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Regis University
Rueckert-Hartman College for Health Professions
Loretto Heights School of Nursing
Doctor of Nursing Practice Capstone Project

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Scripted Communication

Shannon L. Cook

Submitted as Partial fulfillment for the Doctorate of Nursing Practice Degree

Regis University

August 7, 2013

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Abstract

Variables related to scripted communication and patient satisfaction was studied. Patients who were admitted to the hospital and had inpatient status considered for the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey. Inclusion criteria for the study population were if the patient was not a newborn, deceased, a ward of the state, or a No Publicity patient. The HCAHPS survey was only sent every 90 days per The Agency for Healthcare Research and Quality (CRMC, 2012). The independent variable was scripted communication with the use of AIDET (Acknowledge, Introduce, Duration, Explanation, Thanking) measured by the HCAHPS survey. The dependent variable was patient satisfaction. This Capstone project increased physicians, nurses, and hospital awareness of patient centered communication directly impacts patient satisfaction.

Executive Summary

Scripted Communication for Patient Satisfaction

Problem

The cost of health care is escalating at rates faster than the national income (kaiserEDU.org, n.d.), financially burdening patients, families, providers, and health care facilities (Press Ganey, 2013). The Patient Protection and Affordable Care Act of 2010 is changing the United States technologically advanced focused health care to a system focused on quality, patient satisfaction, and outcomes (Studer, 2010). The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is the first national, standardized, public reported survey of patients' perspectives of the care they received while hospitalized. As the health care system evolves into a quality and outcomes focused system, there is urgency for hospitals to start hardwiring high performance for their nurses, providers, and support staff. The PICO statement for this project is P: Investigating the use of AIDET to increase patient satisfaction. I: Application of AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you) with all patient interactions. C: Patient satisfaction before use of AIDET. O: Decreased patient anxiety and increase in patient satisfaction and growth to the hospital.

The purpose

The purpose of the Capstone Project was to demonstrate scripted communication tool AIDET increases patient satisfaction and participation by decreasing patient anxiety levels. This outcome will have potential to impact clinical practice, patient satisfaction, and patient outcomes.

Goal

The goals of the Capstone project were to promote effective communication, hardwire high performance, build rapport, and positive outcomes between patients, providers, and nurses.

Objective

The objectives of this Capstone Project were to investigate the utilization of AIDET by providers and nurses on the patient experience, overall patient satisfaction with the health care system, and the growth of hospital services.

Plan

The DNP Project Process Model (White & Zaccagnini, 2011), was used as the guideline for the Capstone Project. Steps 1 and 2: Needs assessment was completed after identifying the need within the hospital environment to address increasing patient satisfaction; problem statement written; and systematic literature review completed. Step 3: Goals/objectives/mission statement developed. Step 4: Theoretical underpinning chosen to support the Capstone Project. Step 5: Work planning was done including timeline/budget/statistics/writing of project proposal. Step 6: Logic Model (Zaccagnini & White, 2011) developed and evaluation planning done. Step 7: IRB approval obtained from hospital and Regis University. Data collection and statistics collected. Dissemination of findings.

Outcomes and Results

A total of 349 eligible patients completed the HCAHPS patient satisfaction survey from November, 2012 through January 2013. Data analysis revealed AIDET was effective at reducing patient anxiety, increasing patient satisfaction, and recommending the hospital. Physicians and nurses scored in the 80th percentile utilizing AIDET to decrease patient anxiety, build rapport. Of all the respondents 62% recommend the hospital to family, friends, and the community.

Acknowledgements

I would like to thank my mom who has taught me determination and perseverance, friends especially Rebecca Bowman who graciously proof read all my papers and helped me recognize my passionate emotional writing skills cannot be used in a doctoral program, family, and Dr. Finn for all their patience, support, and constructive criticism while I have dedicated the last two years pursuing my doctorate and achieving a life-long goal.

A special thank you to the rural hospital I work in for their assistance and support with my Capstone project.

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Scripted Communication Background

As technology evolves in healthcare it allows for primary care providers and specialists to prolong life, perform extraordinary measures increasing survival rates, and life expectancy. Increases in survival rates and life expectancy is escalating health care rates faster than the national income (kaiserEDU.org, n.d.), financially burdening patients, families, physicians, advanced practice providers, nurses, and health care facilities (Press Ganey, 2013). The Patient Protection and Affordable Care Act of 2010 is changing the United States technologically advanced focused health care to a system focused on quality, patient satisfaction, and outcomes (Studer, 2010).

The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) is the first national, standardized, public reported survey of patients' perspectives of the care they receive while hospitalized. As the health care system evolves into a quality and outcomes focused system, there is urgency for hospitals to hardwire high performance in their physicians and nurses. This capstone proposal discusses the use of scripted communication to improve patient satisfaction by decreasing patient anxiety and growth of hospital services.

Problem Recognition and Definition

Focusing on patient satisfaction and outcomes creates urgency for providers to perform at a higher standard. Measuring patient satisfaction and outcomes transitions the healthcare system from paying for reporting to a system of paying for performance system, tying the amount of reimbursement to patient satisfaction surveys that are predicted to double by 2017 (Studer, 2010).

The reimbursement process of patient outcomes and satisfaction are shifting hospitals to focus on HCAHPS (Studer, 2010). The pay for quality reimbursement system is important to hospitals because it encourages a culture of excellence ensuring the organization is consistently meeting its mission, protecting its bottom line, and enhancing its reputation. (Studer, 2010)

HCAHPS survey questions measure frequency of various categories of questions. Will the patient recommend the hospital to friends and/or family members? What was the overall rating of the hospital (Studer, 2010)? Communication questions are important and identify the communication style of the physicians, nurses, and the hospital.

Communication is essential to health care provider relationships, patient provider relationships, patient outcomes, and patient satisfaction. Patients experience anxiety when it comes to their health and disease processes. Physicians and nurses can reduce patient anxiety by applying the acronym AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you) (Studer, 2010).

Purpose

The purpose was to evaluate patient satisfaction of hospitalized patients by physicians and nurses utilizing the scripted communication tool of AIDET by The Studer Group.

