needed evidence in support of care coordination and timely access. For peer-reviewed nursing articles and journals, nursing databases that I used included Medline and the Cumulative Index of Nursing and Allied Health (CINAHL). The Cochrane Library and Walden University Database were used for evidence-based research articles. Terms that I used for conducting the literature search were *disability, health promotion, disability best practice, disability guidelines, AGREE II model, disability barriers, access, and access to care, care coordination, coordination, accessibility,* and *physical disability*. Key terms that I used for the CCRP were *disability, health promotion, health, care coordination,* and *health care.*

Collection and analysis of the evidence that supports timely access and care coordination for those with disabilities provided a scientific foundation in which to guide ways to improve practice and care outcomes. Findings from the collection and analysis aided with guideline development and interventions that could be designed to meet the needs of a targeted population. As outlined by the American Association of Colleges of Nursing (2006), *AACN Essentials for the DNP - Organizational and Systems Leadership for Quality Improvement and Systems Thinking* an integral part of the DNP is to apply those skills of leadership and clinical expertise in an effort to improve health outcomes. Literature that I explored for the review ranged in date from 2001 to 2018 with the inclusion of older evidence in support of the problem addressed in the CCRP.

Evidence Generated

Participants

For the purpose of the CCRP, the “participants” were the project stakeholder team who helped develop the plan and evaluate the project. The stakeholder team also provided their input and expertise during each phase of the project. Members of the team were selected based on their continued work with the program and their expertise in their respective fields as related to those with disabilities. The multidisciplinary team included a master’s prepared Nurse Researcher (NR) and a master’s prepared clinical nurse specialist (CNS), both advanced practice nurses who served as content experts, a doctoral-prepared assessment expert, and my preceptor who is a medical doctor (M.D.) with expertise in research and disabilities. The stakeholder team led by myself was convened for this initiative. By involving those representatives of the targeted population a program planner can identify public values and concerns, develop a consensus of those persons that are affected by the problem, and produce solutions that are both effective and efficient by way of a process that is open and conclusive. Representative involvement enhances shared responsibility, communication, and cooperation (Kettner, Moroney, & Martin, 2013).

Outcomes

The outcomes for this DNP project were as follows:

Outcome 1. Literature Review Matrix (Appendix A).

Outcome 2. Online Care Coordination Referral Manual (Appendix B).

Outcome 3. Online Service Referral Process Protocol (Appendix C).

Outcome 4. Team Member Evaluation (Appendix D).

I developed the literature review matrix that showed the evidence that supported and guided the CCRP. The resource manual and protocol were developed based on the evidence from the literature and input from the project team. Evaluation of the outcome products was conducted by the identified experts from within the team. Ongoing evaluation of the project occurred in meetings. In addition, an anonymous team member evaluation of the CCRP process and my leadership role was conducted at the end of the project. According to Kettner, Moroney, and Martin (2013), evaluation of programs should be a learning tool and an ongoing premise that is used to improve the effectiveness of an organization.

IRB

With any program, ethical implications must be considered before moving forward. The CCRP team members are the "participants" who were selected based on their roles within the organization and ethical considerations protecting human subjects were adhered to. There was no anticipation of harm or risk to the team. Approval was granted from the Walden University Institutional Review Board (IRB; Appendix E). The organization for which the CCRP was developed had no IRB therefore sole approval was sought from Walden and was granted.

Analysis and Synthesis

The analysis and synthesis of the CCRP was conducted on the literature review matrix. In order to choose the most appropriate items to go in the manual, recommendations generated from the stakeholders via the weekly meetings was gathered, filtered, and used for inclusion in the manual. I, along with content experts, was involved with selecting the final items for the manual.

Summary

In Section 3, I further identified the purpose of the CCRP and supported the need for a viable solution for those with disabilities gaining access in a timely manner. The stakeholder team was identified and their roles defined as part of the project. The outcome products for the project were highlighted as was permission from the Walden IRB to further conduct ongoing analysis and synthesis for the CCRP. In Section 3, analysis and synthesis of the evidence-based literature supported the practice-focused question bridging the gap between the evidence and a need to develop an online resource manual for the facility. The literature in support of the project was identified and the summative evaluation was explained along with a description of the team and approval by the Walden University IRB that was granted for the project. In Section 4, I focus on the findings and recommendations for the project.

Section 4: Findings and Recommendations

Introduction

The problem that was addressed in the CCRP was the lack of timely access to health care and preventive care services for clients with disabilities. The gap in practice that this project addressed is the evidence-based literature that speaks to the importance of adequate access to care for patients with disabilities (Popplewell et al., 2014) and the identified lack of access to care in a timely manner by patients in the organization for which the CCRP was developed. In this project, the question addressed was: What evidence from the literature supports the development of a resource manual and protocol to support nurses in the outreach program who are providing care coordination to patients with disabilities? My purpose in the CCRP was to analyze and synthesize the evidence-based literature to support the CCRP and to develop an online health care resource manual and protocol to guide nurses in the outreach program who provide care coordination for patients with disabilities.

Findings, Implications, and Recommendations

Findings

Outcome 1. Literature Review Matrix (Appendix A)

Findings. I presented an analysis and synthesis of 35 articles to the team for consideration in the project. The Johns Hopkins Nursing Evidence Based Practice Tool (Dearholt & Dang, 2012) was used in appraisal of each reference contained in the matrix. The levels used for the matrix were Level I (clinical randomized trials), Level II (case controlled trials), Level III (studies with surveys and questionnaires), and Level IV (literature review). The articles covered access to health care, access to health care for those with disabilities, access to timely health care, access to health promoting interventions, and disparities in access to health care for those with disabilities. The 35 articles that I used for the matrix were predominately Level III articles, which denoted non-experimental or qualitative studies. The criteria for inclusion were studies addressing access to care associated with those with disabilities. Studies that I excluded were those that did not meet the inclusion criteria, were not in English, included participants fewer than a total of 15, and those that did not have a study design. Keeping in alignment with the inclusion/exclusion criteria 23 articles were then chosen to be used for the literature review matrix.