PICO Statement

This project is an evidence-based practice (EBP) project in which a program evaluation or standard of care intervention was completed. The project was internal to an agency and informed the agency of issues in healthcare quality, cost, and satisfaction. The results from this project are not meant to generate new knowledge or be generalizable across settings but address

a specific population, at a specific time, in a specific agency. This project translates and applies the science of nursing to the health care field. EBP Projects utilize the acronym “PICO” rather than using a hypothesis, PICO stands for: P – Population or disease; I – Intervention or Issue of Interest; C – Comparison or Current Practice; and O – Outcome (Melnyk & Fineout-Overholt, 2011, p. 31). As reimbursement processes change patient and provider responsibility is increasing to promote health and optimal patient outcomes. This project question is, "Will AIDET improve patient satisfaction, communication, and build loyalty to a rural hospital in Wyoming (CRMC, 2011).”

Project Identification

The problem has been identified through the clinical experience and reimbursement changes of patients admitted to the hospital. The problem for patients admitted to the hospital was poor patient physician and nursing communication increasing anxiety levels leading to poor outcomes and non-compliance with treatment plan increasing readmissions after discharge.

Project Significance

The Capstone project was imperative to patients and hospitals because of increasing anxiety levels, outcomes, re-admission rates, and reimbursement changes. Patients experience anxiety when their health is compromised and they are in an unknown health care environment.

Theoretical Foundation

Dr. Katharine Kolcaba’s comfort theory, Dr. Watson’s caring theory, and Kurt Lewin change theory are essential to the patient centered environment by encouraging communication. A supportive environment cannot exist without comfort, caring, and change. Comfort is directly

and positively related to patients engaging in health seeking behaviors, called subsequent patient outcomes (Kolcaba, 2011). When patients feel comfortable they are often willing to participate and take responsibility for their own health. Comfort is abstract to each and every one but is guided by human behavior. Patients have implicit and explicit comfort needs that, when met, strengthen them and motivate them to be an advocate for their health care and encourages adherence to their own health regimens (Kolcaba, 2011).

Dr. Katharine Kolcaba's (2011) concept analysis began with an extensive review of literature about comfort from the disciplines of nursing, medicine, psychology, psychiatry, and ergonomics. Florence Nightingale also disputed the importance of comfort in her works with nursing (McDonald, 2001). Comfort has been studied in detail but remains theoretical without distinctive definition. Dr. Kolcaba (2011), believed comfort needs occur in both the physical and mental context of the human experience.

Comfort is important to patients, physicians, and nurses because if uncomfortable it is difficult to form caring intellectual relationships. The question is what creates a caring engaging atmosphere? Private quiet warm hospital rooms, coffee, tea, water, soft drinks, cozy sturdy furniture, and handicap accessibility? Greeting patients by their last name, sends a message of respect: be willing to sit down with the patient and discuss issues about their lives as well as the life of the physician or nurse; creating understanding for patients and families sends a message that they are viewed as individuals, patients, and as family members (Studer, 2010).

A component of comfort is decreasing the amount of wait time for procedures and appointments times (Studer, 2010). Decreasing the wait time is complicated because it requires patients to be up front and honest about their health status. Accurate scheduling helps organize

hospital rounds and procedures. Daily havoc is encountered such as a sick patient who requires longer hospital rounding or procedure time. Patients experience crisis in their lives or health status which requires immediate attention. Colleagues become ill and their patients need to be seen. Physicians and nurses are used to multitasking and adjusting to their high paced profession all the while focusing on the patient to make he or she feel like the most important patient!

Dr. Jean Watson's caring theory (2007) sets a foundation for the nursing profession by recognizing its values, knowledge, practices, ethics, and mission to patients and families (Parker & Smith 2010). Within this unique caring and healing arts framework called "carative factors" they complement conventional medicine but stay in stark to "curative factors" (Parker, & Smith 2010). The conceptual elements of Dr. Watson's theory involve ten carative factors of the transpersonal caring relationship, caring in the moment, caring occasion, caring and healing modalities. But most importantly are the Caritas which came from the Latin word meaning to cherish and appreciate, giving special attention to, or loving (Parker, & Smith, 2010).

Dr. Jean Watson refers to her study of caritas as way of connecting caring to loving by embracing altruistic values and practicing loving kindness with self and others, instilling faith hope, and honor. Sensitivity to self and others nurtures individual beliefs and practices. Developing helping trusting caring relationships promotes and accepts positive and negative feelings as well as differing comprehension styles (Watson, 2007). Be open to mystery and allow miracles to enter. Authentically listen to one another's story while utilizing creative scientific problem-solving methods to promote patient-centered decision making (Watson, 2007). Practicing according to Dr. Watson's caring theory builds the clinician patient relationship and promotes inner healing for self and others.

Change is a common thread in the health care industry affecting health care professionals, patients, and families. Kurt Lewin change model has three stages unfreeze, change, refreeze (Lewin, 2011). Unfreeze is the first stage that involves preparing the rural hospital, physicians, and nurses to accept change is necessary. This will involve breaking down the status quo of everyday practice within the hospital. The key to unfreezing behavior is to develop a compelling message showing why the existing way of providing patient care cannot continue (Lewin, 2011). The compelling message will be focused on reimbursement changes and patient satisfaction. Preparing the hospital, physicians, nurses, and support staff successfully will need to start at its core by challenging the beliefs, values, attitudes, and behaviors that currently define it (Lewin, 2011). The unfreezing process of change is usually the most difficult and stressful and may evoke strong reactions from the physicians, nurses, and support staff but that is exactly what needs to happen so that the change process can begin. Forcing the hospital to re-examine its core will effectively create a controlled crisis, which in turn can build a strong motivation to seek out a new equilibrium (Lewin, 2011).

The change stage is where physicians, nurses, and support staff resolve their uncertainty and look for new ways to communicate with patients and each other. Through this change stage the physicians and nurses believe and act in ways that support the new direction of increasing patient satisfaction within the hospital. The transition from unfreeze to change will not happen quickly. In order to accept the change and contribute to making the change successful, physicians and nurses need to understand how scripting communication benefits them by increasing patient satisfaction through a patient centered environment leading to better patient outcomes (Lewin, 2011).