Evaluation. Upon evaluation by the team and myself, the team collectively agreed upon 23 articles in support of the CCRP. Articles that failed to include disability, health promotion, access, health, and care coordination were excluded because the team deemed them insignificant to the CCRP and determined that no further insight would be gained.

Data. None

Recommendation. The team approved the articles and recommended that the literature review be ongoing.

Outcome 2. Care Coordination Referral Manual (Appendix B)

Findings. The team discussed the recommendations on disability and health as laid out by the Office of Disease Prevention and Health Promotion (2016) and scholarly projects on health care access guidelines for the development of the protocol. The team determined that the manual and protocol be based upon the Office of Disease Prevention and Health Promotion (2016) and the 2010 National Quality Forum (NQF) indicators or guidelines (2010), which are both referred to by the organization when seeking to create guidelines or protocols. The online care coordination referral manual was guided by these guidelines and the evidence-based literature as well as the input from the nurses.

Evaluation. The team provided ongoing formative evaluation of the manual during meetings. The team agreed that upon completion of the online manual, the nurses would be better able to keep track of services provided in a timely and efficient manner. With the manual being in an online format, the team felt as though care would also be streamlined for their clients.

Recommendation. The team recommended to the organization leadership that the manual be incorporated into the practice of the nurses. The team suggested that contacts be updated by the nurses on a monthly basis in order to keep in alignment with best practices of the organization.

Outcome 3. Service Referral Process Protocol (Appendix C)

Findings. The protocol was developed with the guidance of the outreach coordinator and created in a format similar to other protocols developed by the site agency.

Evaluation. Upon completion of the service referral process protocol (SRPP), which was based on the guidelines of the National Quality Forum (2010), the protocol was submitted to the physician for approval and permission for implementation was given.

Recommendation. None.

Outcome 4. Team Members Evaluation of CCRP, Process, and My Leadership (Appendix D)

Findings. Each team member was sent an anonymous team member evaluation which they were asked to complete and return anonymously through interoffice mail (Appendix D). A common theme that emerged from the evaluation was that the team members appreciated the small team which enabled ease of meetings and open communication. With the small team and open communication, members felt that achievement of the set goals was accomplished. Each member of the team was pleased to be a part of the project and the fact that hands on involvement made a significant difference. The team voiced that time management could be improved upon; members of the team would have liked to have given more time to showcase and test the project to the partnering sites. Overall, the team saw me as an effective leader who asked for help when needed and was able to meet the goals of the project. Improvement suggestions from the team touched upon meeting time constraints and similar evidence-based projects for sites such as their organization.

Evaluation. The members of the committee were in favor of a team approach from the start of the CCRP. Each member voiced that through communication and the planned meetings they were afforded the ability of meeting the goals of the project. Having direct influence in the creation of the final products of the CCRP, the committee members showed favorability with their involvement. The committee stated that the project goals were met because of hands on involvement by me, flexibility, offering of assistance, and addressing questions promptly. Upon completion of the online manual for the CCRP, the final entries were viewed by the nurses of the outreach staff and the physician and accepted.

Recommendation. None

Implications

From the creation of the literature review matrix, common themes that emerged in support of the manual and protocol were:

- Interventions should be specific to those with disabilities.
- Health care professionals need to become more knowledgeable regarding those with disabilities.
- Strategies to promote health for those with disabilities must address access barriers.
- Future research must focus more on those with disabilities and creating/finding ways to meet their needs.

- Care coordination can be key in those with disabilities gaining access to health promoting resources.
- Changes to policy and community programs could potentially reduce the gap in health care access for those with disabilities.

The development of the online Care Coordination Referral Manual and the online Service Referral Process Protocol is intended to have a direct effect on the practice of the nurses in the outreach program thus enhancing their current system. The CCRP contributes to social change by enhancing patient safety and fostering quality of life. The Care Coordination Referral Manual (Appendix B) and the Service Referral Process Protocol (Appendix C) will be incorporated into the nursing policies and procedures of this community outreach program. These materials may promote positive social change upon dissemination to other health providers who wish to adopt this process to improve coordination of care for people with disabilities in their respective health settings.

Contribution of the Doctoral Project Team

A strong leader has the ability to design effective teams whose roles have been defined, are able to work through diversity as a whole, and produce meaningful results in a timely manner (Kelly, 2011). Strong leaders possess the skills necessary to drive change and thereby recruit those members of the team who have that same drive and vision (Davis, Solomon, & Gerenflo, 2010).

With the doctoral project team being so diverse, I learned to incorporate various approaches into problem solving. Although I was the leader of the project, each team member had their own set of responsibilities as part of the CCRP. Members of the team were a doctoral prepared assessment expert, the medical director, nurse researcher, and a CNS. The latter two served as content experts. All members of the team were responsible for providing input on the content of the literature review matrix as well as completing a qualitative summative evaluation. Based upon this evaluation I was able to extrapolate strengths and limitations of the CCRP.

Strengths and Limitations of the Project

Project Strengths

The strengths attributed to the CCRP were (a) an in-depth literature review that helped to create an online evidenced-based protocol and an online care coordination referral manual, (b) support from the nurses in the community outreach program who provided feedback and gave suggestions for creating and developing the project, and (c) the director and my mentor for allowing me the opportunity to strengthen and showcase my skills as a leader in developing the CCRP.

Limitations of the Project

The limitations of the project hinged around time and not being able to fully implement the project until after graduation. Once the nurses were on board, convincing them to fully embrace the CCRP as a time-saving change in order for them to move away from the current paper-based system presently being used was a challenge and took some convincing on my part. Engaging in the IRB process was another time consuming factor since the organization did not have an IRB. This in turn took time away from the ability to further create the outcome products until approval was given to move forward with the project. Another limitation that I found to be a challenge was trying to work around everyone’s schedule to be able to meet all at once.

Section 5: Dissemination Plan

The products created under the CCRP will be disseminated to the organization as well as showcased to partners of the community outreach program during Spring 2019. Although informal, the presentation of the CCRP will be presented in the form of an oral presentation with a power point visual. Several of the partnering organizations hold workshops and mini fairs throughout the course of the year which will serve as venues to present the CCRP. I plan to continue to work with the nurses in the outreach program as they strive to orchestrate viable solutions to facilitate timely access for those with various disabilities. A project such as the CCRP can be used across an array of disciplines such as general practitioners, community health nurses, allied health professionals (i.e., dieticians, psychologists, health educators, social workers) contributing to improved health outcomes for all persons with disabilities, thereby lessening overuse of services deemed crucial. Future plans are to submit an abstract to the Quality and Safety Education for Nurses Institute, an affiliation of the Frances Payne Bolton School of Nursing at Case Western Reserve University who calls for abstracts for their annual conference. The conference places focus on projects relating to safety, quality, and health care education.

Analysis of Self

Analysis of Self as Scholar

As a nurse, I have been educated in the art and science of nursing with the hopes of helping individuals to attain, maintain, and restore health across their lifespan. As a

DNP prepared practitioner, I will be tasked with the job of bringing the evidence to the practice setting. Through my involvement with the CCRP, I no longer accept the status quo and now look for new and innovative ways to gather and apply the evidence to help those whom I serve. Zaccagnini and White (2011) pointed out that every advanced practice nurse should be a nurse scientist, gathering evidence at the patient's side, making observations, having experiences, responding to the patient's experiences, and thinking about reasons, theories, or concepts that might organize the evidence. As a practitioner, this guidance serves as my foundation to consistently strive to be on top of the evidence to educate my patients with the most up to date information—information that is based on best practices discerned from the evidence. By using and engaging in evidence-based practice during my project, I gained an increased knowledge in project development with a new sense of commitment of ensuring that those nurses with whom I collaborate and work side by side will continue to grow in their profession via the utilization of evidence-based practice. My plans for the future are to teach those in my area who are unfamiliar with evidence-based practice and help them to incorporate evidence-based practice into their daily work. I also plan to work further with the nurses in the outreach program to bring them up to speed with best practices based upon EBP that are conducive to their unique setting. Through the experience of the CCRP, my personal growth has been achieved via multidisciplinary collaboration, which speaks to DNP Essential VI, relating to interprofessional collaboration for improving patient and population health outcomes (AACN, 2006).

Analysis of Self as Practitioner

Nurses in the outreach program identified a disassociation between the time taken for them to procure resources and the time that clients actually connect to utilize those services. Leadership in the organization voiced their concerns about the increasing number of complaints from clients serviced by the organization. The intent of the CCRP was to support the nurses in the organization to assist those with disabilities in acquiring needed health care and preventive care services in a timely and seamless manner. This intended transformation would potentially increase nursing satisfaction but more importantly foster better patient outcomes. The CCRP allowed me to work as part of an interdisciplinary team, experience different leadership roles, and engage in evidence-based practice which was the basis of my project design. During the designing of the CCRP I was granted the opportunity to provide direction and feedback thereby increasing my knowledge as a scholar. My personal goal of applying leadership skills and clinical expertise in an effort to improve health outcomes has been met.

Analysis of Self as Project Manager

Being the project manager for the CCRP was a revelation to myself that I have the capabilities to take on activities that I would previously had not engaged in. My evolution as a leader was made prevalent during this experience. By working in collaboration with the various types of leaders and being exposed to different leadership styles I was able to nurture my own style. With the group having various schedules and commitments, my communication skills played a major part in this endeavor as well as those skills being greatly challenged at times. Throughout the project, collaboration was essential as well as beneficial for all involved. The great part about the project was that for the most part, everyone was on board and I experienced minimal resistance. During those times of slight resistance, I was able to grow and learn from my mistakes. My critical thinking skills were in use during every phase which in turn aided me in looking at things from a different perspective and achieving the desired outcome with that change of perspective. All in all, the entire experience has been a positive stepping stone for me and will further help the nurses in the program to provide efficient quality care to those that they service.

Summary

The purpose of the CCRP was to analyze and synthesize the evidence-based literature to support the project and to develop an online health care resource manual and protocol to guide nurses in the outreach program who provide care coordination for patients with disabilities. In support of social change, the project brought to light the need to continue to foster interventions in support of decreasing those health threatening barriers that inhibit those with disabilities from being afforded the same liberties to health promoting resources as those who are not disabled. A project such as the CCRP has the potential to benefit the disabled, their families, and the community on a large scale. Care coordination plays a pivotal role in our everyday lives but in those with disabilities, the difference in readily available resources and long awaited resources can have a major impact on their daily living. Making the necessary provisions to facilitate those resources that promote the health and well-being for this population is a welcoming addition to any setting.