As the changes take shape and the physicians and nurses are embracing scripted communication tool of AIDET the hospital is ready to refreeze. The refreeze stage helps the physicians and nurses internalize and institutionalize the changes (Lewin, 2011). This means mandatory workshops for physicians and nurses. Changes to the orientation process that focuses on scripted communication for all new physicians, nurses, and support staff. The hospital expects its physicians, nurses, and support staff to be accountable for using the scripted communication tool AIDET. With a new sense of stability physicians and nurses will feel confident and comfortable communicating in a patient centered environment (Lewin, 2011). Part of the refreezing process is celebrating the success of the change by increasing patient satisfaction and outcomes. Refreezing will help the physicians and nurses find closure while thanking them for enduring change, and helping them believe that future changes will be successful (Lewin, 2011).

Applying the comfort, caring, and change theories in health care is challenging because of individual personal needs, goals, fear of change, and unknown sterile environments patients find themselves in (Studer, 2010). Physicians and nurses must develop routines of delivering care and communicating with patients because of their tight schedules and increased patient loads. The importance of the change, comfort, and caring theories promote wellness while individually treating patients in an open, warm, comfortable, and patient centered environment increasing patient satisfaction, outcomes, and reimbursement.

Literature Selection

A comprehensive review of the literature was performed on the concepts of patient satisfaction with providers in primary care and specialty areas of healthcare utilizing scripted

communication. The data bases utilized were CINAHL, Ovid, Medline, Google Scholar, and The Studer Group. The key words investigated were patient satisfaction by physicians, advance practice providers, specialists, nurses. Communication styles of physicians, specialists, nurses, patient provider communication processes, patient-centered communication, interpersonal communication, empathy, behavior modification, anxiety, trust, adherence, change theory, and scripted communication. This search yielded 32 articles for consideration (Attachment A literature review). The literature search was narrowed to the use of scripted communication by The Studer Group. The Studer Group specializes in hardwiring excellence by utilizing a communication acronym AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you) with all patient interactions to personally connect with patients, reduce anxiety, and increase patient-satisfaction (Studer, 2010).

Multiple factors exist in patient satisfaction regarding their healthcare, which is ultimately determined by the individual patient and his/her value system. Dunn (2011) identified positive qualities associated with health care providers, including the provision of specific health education information and adequate duration of the patients visits, patient age, patient health status, and socioeconomic standing. It is believed that highly satisfied patients tend to positively view their ability to obtain health care, participate in there plan of care, and are more likely to return for follow up visits.

Practicing in a highly technological environment is difficult for physicians and nurses but the ultimate goal is to provide the best possible health care for all patients. This requires going beyond a list of differential diagnoses, test ordering, and examining patients. Effective patient provider communication is essential in driving quality, safety, and perception of care (Studer, 2010). As health care continues to evolve, so must physicians and nurses communication styles.

Regardless of the circumstances, communication is a critical factor in ensuring better patient care. Research confirms the way physicians and nurses communicate with patients the better the patients understand their role in the treatment and management of an illness or condition driving quality outcomes (Studer, 2012).

Essential communication tactics resulting in effective communication with patients are courtesy, listening, treatment, time explanations, medication instruction, and continuity of care (Studer, 2012). Making eye contact, shaking the patient's hand, and using key words are all aspects of nonverbal communication. When using an electronic medical record (EMR), open up the EMR to the patient so they can see what the physician or nurse is viewing this action will explain why physicians or nurses may not be looking at them but lets them know they are still listening, processing, and caring about them as a person (Studer, 2012). Sit whenever possible it only takes a few seconds to position one's self in proximity of the patient. Multiple studies show that patients overestimate the time that physicians and nurses spend with them during an exam when they are seated versus standing (Studer, 2012). Describe medication in a way patients can understand, encourage them to ask questions, and if appropriate use the-teach back method (Studer, 2012). Remember patient's recollection of information may be short so it is very important to replicate the information in written form so they can read it.

Managing up the care team to the patient and in turn the team will manage up the physician and nurse. Managing up reinforces to patients that a connected and united team is caring for them and reiterates they will receive excellent care (Studer, 2012). Today's patients desire to be active participates with in their healthcare. Remembering what we say and the words we choose have tremendous impact on patients. The right words can calm, comfort, and reassure patients. The wrong words will produce anxiety and create confusion in an already

stressful situation. Examples of anxiety producing words are hope, hopefully, probably, as soon as we can, as soon as possible, pretty quick and in a few minutes are all vague answers that are meaningless to the health care team strategy and encourage the patient to set unrealistic expectations (Studer, 2012).

Effectively communicating with patients will set realistic expectations, encouraged patients to participate in their care, attain better health outcomes, and comply closer with treatment regimens. Physicians and nurses who communicate effectively have fewer law suits, better patient outcomes, better clinical compliance with treatment regimens, lower 30-day readmission rates and have a better patient perception of care (Studer, 2012).

Patient satisfaction in healthcare is complex and multifaceted phenomenon (Dunn, 2011). Patient satisfaction surveys and research have been used as benchmarks for many facilities employing physicians and nurses. The problem with measuring patient satisfaction is that it is extremely difficult. There is tremendous professional significance to research patient care and patient satisfaction by physicians and nurses in hospitals for reimbursement purposes (Studer, 2010). The data regarding the specific elements of scripted communication delivered in an inpatient setting can demonstrate favorably and impact general patient satisfaction (Dunn, 2011). This data is highly abstract and varies by differing patients values.

There are several measurement tools for standardizing and measuring patient satisfaction however the HCAHPS is the first national, standardized, publically reported survey of patients' perspectives of hospital care. The survey was developed by the Centers for Medicare and Medicaid Services (CMS) together with the Agency for Healthcare Research and Quality (AHRQ) (Studer, 2010) (Appendix B).