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Appendix A: Literature Review Matrix

Author/ Date	**Theoretical/ Conceptual Framework**	**Research Question(s)/ Hypotheses**	**Methodology**	**Analysis & Results**	**Conclusions**	**Grading the Evidence**	**Implications for practice**
Anderson, W, Wiener, J., Khatutsky, G., & Armour, B. 2013.	2004-2007 Medical Expenditure Panel Survey	What is the prevalence of overweight and obesity among noninstitutionalized adults with and without disabilities? What are the relative additional health care expenditures for being overweight and obese (compared to normal weight) among noninstitutionalized adults with and without disabilities? What types of healthcare services have the highest expenditures associated with obesity for people with and without disabilities?	To estimate additional health expenditures by service, age group, and payer descriptive and multivariate methods used.	Analytic Sample of adults >19 years (*n*=39,457) from 2003-2006 National Health Interview Survey Sample Adult File.	For people with disabilities, obesity plays a significant role in increased health care expenditures posing a serious threat to current and future health care spending.	Level III	Public health interventions targeting obesity should be designed to include those with disabilities as well as soliciting input from this population. In preventing, delaying, or reducing obesity in this population, data specific to them should be generated.

		Which age and payer (Medicare, Medicaid, private pay) subgroups within these two populations have the highest expenditures?					
Baxter, K. & Glendinning, C. (2010).	Examined current status of disabled adults' and older persons use of information as related to support service choices	Disabled adults and older people should have a choice when making decisions about support services	Qualitative longitudinal study explored how 50 peoples' (disabled working age and older) use of information aided in decision making regarding services in England	Participants were interviewed three times between 2007 and 2009 using a semi-structured topic guide	People make choices about support services based upon the information that is already known and most are not presented with choices about various services. Results point to the targeted group as being disadvantaged.	Level III	Those with increasing support needs should have access to information about relevant services from knowledgeable healthcare professionals.
Davidsson, N. & Södergård, B. (2016).	US Department of Health and Human Services three steps of accessing health care	To explore perceptions regarding barriers and facilitators for accessing healthcare among	Small qualitative study. Participants with physical disabilities aged 46-87	Nine in-depth interviews conducted using a semistructured interview	Findings from the study suggesting barriers and facilitators to health	Level III	Future research is needed regarding patients without insurance and low

		physically disabled residents.	living in rural Louisiana. All participants with different physical abilities, all needed assistive devices for movement. Incomes consisted of disability, retirement or salary. Participants recruited from local churches and word of mouth. Interviews conducted in the homes or at the Council of Ageing.	guide (women $n=5$ and men $n=4$). Transcribed interviews analyzed using content analysis. External person used with no relation to the study to ensure validity.	care access were insurance coverage, financial resources, education and guidance about health care, transportation, physical accessibility in facilities, quality and continuity of care, and needs to make health care accessible.		income not eligible for Medicare/Medicaid.
Dobbertin, K., Horner-Johnson, W., Lee, J. C., & Andresen, E. M. (2015).	2002-2008 Medical Expenditure Panel Survey	Study examines whether the same kinds of disparities seen in the general population are present for people with disabilities and if controlling for those disparities would affect differences between people with disabilities	Examine relationship of socio-demographic and disability variables when having a usual source of care.	Bivariate and multivariate logistic regression analyses.	People with and without disabilities are similar in regards to disparities.	Level III	Interventions aimed at increasing usual source of care must address the unique concerns of those with disabilities which should also include communication and physical accessibility. There are also calls for

		and people without disabilities.					clinicians who are disability competent as well.
Duta, A., Garvey, R., Chan, F., Chou, C., & Dittchman, N. (2008).	Effect of vocational rehabilitation services on employment outcomes for people with sensory, physical, and mental impairments in the United States	How do demographic variables and the provision of cash or medical benefits relate to the employment outcome of people with disabilities receiving vocational rehabilitation services? What rehabilitation services are directly related to the employment outcome of people with disabilities who qualified for state vocational rehabilitation services?	5000 clients for each of the disability groups from closed cases obtained from the U.S. Department of Education, Rehabilitation Service Administration Case Service Report (form 911)	Logistic regression analysis computed for each impairment group to examine the association between vocational services and employment outcomes.	This study provided support for the utilization of rehabilitation services for those with sensory, physical, and mental impairments in order to achieve successful employment outcomes.	Level III	People with disabilities can benefit from vocational rehabilitative services.
Gettens, J., Hoffman, D., & Henry, A. (2016).	Common Health Working (CHW) – provides Medicare coverage to those working with severe disabilities	For working age adults with disabilities, does existing insurance solely meet their employment-related healthcare needs?	Sample included people aged 21-64 enrolled in CHW in 2012 and had private insurance, Medicare or both as their primary health	Community-based services, not covered by Medicare or private insurance accounted for 63% of all expenditu	From a cost perspective, wraparound services are more cost efficient in community-based services for	Level III	Healthcare needs of the working disabled should be explored by policymakers in an effort to create programs that support the working

			insurance. Medicaid Buy-In Program was used by all for wraparound coverage. To estimate expenditures and use, claims were analyzed.	res. Number using community-based services were low, but expenditures were high. Medicare recipients showed higher expenditures than those with private insurance.	employed people with disabilities.		disabled and allow them to remain in the workforce.
Howieson, J., & Clarke, K. (2013).	Development of accessible information resources on screening programs for the learning disabled	Hypothesis states those with learning disabilities are more likely to receive poor standards of care when using conventional healthcare services.	Non-experimental initiative aimed at developing educational materials to improve accessibility of information for the learning disabled and staff involved in their care at a hospital in the UK.	Development of easy read booklets, communication aid, and DVD resources. Results indicated user-friendly and accessible resources can improve access to screening programs.	Accessible user-friendly formats about crucial healthcare information ensures the healthcare needs of those with learning disabilities as well as enhances the skills of staff in primary and acute care settings.	Level III	Practitioners need more education on the benefits of more accessible resources for the disabled.
Iezzoni, L., Kilbridge, K., & Park, E. (2010).	Definition from the International Classification of Functioning, Disability and Health used	Explore how physical access affects breast cancer diagnosis and treatment	Qualitative analyses of interview transcripts from 20 women with mobility impairments	Participants n=20 identified issues such as inaccessible equipment	Numerous physical barriers were experienced by those women with major	Level III	Healthcare providers should be proactive with accommodation planning for

	as the conceptual model		with early stage breast cancer developed prior to age 60; interviews were individually audiotaped lasting 1-2 hours	, examining tables and weight scales; staff injury when transferring patients and unavailability of equipment during scheduled patient appointment	mobility issues during the diagnosis and treatment of their breast cancer.		those with disabilities gaining access. Accessibility must also be considered by these providers concerning new equipment, building new facilities, renovation of older buildings, and availability of equipment during patient appointments.
Ipsen, C., Ravesloot, C., Arnold, N., & Seekins, T. (2012).	Adaptation of the Living Well With a Disability health promotion program	Would participation in a health promotion program reduce limitation from secondary conditions and increase rates of employment among working adults with disabilities?	Vocational rehabilitation clients (*n*=297) in randomized trial of Working Well health promotion program. Data collected at 0, 3, 6, 9, and 12 months from control and intervention participants using symptom questions from the BRFSS.	Data analyzed with repeated measures ANOVA that compared health changes over time. Although both groups reported lower rates of limitations, the intervention group attending over half of the	Vocational rehabilitation clients attending the Working Well program demonstrated reduced limitations with secondary health conditions and represented a strategy for overcoming barriers to	Level I	Strategies such as the Working Well program that promote health in those with disabilities can have a significant effect on positive health outcomes in this population.

				Working Well sessions were significantly lower (*p* = .004).	employment for those working with disabilities.		
Ishaque, M. Y., Rahim, S., & Hussain, M. H. (2016).	Factors limiting access to dental care for Persons with Disabilities (PWD)	To assess barriers perceived by persons with disability living in Islamabad and to determine if they believe that oral health is pertinent to overall wellbeing.	Cross-sectional study of Persons with Disabilities aged 15-90 y.o. at general community organizations in Islamabad (*n*=500) dependent upon others to reach dental facilities. Study used 12 item self-administered questionnaire; study lasted a period of six months.	Data from responses received (n= 400) was analyzed using SPSS version 20. Major barriers found were transportation *n*= 192 (48%), cost of dental treatment *n*=158 (39.5%), and inability to sit on dental chair *n*=125 (31.25%).	There were significant barriers that impeded access to dental care for those with disabilities.	Level III	Barriers of access need to be addressed in order for those with disabilities to participate in health promoting behaviors.
Jones, E., Pike, J., Marshall, T., & Ye, X. (2016).	Adelphi MS III Disease Specific Programme	As Multiple Sclerosis disability increases, costs and burdens also escalate	Cross-sectional survey taken between 2013 and 2014 of patients with MS (age >18 years) *n*=715; perceptions of patient's diagnoses and health-	Regression analysis used to explore relationship between disability (determined by latest Expanded Disability Status Scale), health	In the US, healthcare costs and healthcare resource utilization increase as disability progresses in those with MS.	Level III	All efforts should be made to develop treatment or interventions that slow down or delay disability progression for those with MS.

			related quality of life collected through patient self-completion questionnaire and a physician reported patient record form	care resource utilization, health care costs, health related quality of life and current relapse			
Liebel, D. V., Powers, B. A., Friedman, B., & Watson, N. M. (2012).	PRECEDE-PROCEED planning model (improve self-care management and promote better health)	What were the facilitators to effective disability maintenance/improvement for participants receiving nursing home visits? What were the barriers to effective disability maintenance/improvement for participants receiving nurse home visits?	Qualitative Descriptive Analysis	Involving data from nurses' progress notes and case studies (sampled from the Outcome and Assessment Information Set mandated by US Medicare certified agencies for Medicare/ Medicaid homecare patients) Results indicated nurse home visiting intervention successful	An interdisciplinary collaborative approach to interventions for chronically ill older persons with disability serves as a successful strategy for incorporation into best practice models.	Level III	Interventions such as disease self-management, behavior change models, interdisciplinary communication and collaboration should be included in best-practice models aimed at delaying worsening disability.
Lindstrom, L., Kahn, L. G., & Lindsey,	Ecological framework to impact individual skills, create training	Young adults with disabilities face workplace barriers,	Qualitative case studies conducted seven to ten years post high school	Results of the literature review identified barriers	For young adults with disabilities, opportunities to	Level III	The importance of advocacy for young adults with disabilities

H. (2013).	opportunities, and enhance work place environments	inaccessible meaningful jobs, and minimal opportunity for career retention and advancement	on adults with learning and physical disabilities working for minimum wage	and strategies for young adults with disabilities and the need for more longitudinal research to unearth patterns of career development for this population	develop skills, knowledge, and experiences must be created in order to achieve successful employment		gaining equal access to career opportunities
Liu, C., Bryson, C., Burgess, J., Sharp, N., Perkins, M., & Maciejewski, M. (2012).		Examines the difference in outpatient utilization in VA and Medicare between disability-eligible and age-eligible veterans who used VA primary care services	Retrospective cohort study using administrative data which covered Fiscal Year 2000-2005 that tracked Veteran's Administration primary care users who were also eligible for Medicare	Descriptive and bivariate statistics used to assess differences in patient characteristics between community-based and hospital-based VA patients	The study showed that for VA care, there is greater outpatient care needs among disability-eligible veterans than age-eligible veterans.	Level III	Care coordination plays an essential role in ensuring efficient use of resources and high-quality care.
Maart, S., & Jelsma, J. (2014).	Conceptual framework of the International Classification of Functioning Disability and Health	Hypothesized that a combination of environmental factors and functional limitations had the greatest impact on	Descriptive study used random clustering sampling in Cape Town to interview 152 people with disability; participants were sampled	Disabled were more than likely to be male, unemployed; other reported unmet needs percentages were 54%	Results of the study indicated that there is an urgency to improve access to rehabilitation services that are inclusive	Level III	In order to access appropriate care, those with disabilities need interventions that are designed to address finance and