In May of 2005, the National Quality Forum endorsed HCAHPS, and in December the Federal Office of Management and Budget finalized the survey to be voluntarily implemented throughout the United States (Studer, 2010). In March of 2008 public reporting of data collection began and the reports were easily accessible through the Hospital Compare website. The goals of HCAHPS are to produce comparable data on patients' perspective of care so that consumers can make objective and meaningful comparisons among hospitals (Studer, 2010). HCAHPS also creates incentives for hospitals to improve their quality of care, while enhancing accountability within the healthcare organization to improve quality patient-centered care (Studer, 2010). In March 2010 patient-centered care, quality care progressed from being a volunteer program to being a legislative and reimbursement issue to ultimately becoming front and center nationwide (Studer, 2010). The reimbursement changes create urgency for hardwiring hospital employees, physicians, nurses, and volunteers for high performance using scripted communication tool to reduce patient anxiety and increase patient satisfaction.

There was not a fixed level that reliability needs to reach for a measure to be useful, but 0.7 is a commonly used rule-of-thumb. The hospital-level reliabilities of communication with doctors (0.76), communication with nurses (0.89), responsiveness of hospital staff (0.81), cleanliness and quiet of the physical environment (0.77), and discharge information (0.75) are all above the rule-of-thumb. Pain control (0.62) and communication about medicines (0.68) are a little lower (The Agency for Healthcare Research and Quality, 2012).

Project Plan and Evaluation

Market Analysis

Wyoming is a rural state with low population density and a growing population of baby boomers. Wyoming has no state income tax, minimal traffic, wide-open areas, and low crime rates (Wyoming Health Matters, 2009). There are numerous small towns and communities within the state of Wyoming. The small towns and communities are miles from each other with limited resources. Laramie County has the largest population in Wyoming and includes the capital, Cheyenne. There are two large hospitals in Wyoming separated by 500 miles offering a multitude of services. Specialists are available to provide expertise in difficult disease processes. Emergency services are available for residents, including medical flight services. In Laramie County, 24.3% of 45-65 year olds are without access to a health care provider. This number compares to 26.1% without access to a health care provider in Wyoming. These rates are higher than the national rate of 18.4% of adults without access to a primary health care provider (Wyoming Health Matters, 2009).

Customer Profile

The average age of Laramie County residents is 35.5 years of age. The primary language spoken in Laramie County is English but approximately 8% of residents are bilingual (U.S. Census Data, 2010). Racial demographics are 88.9% Caucasians, 10.9% Hispanic/Latino, and 2.6% African Americans. Immigrants make up 3% of the population. There are approximately 18,535 residents in the age group range of 18 to 64 in 2010, representing 22.7% of the total population in Laramie County (U.S. Census Bureau, 2012).

It is estimated 9.6% of the population in Laramie County are at poverty level or below. The median household income in Laramie County is approximately \$62,200 and Wyoming's overall median income is approximately \$63,545 (City Data, 2012). Approximately 91.6% of

residents in Laramie County graduated from high school, 22.9% have bachelors or higher degrees (U.S. Census Bureau, 2012).

Health Status Indicators in Laramie County

Health indicators for adults ages 45-65 in Laramie County include the following factors: affordable medical care, lack of exercise, overweight, obesity, diabetes, hypertension, elevated cholesterol, mental distress, suicide, and the lack of primary health care providers. In the 45 to 65 year old population 64.3% are considered overweight or obese. Wyoming's obesity rate is 63%, similar to the nation's obesity rate of 63.8% (Wyoming Health Matters, 2009). According to Wyoming Health Matters (2009), approximately 8% of adults between 45 and 65 years of age in Laramie County have been diagnosed with diabetes. The rate of adults with diabetes in Laramie County is slightly higher than the state rate of 7%, and significantly lower than the national rate of 23%. Hypertension is reported in 6.2% of this population, compared to 25.1% in Wyoming and 27.5% in the U.S. Elevated cholesterol affects 27.8% of adults in Laramie County, compared to Wyoming and the nation at 29.4%. In Laramie County, 45-65 year olds report that 6.8% of them rarely or never get the social or emotional support they need, while 8.8% are reporting frequent mental distress. This lack of social and emotional support is detrimental to wellbeing, and can in fact affect their mortality rates. Suicide in Laramie County is high at 16.8 deaths/100,000 population (Wyoming Health Matters 2009).

According to Wyoming Life Expectancy (2011) the leading causes of death in adults are: heart disease, cancer, accidents, chronic lung disease, stroke, diabetes, influenza, pneumonia, Alzheimer's, suicide, liver disease, blood poisoning, kidney disease, Parkinson's, hypertension, and renal disease.

Resources for Collaboration

The most accessible resource for collaboration is the hospitals network of services, facilities, physicians, and nurses. The hospital has developed a Physical Activity and Obesity Team, Access to Care Team, and Overcoming Cancer Group. The hospital (2011) has established four family practice clinics, and 14 specialty clinics including: cardiology, oncology, hematology, rheumatology, infectious disease, pulmonary, intensive care, wound care, neurology, weight loss, orthopedics, sports medicine, sleep disorders, and pediatrics to increase access of care and promote health care to its residents.

Current Access to Care

The rural hospital is a community hospital founded in 1867 by the Union Pacific Railroad (CRMC, 2011). The hospital is a 218 bed facility and is split into three campuses. The West Campus hosts acute-care services including a trauma center, inpatient and outpatient surgery, intensive care, physical therapy, obstetrics, neurology, cardiology, oncology, endoscopy, and a flight team. The East Campus hosts most of the outpatient services for the hospital, including a rehabilitation center, and behavioral health services. The third campus hosts the physician's office building where varying specialist's offices are located with direct access to the inpatient facility. The health care plaza is located 0.5 miles from the hospital and host primary care providers, outpatient laboratory, outpatient radiology, and the new Program of All-Inclusive Care for the Elderly (PACE) (CRMC, 2011).

Wyoming is ranked 47th in the number of physicians per 100,000 resident populations in 2006, with 148 doctors per 100,000 people. The national average is 267 per 100,000 (U.S. Census Bureau, 2011). There are only 89.6 primary care physicians per 100,000 in Wyoming

(American Health Rankings, 2012) and only 61 primary care physicians per 100,000 in Laramie County (Dartmouth Atlas of Healthcare, 2013). The Laramie County Needs Assessment (2005) reported 185 physicians in active practice, 33 advanced practice registered nurses (23 with prescriptive authority) and 838 registered nurses.