		access to services	from a large community based survey that asked about use of health related services	(home-based care); 34.5% (assistive devices); 28.9% (medical rehabilitation services); 2.5% (health services); over 65 y.o. less likely to have had required medical rehabilitation; sensory and language responders reported greater unmet needs. Transport problems 72% and inadequate finances 71% were considered main problems	of assistive devices in order for those with disabilities to gain access to appropriate overall care.		transportation barriers.
Mahmoudi, E., & Meade, M. A. (2015).	2002-2011 Medical Expenditure Panel	To examine the effect of physical disability on access to care in the areas of medical care, dental care, and prescription drugs.	Logistic regression analysis of adults in the US aged 25-64 (*n*=163,220) with and without physical disabilities using	Compared to adults without physical disabilities, adults with disabilities have 1.75 times greater odds of	Those with physical disabilities face increasing odds of having health care needs that go unmet.	Level III	Changes in community programs and policy could potentially reduce the gap in health care access when tailored to

			pooled data from 2002-2011 Medical Expenditure Panel Survey examining access to health care , namely medical, dental and prescription medication needs.	unmet medical care, 1.57 times greater odds of unmet dental care and 1.85 times greater odds of not getting medications when needed (for all $p < 0.001$).			the needs of the disabled
Miller, N. A., Kirk, A., Kaiser, M. J., & Glos, L. (2014).	Anderson’s Behavioral Model of Health Care Access	To examine disparities among disabled adults in the U.S. to the degree in which health insurance extenuates disparities by ethnicity, socioeconomic status and race	Data from 2001-2007 Medical Expenditure Panel Survey of adults 18-64 y.o. (complete cases) with disabilities (*n*=10122); dependent variables used were three access measures drawn from AHRQ National Disparities Report and independent variables	Results showed among adults with disabilities, evidence of disparities and use were found. Concerning ED use, adjusting for health insurance reduced the disparities. Across most measures, the uninsured experienced poorer access; reporting delays or inability	Among adults with disabilities, health insurances’ effect on reducing differences by ethnicity, socioeconomic status and race on access to healthcare were deemed limited.	Level III	Going forward, research conducted on the disabled should focus more on patient-provider interactions and physical accessibility.

				to obtain care.			
Popejoy, L. L., Stetzer, F., Hicks, L., Rantz, M. J., Galambos, C., Popescu, M., … Marek, K. D. (2015).	Aging in Place Program	To compare utilization of and cost outcomes of patients that received long-term care coordination in an Aging in Place Program (AIP) to patients who received care coordination as a routine service in home health care (HHC).	Quasi-experimental time series nonequivalent control group design. Older adults in Missouri who lived in their community homes; AIP participants (*n*=213) received nurse coordination care 2000-2002 from HHC agency Senior Care. Care coordination intervention in AIP consisted of nurse care coordinators working with a multidisciplinary team. Participants were seen monthly by a nurse care coordinator.	Hospitalizations were reduced 0.44 events/year; ED visits reduced 0.2 events/year. Results were apparent due to 80% of AIP and HHC patients not being rehospitalized in a year and 40% of AIP and HHC not utilizing the ED.	Through care coordination given by nurses, Medicare program costs were reduced by way of service utilization reduction. The AIP program significantly reduced rehospitalizations.	Level II	Nurses have the potential to influence cost outcomes and make a direct impact on health and functional abilities.
Popplewell, N., Rechel, B., & Abel, G. (2014).	General Practice Patient Survey (GPPS)	To compare patient-reported access to English primary care for adults with and without disabilities	Secondary analysis of 2010/2011 GPPS data using cross-sectional survey; sampling consisted of registered	Logistic regression used for secondary analysis of GPPS with a response rate of 35.9%.	Estimated prevalence of unmet need due to difficulty getting to surgery (*n*=38,468; 95%CI)	Level III	Improvement is needed for those with physical disabilities gaining access to primary care.

			adults in UK National Health System *n*=1,780,977 as reported from English general practices *n*=8384; practitioners provided information on chronic conditions that limited basic physical activity; 41, 389 of sample reported no need to see doctor in prior 6 months		and difficulty getting into the building (*n*=1,634,853; 95% CI). In England, compared to those without physical disabilities, those with physical disabilities experience worse physical access.		
Reichard, A., Gulley, S. P., Rasch, E. K., & Chan, L. (2015).	Examination of interrelationships between chronic conditions, disability, service use, and cost.	Study aimed to (1) identify high utilizers of healthcare in the US working age (18-64), (2) examine the overlap between this group and people with chronic conditions and/or disabilities, (3) identify predictors of high service use or cost among these subpopulations, (4)	Sample size *n*=53,586 from pooled annual file of 2006-2008 Medical Expenditure Panel Survey Household Component (MEPS-HC). Creation of indices for identification of increased or high utilization and cost groups.	Descriptive analyses, bivariate comparisons, and multivariate analyses used.	High utilizers of healthcare services cannot be effectively identified via diagnosis alone. Regarding chronic conditions and those with disabilities, the disabled must be looked upon as a single population and	Level III	New approaches are needed to provide better coordination of care for those with disability and chronic conditions.

		recommend approaches for stratification of individuals with high health care utilization.			defined as such.		
Rimmer, J., Vanderborn, K., Bandini, L., Drum, C., Luken, K., Suarez-Balcazar, Y., & Graham, I. (2014).	Comprehensive set of methods and criteria modeled after Guidelines International Network ADAPTE framework.	To develop a set of methods and criteria that facilitates the inclusion of those with disabilities in mainstreamed health promotion research and programs.	Series of online and in-person meetings facilitated the completion and finalization of decision algorithms used to develop the GRAIDs framework. Framework was established in conjunction with an internationally recognized scholar in guideline adaptation.	Extensive review of literature identified expert panel members for working group; panel used 38 criteria for establishing framework.	Methods and criteria developed to promote inclusive health promotion guidelines, strategies and practices for people with disabilities. Resulted in creation of Guidelines, Recommendations, and Adaptations Including Disability. (GRAID).	Level III	The study indicates the need to educate professionals on how to include those with disabilities in research and health promotion programs. Future implications denote the need for testing the effectiveness of GRAIDs in real world, inclusive health promotion settings.
Vermeulen, J., Neyes, J., van Rossum, E., Spreeuwenberg, M., & deWitte, L. (2011).	Effective interventions that prevent disability can diminish the burden caused by disability.	Which factors predict frailty – related ADL disability?	Reviewed 28 longitudinal cohort studies that measured frailty indicators (weight loss, gait speed, physical activity, lower extremity	Systematic approach involving PubMED, EMBASE, and CINAHL from January 1975 to April 2010 was performed	The review showed that in community-dwelling elderly aged 65 and older, physical frailty indicators can predict	Level IV	Interventions aimed at preventing ADL disability in the elderly should be inclusive of indicators that involve physical frailty.

			function, grip strength, balance) in community-dwelling elderly people.	that yielded 68 full text articles for final review.	ADL disability.		
Zheng, Q., Tian, Q., Hao, C., Gu, J., Lucas-Carrasco, R., Tao, J., & … Hao, Y. (2014).		To investigate the level of quality of life, self-perceived quality of care and support, severity of disability and personal attitudes toward disability among people with physical disability in China.	Cross-sectional study conducted in China from March to August in 2008 of persons 18 and older with a physical disability; multi-stage sampling techniques were used with 1853 persons with disability completing questionnaire			Level III	Clinicians must foster better interventions for those with physical disabilities with focus geared toward understanding their needs and current state of health care.

Appendix B: Online Care Coordination Referral Manual

Care Coordination Referral Manual

Outreach Program

Template for Online Care Coordination Referral Manual

Name of Agency:

Address of Agency:

Telephone Number:

Contact Person:

Services Provided:

Affiliations:

Appendix C: Online Service Referral Process Protocol

FORM A
ONLINE SERVICE REFERRAL PROCESS PROTOCOL

Guideline or Protocol?	Clinical Protocol
Date of Most Recent Version:	New
Title:	Service Referral Process
Program at Which Active:	Community Outreach

1. Development

There are times when clinical situations arise that nursing needs to be able to refer patients to the next suitable provider of care/services. A referral should be performed within <30 minutes of the client's initial intake. Obtaining the referral in a timely manner is important and should not be delayed.

2. Criteria for use

The Service Referral Process Protocol is applicable to all clients serviced by the Community Outreach Program.

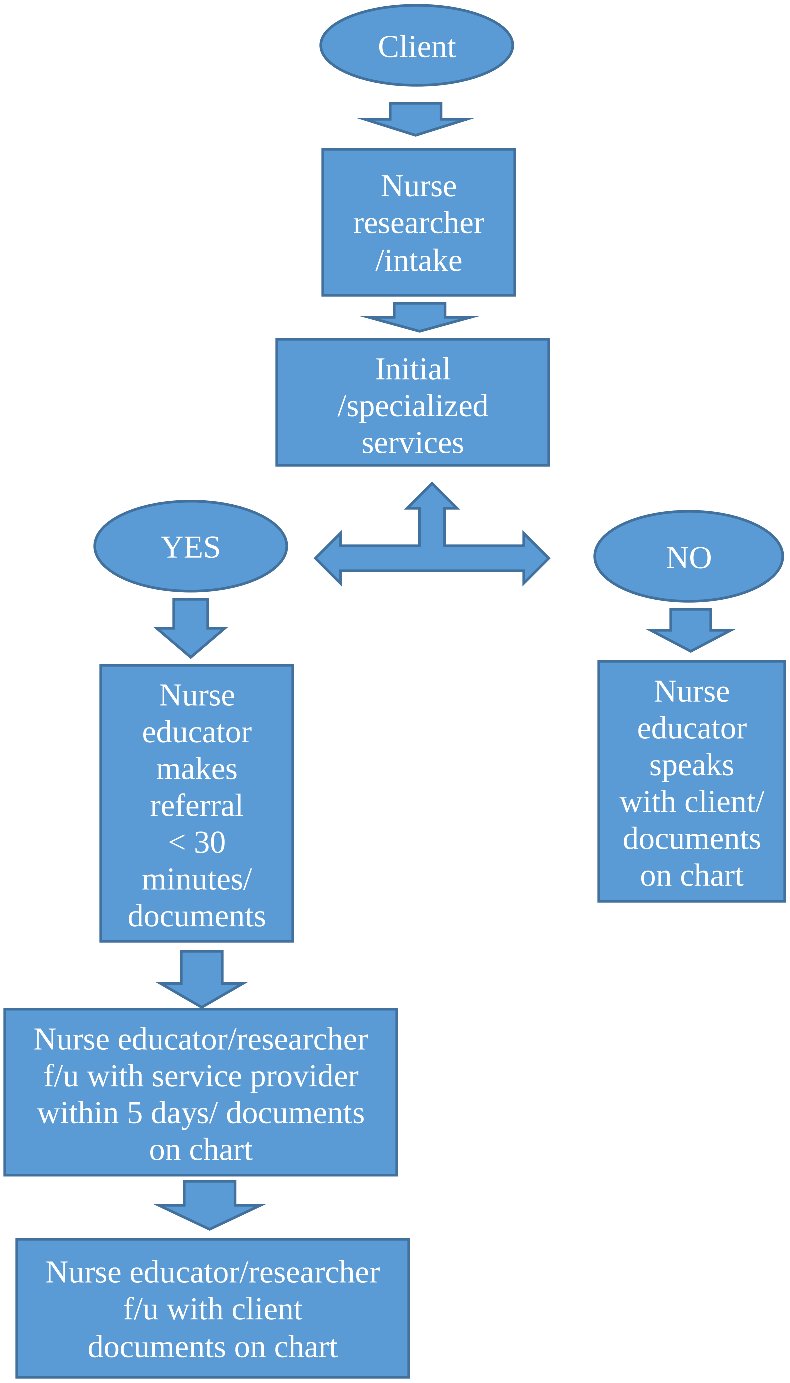
3. Content

The Service Referral Process Protocol will be imbedded into every initial service intake. Nurses in the outreach program will place the service referral protocol on each client service chart which will allow the nursing staff to start and/or continue with the process of service procurement for clients.