Strengths/Weaknesses

A strengths/Weaknesses/Opportunities/Threats (SWOT) assessment was conducted for analysis prior to the project to assess the strengths, weaknesses, opportunities, and threats that the project investigator encountered and the applicability of the project. The strengths of the study were identified and included the benefit to the patient through scripted communication tool AIDET to decrease anxiety. HCAHPS patient satisfaction survey is a lengthy survey with 64 total questions depending on how the patient answers the questions the questioner self-guides the patient through the survey. Since patient satisfaction is essential to physician and nurse performance this evidence based project benefits hospital, physicians, nurses, and introduces the role of a Doctor of Nursing Practice (DNP) clinician and the benefit of advanced education (Appendix H).

The weaknesses of the study were a small sample size and limited resources. The study findings provided scripted communication tool of AIDET by identifying five different communication questions regarding the physician and nurse. The small sample size was felt to be a threat because it could affect the power of the statistical analysis, the potential for limited patient participation was a concern because without it data collection would be hindered, and the potential reimbursement for hospital services would decline reducing services available to

patients and the community. The SWOT analysis provided guidance to the researcher as the project was undertaken. The SWOT analysis is displayed in Table

Stakeholders

Although the current health care system prolongs and saves many lives it is costly. Patients, physicians, nurses, and hospitals are stakeholders due to increasing cost and utilization of healthcare services. Changing the hospital environment to a patient centered environment will require a shift thought processes and practices from a disease focus to quality outcomes by hardwiring high performance.

Hospitals are required to submit a minimum of 300 HCAHPS surveys of eligible patients (18 years or older discharged from general acute care hospital after an overnight stay) for a reporting period (Studer, 2010). The survey questions measured frequency rather than satisfaction on six composites questions regarding communication with providers and nurses, responsiveness of hospital staff, pain management, communication about medications, cleanliness of hospital, and quietness of the hospital (Studer, 2010). There are three additional HCAHPS questions focusing on discharge information, willingness to recommend the facility using a “Yes” or “No” answer, and overall rating of the hospital from 0-10. The percentage of patients who give the hospital a rating of nine or ten are top-box results, as well as the percentage of patients who report a definite yes, they would recommend the hospital (Studer, 2010). Hospitals are striving for top box results because it demonstrates best practices.

Hospitals are required to focus on the clear connection between quality and patient satisfaction while creating a culture of excellence vital to the hospital success (Studer, 2010). Creating a patient centered culture through HCAHPS top box results is requiring hospitals to

contract with outside vendors such as The Studer Group who specialize in hardwiring high performance while creating a patient centered environment.

Cost-Benefit Analysis

The hospital contracts with Press Ganey to conduct its HCAHPS survey via mail. According to Jordon, White, Joseph, and Carr, D. (2005) the estimated HCAHPS cost \$15-\$25 per completed survey. This estimate is based on the cost of non-representative scan of survey companies. While another major hospital vendor who collects patient satisfaction data decided it would distribute HCAHPS at no cost to hospitals. But the overall estimation of costs to hospitals for distributing the HCAHPS survey was \$8.65 per complete survey assuming hospitals conduct two waves of mailing as is called for in the framework endorsed by the AHRQ (Jordon et al., 2005).

An aspect to consider is that over time the price of collecting HCAHPS via mail may decrease if there is a significant market for collecting HCAHPS as a standalone instrument. One reason for this is that the HCAHPS instrument is widely available and depending on how CMS chooses to approve companies for HCAHPS collection, there may be few barriers to entry (Jordon et al., 2005).

Phone survey costs for HCAHPS are estimated to be between \$35 to \$75 ranges. As with the mail survey costs, these estimates are based on the cost by scan of survey companies utilized in the past (Jordon et al., 2005). The data for mixed mail and phone costs are unreliable and vendors of patient satisfaction surveys are unable to estimate this information. Active collection through a secure web site is a new concept that may estimate an overall cost of approximately \$3000 per hospital (Jordon et al., 2005). Estimated overall costs associated with the HCAHPS

survey is between \$3,300 and \$4,575 for hospitals collecting survey data for 300 patients. Given these estimations the nationwide cost of implementing HCAHPS as a stand-alone instrument is between \$13.8 and \$19.1 million, assuming all eligible hospitals chose to participate (Jordon et al., 2005).

Costs related to the implementation of the Capstone Project were determined based on The Service Excellence Department existing workload and CMS requirements. The costs were determined to be minimal due to the use of the existing patient satisfaction survey process, hardware, contracts with Press Ganey, personnel, and facility access. Time meeting with the statistician and time away from patient care were calculated and found to be minimal.

The benefits of the Capstone project and HCAHPS surveys are designed to support consumer choice, encouraged physician and nursing accountability, and create patient perspective-driven performance incentives. Eventually all reimbursement will be focused on patient outcomes and performance so patients can choose who they entrust their healthcare to (Studer, 2010).

Mission/Vision/Core Values of the Capstone Project

The mission statement of this capstone project is to study the effects of scripted communication on patient satisfaction surveys measured by HCAHPS. The vision is to assess the rural hospitals patient satisfaction and growth by utilizing The Studer Groups communication process of AIDET. The core values of The Capstone Project include respect, autonomy, diversity, dignity, collaboration, teamwork, and quality evidence based patient centered care.

Goals

The goals for this Capstone Project are to improve communication between physicians, nurses, patients, families, employees, volunteers through the use of AIDET to decrease anxiety. As the hospital focuses on the HCAHPS and Press Ganey patient satisfaction surveys it hardwired a culture of excellence, high performance, and assured optimal reimbursement for services provided. The patient satisfaction surveys will encourage patient centered healthcare collaboration, growth, and loyalty to the community and state of Wyoming.

Participation in the Study

There were no known risks of the study to patients who participate in the HCAHPS patient satisfaction survey. There was a possibility the patient may not honestly answer the questions for fear of being identified through their answers. There was no known threat to safety as this is not a vulnerable population. This study did not have any impact on the individual patients and their personal health care. There is not a financial incentive for subjects to complete the surveys. There are no known future risks to patients who participate in the survey process.