Process for Nursing:
1. Ensure protocol is on intake chart
2. Determine the need for further/specialized services
3. Nurses to notify next provider of services giving a synopsis of client needs. Documentation of date, time and contact person to be placed on client intake chart.

4. Nurses will follow up with recommended provider of services within 5 days and notate on client intake chart whether services were received/not received by client.

Process for Protocol



Appendix D: Anonymous Team Member Evaluation Stakeholders/Committee Members

TITLE OF PROJECT: **Care Coordination Referral Project**
Student: Leonore Bingham

Thank you for completing the Team Member Evaluation on my project. Please complete and send anonymously via interoffice mail to:

I. This project was a team approach with the student as the team leader.

a. Please describe the effectiveness (or not) of this project as a team approach related to meetings, communication, and desired outcomes etc.

1. With such a small team, the ease of meetings, communication, and desired outcomes were highly favored as there was an overall consensus for achieving goals.
2. Having a team approach allowed for ease of setting up meetings as well as kept the lines of communication open between the members of the team. In the end, achieving the set forth outcomes was a win for all.
3. The team approach allowed for a greater flow of goals and ideas amongst members to effectively achieve the desired outcomes.

b. How do you feel about your involvement as a stakeholder/committee member?

1. A pleasure to be a part of such a helpful project.

        2. Being involved as a member helped to bring forth what was needed for the outreach program.
        3. Having the hands-on involvement made my involvement more meaningful as hands on has always been an added plus in my daily practice.
    c. **What aspects of the committee process would you like to see improved?**
        1. Time management can always be improved upon.
        2. Representation from areas other than those which the project applies or has a direct impact upon.
        3. Involving those partnering sites to see what obstacles they are running up against in their daily practice.

II. **There were outcome products involved in this project including a literature review matrix, an online resource manual, and a service process protocol for the nurses in the outreach program.**
    a. **Describe your involvement in participating in the development/approval of the products.**
        1. I was fully involved with both the development and approval of the outcome products as they had a direct effect on my practice.

    2. From the beginning of the project and up to the present I worked with the leader of the project to bring the products to life for use in the outreach program.
    3. I was a responsible helping the team leader develop a project that would be useful in our area and one that she would be passionate about. After the leader came up with a viable project, I was fully on board and involved in every aspect of the project.

  b. **Share how you might have liked to have participated in another way in developing the products.**
    1. I would like to have participated in another way by the offering of more of my time for the student.
    2. With so many ideas that were brought forth for the program, I would have loved to work more closely with the student to go around to our partnering programs and show them how something like this could benefit them as well.
    3. I would love to have tested the products with other partners.

III. **The role of the student was to be the team leader.**

  a. **As a team leader how did the student direct the team to meet the project goals?**
    1. The student was very on point with meeting the project goals and very attentive to what needed to be done.

        2. As a team leader, the student was very focused on the project goals and did not let anything falter. Overall, the student was a very effective team leader.
        3. The student as the team leader, frequently checked to make sure that all goals of the project were being met. Each meeting would start with the project goals and where we stood as far as meeting those goals.

    b. **How did the leader support the team members in meeting the project goals?**

        1. The leader supported us by being very hands on and addressing any questions that we had in a prompt manner.
        2. When we asked for help in understanding the goals or any aspect of the project, the leader offered that flexibility for us to ask for help when needed.
        3. The leader frequently spoke to and offered assistance to the members to ensure all goals could and would be met within the specified time.

IV. **Please offer suggestions for improvement.**

        1. Finding more evidence-based practice projects that are conducive to programs such as ours.

2. Always having a plan B when things on the agenda are not ready or up for discussion. Important to keep things moving and not dwell on what is not available.
3. The importance of always having an agenda and meeting time constraints.

Appendix E: AGREE II Instrument

Domain 1: Scope and purpose
The overall objective (s) of the guideline is (are) specifically described. The health question(s) covered by the guideline is (are) specifically described The population (patients, public, etc.) to whom the guideline is meant to apply is specifically described.
Domain 2: Stakeholder involvement
The guideline development group includes individuals from all the relevant professional groups. The target users of the guideline are clearly defined.
Domain 3: Rigour of development Systematic methods were used to search for evidence. The criteria for selecting the evidence is clearly defined. The methods for formulating the recommendations are clearly defined. The health benefits, side effects and risks have been considered in formulating the recommendations. There is an explicit link between the recommendations and the supporting evidence. The guideline has been externally reviewed by experts.
Domain 4: Clarity of presentation The recommendations are specific and unambiguous.

The different options for management of the health issue are clearly presented. Key recommendations are easily identifiable.
Domain 5: Applicability The guideline provides advice or tools on how the recommendations can be put into practice. The guideline describes facilitators of and barriers to its application. The potential resource implications of applying the recommendations have been considered.
Domain 6: Editorial independence Not applicable to the CCRP

Melissa C. Brouwers et al. CMAJ 2010;182:E839-E842