Benefits of the Study

Participating in HCAHPS patient satisfaction survey encourages patient centered care by identifying patient perspectives of the care they are receiving at a rural hospital in Wyoming. An unintended consequence of patients not participating in the survey process is poor patient satisfaction, misunderstanding of what patients and community health and medical needs, decreased future reimbursement leading to a decrease ability to provide health care services, advanced life saving services, employ physicians, advanced practice providers, specialists, and support staff driving healthcare out of the community and state. A potential benefit to answering the survey is assisting the rural hospital to gain an understanding of patient satisfaction through

the eyes of the patient and community to improve its services. Patients benefit when patient satisfaction is high and play active roles in their health care.

Logic Model

The conceptual model of research selected for this capstone project is the logic model that according to Zaccagnini and White (2011) is a detailed picture of how the project will flow from beginning to end (see attachment B) . It is important to explore the phenomenon of caring on patient-provider relationship (Dunn, 2011). Does caring impact patient-provider relationships and outcomes? Residents of Wyoming are experiencing a shortage of healthcare providers increasing crisis care and overflow of unnecessary emergency services (CRMC, 2011). The desired outcome is to build caring patient-provider relationships, increase patient satisfaction, encouraged patient responsibility, build a healthier community, while reducing crisis care. Patient-provider relationships should be based on open communication, respect, human needs, value systems, and security (Studer, 2010). Strategies for developing patient-provider relationships are to spend uninterrupted time with patients, cultural sensitivity, supportive environment, and application of Dr. Katharine Kolcaba's, Dr. Jean Watson's, and Kurt Lewin theories. Practicing according to the comfort, caring, and change theories enables patients to feel valued, part of the decision making process, confident, and responsible for their health care outcomes (Dunn 2011).

The Studer Group (2010) encourages patient centered care by clearly communicating with patients through implementing individualized patient care at the time of admission. The hospitals mission and value statement is to consistently provide excellent care to patients (CRMC, 2011). Increasing patient satisfaction through the patient centered approach is

important for Wyoming to understand the values and needs of its communities and state. Encouraging communication is essential to measuring patient satisfaction by asking standardized measurable patient centered questions. Utilizing a white communication board in patients rooms eases expectations by clearly communicating who is taking care of them, upcoming procedures, medications, and encourages patient's and family members to write their questions for physicians and nurses to answer.

Physicians, advanced practice nurses, nurses, employees, and support staff encouraged communication by utilizing AIDET. Focusing on individual patient needs encourages providers, nurses, and support staff to interact respectfully. Recapping patient responses by actively listening creates comfortable caring patient centered environment. Updating and answering communication boards consistently is vital (Studer, 2012).

Population/Sampling Parameters

Patients who were admitted to the hospital and were deemed status of an inpatient were considered for a HCAHPS patient satisfaction survey if they were not a newborn, deceased, a ward of the state, or a No Publicity patient (CRMC, 2012). Patients with duplicate admissions and discharges within the same month or who already received an HCAHPS survey within 90 days, missing diagnoses, and discharge dates will be further investigated before a patient can receive a survey. The HCAHPS survey can only be sent every 90 days per The Agency for Healthcare Research and Quality (CRMC, 2012).

Setting

This study took place at a rural hospital in Wyoming inpatient population from November 1, 2012 through January 1, 2013 and sought for a sample size of N= 150. The

potential threats to the study's validity include a low statistical power, missing data, and the length of the HCAHPS survey. As patient's filled out the HCAHPS survey their answers directed them through the survey any missing data could affect the study outcome.

The hospital contracted with Press Ganey and sent all its qualifying inpatient admission data for further review. Press Ganey evaluated inpatient's data and electronically selects a simple random sample of eligible inpatients to receive the HCAHPS survey. Patients were mailed a self-addressed postage paid HCAHPS patient satisfaction survey with a cover letter explaining the purpose and importance of the survey. When the patient satisfaction survey was completed it was considered consent of participation. The survey was mailed back to the rural hospital where it was directed to the service excellence department. For this evidence based project I worked alongside the hospital's statistician for review and statistical analysis for physician and nurses' communication.

Protection of Human Rights

Press Ganey evaluates inpatient's data and electronically selects a simple random sample of eligible inpatients to receive the HCAHPS survey. The fidelity and veracity of the HCAHPS patient satisfaction survey was confidential. All subject information was anonymous. The patient satisfaction surveys were kept in the service excellence department accessible only by employees name with badge clearance. All surveys and statistics were compiled on a secure password restricted computer.

The project investigator as well as the Capstone Chair has successfully completed the CITI training developed to ensure the project investigator is adequately prepared for ensuring protection of human subjects (Appendix C). The Capstone project was approved by Regis

University Institutional Review Board (IRB) as well and the rural hospital Compliance Department who contracts with a separate IRB committee. Letters of approval were obtained and are kept on file (Appendix D & E).

Methodology/Instrumentation/Measurement

This study is a retrospective data analysis of aggregate HCAHPS information from November 2012 through January 2013. The study included more than 175 physicians who actively practice and maintain their privileges at the hospital, 1800 plus employees including advanced practices nurses and nursing staff, and 200 plus support staff who have completed orientation and training phase with The Studer Group.

Patients who were admitted to the hospital and deemed status of an inpatient considered for the HCAHPS patient satisfaction survey if they were not a newborn, deceased, a ward of the state, or a No Publicity patient (CRMC, 2012). Patients with duplicate admissions and discharges within the same month or who already received an HCAHPS survey within 90 days, missing diagnoses, and discharge dates were further investigated before they received a survey. The HCAHPS survey was only sent every 90 days per The Agency for Healthcare Research and Quality (CRMC, 2012)

The study variables and outcomes were determined by a review of professional literature, CMS guidelines, and reimbursement changes. The independent variable was scripted communication with the use of AIDET measured by the HCAHPS survey. The dependent variable was patient satisfaction. The extraneous variables were the patients' health status, emotional health status, and highest level of education, ethnicity, and any assistance filling out the survey.

The level of measurement was ordinal as identified by using a likert scale questionnaire. The HCAHPS survey was subjective, 25 questionnaire with seven background questions and ten specific subsets to patient satisfaction, and the patients were asked to rate the following items: nurse/assistant, physician, care from physician, nurse, your care from this physician during your most recent visit, personal issues, overall assessment (Studer, 2010) (Appendix F & G). The descriptive statistics were used to describe the study population characteristics and represented by graphs. The goal was to examine HCAHPS patient satisfaction scores and identify communication by physicians and nurses utilizing AIDET to increase patient satisfaction. Tables and graphs as appropriate were used to represent the results.

Budget/Resources

As the health care system reimbursement transitions from a pay for reporting to a pay for performance system the rural hospital is actively hardwiring high performance to its physicians, nurses, and support staff. To do this the hospital created a Service Excellence Department that works directly with Press Ganey gathering patient information on admissions and discharges to identify eligible patients for the HCAHPS and/or Press Ganey survey. The service excellence department employs a full time statistician to perform statistical analysis on the HCAHPS and patient satisfaction data, interpret the data, and communicate the data by generating reports to the hospital board of directors, administrators, supervisors, managers, employees, and community (CRMC, 2012).

Areas of improvement, successes, and high or low performing departments are identified through the HCAHPS survey. Compared to the national standards available to the public to view and make choices regarding their healthcare. One fifth of the service excellence budget is spent

on HCAHPS patient satisfaction survey. The rural hospital believes in its mission and values contracting with The Studer Group to create a culture of excellence (CRMC 2011). Patient centered communication is important to the hospital holding its physicians, nurses, employees, and volunteers accountable by always applying AIDET with all communication processes. The belief was AIDET reduces anxiety levels in patients, family members, and support systems leading to better patient outcomes and increasing patient satisfaction. The rural hospital is striving to become a leader in patient satisfaction throughout the state of Wyoming.

This project did not require any budget increases in the service excellence department there was a time constraint for the service excellence statistician who I worked alongside gathering data and interpreting data. The rural hospital and the service excellence department supported this study and were willing to invest the extra time needed to encourage its physicians and nurses to improve healthcare in Wyoming.

Project Findings and Results

The Capstone project findings are reported and organized by objective. The first objective of the assessment was to evaluate the patient's perception of communication by the physicians and nurses utilizing the scripted communication tool of AIDET. The second objective was to evaluate growth and recommendation of the rural hospital by inpatients. The goal was to have 150 patients who were admitted to the rural hospital in Wyoming answer and complete the HCAHPS patient satisfaction survey. Therefore, the population was 617 inpatients and the sample size was 348 respondents. The demographic characteristics reported were age, race, and gender (Table I 4).

The data was entered into Excel for Windows 7. Data collection for the population included age, race, educational level, mental or emotional health, overall health status, HCAHPS scores, communication between patients, physicians, and nurses. Descriptive statistics were used to describe the study population characteristics and represented by graphs. The HCAHPS standardized patient satisfaction survey was used to defined and standardize patient satisfaction for all patients admitted to the hospital. The mean, median, and range were calculated when appropriate and the descriptive statistics were represented appropriately by graphs.

The first objective was to identify if patients felt the physicians and nurses were communicating in a way that decreased their anxiety level. There was not an end domain for scripted communication by physicians and the categories were separated into never, sometimes, usually, and always. Physicians who never utilized AIDET per patient perception were 0.8%. Physicians who sometimes used AIDET were 3.4%. Physicians who usually used AIDET were 17.6%. Physicians who always used AIDET were 78.3% (Table I 10).

Patients who felt the physicians treated them with courtesy and respect were separated into categories of never, sometimes, usually, always. A total of 348 respondents answered the HCAHPS patient satisfaction survey. Two respondents answered they never felt treated with respect by physicians for a total of 0.6% of the patients. Six of the respondents felt they were sometimes treated with courtesy and respect by the physicians for a total of 1.7% of patients. Thirty eight of the respondents felt they were usually treated with courtesy and respect by the physicians for a total of 10.9 % of patients. Three hundred and three of the respondents felt like they were always treated with courtesy and respect by the physicians for a total of 86.5% of the patients. The mean of patients who felt physicians treated them with courtesy and respect was 87.25 %, the median was 22%, and the range was 301 (Table I 7).

Do physicians listen carefully to patients? The categories are never, sometimes, usually, and always. Three respondents felt the physicians did not listen carefully to them for a total of 0.9% of patients. Fifteen of the respondents felt like sometimes they were listened to by physicians for a total of 4.3% of patients. Sixty nine of the respondents felt they were usually listened to by physicians for a total of 20% of patients. Two hundred and fifty eight respondents felt they were always listened to carefully by physicians for a total of 74.8 %. The mean of physicians listening carefully to patients was 86.25%, median was 42%, and the range was 255 (Table I 8).

Do physicians explain in a way patients can understand? The categories are broken into never, sometimes, usually, and always. Three respondents felt the physicians never explained in a way patients understood for a total of 0.9% of patients. Fourteen of respondents felt the physicians sometimes explained in a way they understood for a total of 4.1% of the patients. Seventy five of the respondents felt the physicians usually explained in an understandable manner for 21.9% of the patients. Two hundred fifty one respondents felt the physicians always explained in an understandable manner for a total of 73.2% of patients. The mean of physicians explaining in an understandable manner to patients was 86.75%, the median was 44.5%, and the range was 248 (Table I 9).

Scripted communication by the nurses was categorized into never, sometimes, usually, and always without an end domain. Nurses who never use scripted communication of AIDET with patients were 0.2%. Nurses who sometimes utilized AIDET were 3.7%. Nurses who usually utilize AIDET were 18.7%. Nurses who always apply AIDET were 77.3% (Table I 14).

Do nurses treat patients with courtesy and respect? The categories were broken into never, sometimes, usually, always. No patients answered the never category. Four respondents felt they were sometimes treated with courtesy and respect by the nurses for a total of 1.2% of patients. Forty one of the respondents felt they were usually treated with courtesy and respect by the nurses for 11.8% of the patients. Three hundred and two respondents felt they were always treated with courtesy and respect by the nurses for a total of 87.0% of patients. The mean for nurses who treat patients with courtesy and respect was 86.75%, the median was 22.5%, and the range was 302 (Table I 11).

Do nurses listen carefully to patients? The categories are broken into never, sometimes, usually, and always. The never category did not have any respondents. Fifteen respondents felt the nurses sometimes listened carefully to them representing 5.8% of patients. Eighty one of the respondents felt the nurses usually listened to them representing 23.3% of patients. Two hundred and fifty one of the respondents felt they were always listened to carefully by the nurses representing 87.0% of the patients. The mean of nurses listening carefully to patients was 86.75%, median was 48%, and the range was 251 (Table I 12).

Do nurses explain in a way patients can understand? The categories are broken into never, sometimes, usually, and always. Two respondents felt the nurses never explained in a way patients understood representing 0.6% of patients. Twenty respondents felt the nurses sometimes explained in understandable manner representing 5.8% of the patients. Seventy three respondents felt the nurses usually explained in an understandable manner representing 21.0% of patients. Two hundred fifty two respondents felt the nurses always explained in an understandable manner representing 72.6% of the patients. The mean of nurses communicating

in an understandable manner was 86.75%, the median was 48%, and the range was 250 (Table I 13).

The second objective was to measure patients who responded to the HCAHPS patient satisfaction survey who would recommend the hospital. There are ten categories zero through ten. The top box goal for HCAHPS scores are a nine or a ten for all hospitals and in the future these scores will impact hospital reimbursement. The scores were obtained from 348 respondents and analyzed through frequency and percentages. Top box nine and ten had 221 respondents and 63.5% of patients recommending the hospital. Box eight had 77 respondents and 22.1% of patients recommending the hospital. Box seven had 21 respondents and 6% of patients recommending the hospital. Box six had six respondents and 1.7% of patients recommending the hospital. Box five had 12 respondents and 3.4% of patients recommending the hospital. Box four had three respondents with 0.9% of patients recommending the hospital. Box three had three respondents with 0.9 % of patients recommending the hospital. Box two had one respondent with 0.3% who would recommend the hospital. Box one had three respondents and 0.9% of patients recommending the hospital. Box zero had one respondent with 0.3% of patients recommending the hospital. The overall recommendation of the hospital was 62%.

The global rating item measured for recommendation of the hospital were categorized from definitely no, probably no, probably yes, and definitely yes. A total of 348 patients responded to the HCAHPS survey question if they would recommend the hospital. The definitely no category had six respondents and 1.7% of patients would not recommend the hospital. The category of probably no had 12 respondents and 3.4% of patients that would not recommend the hospital. The category of probably yes had 115 respondents and 33.0% of

patients recommending the hospital. Definitely yes category had 215 respondents and 61.8% of patients recommending the hospital (Table I 15).

There is a positive relationship identified with patient satisfaction and physician and nurse communication with patients. The scripted communication tool AIDET (Acknowledge, Introduce, Duration, Explanation, and Thank you) decreases patient and family anxiety while promoting patient participation and increased outcomes in health care. The HCAHPS patient satisfaction survey uses questions that identify care and communication process of the physicians and nurses. Questions that identify communication processes were “During your hospital stay, how often did the doctors nurses and treat you with courtesy and respect? During this hospital stay, how often did the doctors and nurses listen carefully to you? During this hospital stay, how often did the doctors and nurses explain things in a way you could understand (CRMC, 2012)? All hospitals will be required to participate in the HCAHPS patient satisfaction survey because it is the only standardized patient satisfaction tool to be utilized in the future for identifying quality measurements, quality patient care per provider, health care outcomes, and in the future reimbursement based on quality, outcomes, and patient satisfaction.

The scripted communication tool of AIDET helped the rural hospital decrease patient anxiety by requiring its physicians and nurses to attend workshops on communication. The patient perception of physicians communicating with patients was 78 %. The patient perception of nurses communicating with patients was 77.3% Physicians who always used AIDET communicated with patients felt they were being treated with courtesy and respect were 87.25%, listened carefully to them 86.25%, and explained in an way they understood was 85.75%. Nurses who always used AIDET to communicate with patients felt they were being treated with

courtesy and respect were 86.75%, listened carefully was 86.75%, and explained in way they understood was 72.3% (Table I 10 & I 14).

The dependent variable in this study was identified as patient satisfaction. The extraneous variables are patient perceptions of communication, patients' health status, emotional health status, and highest level of education, and ethnicity. The recognition of these variables associated with a patient or family perception of care and communication by the physicians and nurses were enhanced through the use of the scripted communication tool of AIDET.

Limitations/Recommendations/Implications for Change

Limitations

There were limitations to the capstone study. The first limitation was the small sample size because of the rural hospital in Wyoming. A longer data collection period would have resulted in more respondents, longer data collection period, and a longer timetable. The small population sample was a limitation because of the low statistical power of the information provided. The second limitation was educating the community and inpatients on the importance of the HCAHPS patient satisfaction survey in gaining the patient and community perspective on health care provided by the hospital. Patients deemed as inpatients and eligible to participate in the patient satisfaction survey received cover letter and 64 page survey if no response they received a second survey encouraging to participation. The second attempt may deter the patient from participating in the study because of feeling pressured or feel overwhelmed with the length of the survey.

The third limitation was it was the first evidence-based practice study lead by a practicing nurse practitioner and Service Excellence Department as it is not a research institution. This was

a limitation because of the staff and The Service Excellence did not understand each other's purpose and goals for the study. The Service Excellence staff required verbal and written education of the purpose of the study and how the study would benefit the rural hospital and its providers on understanding the importance of scripted communication, patient satisfaction, and patient outcomes.

Recommendations/Implication for change

Based on the Capstone project the recommendation and implications for change are addressed at this time based on the respondents studied and the variables associated with patient satisfaction measured by the patient satisfaction survey of HCAHPS. The first recommendation was for all physicians and nurses to use the scripted communication tool of AIDET by acknowledging the patient by name and introducing themselves, experience, and specialty. The second recommendation was mandatory communication workshops for physicians held once a quarter offered at two different times during the day. The third recommendation was for mandatory communication workshops for nurses held once a quarter offered several times a day for the nursing staff. The fourth recommendation is for physicians and nurses to sit at the bed side and position themselves in close proximity with the patient or family member, discuss their illness, and goals of care while allowing time for patients to ask questions. The fifth recommendation was for the physician or nurses to write down information so patients can read it and have time to process the information. The sixth recommendation was to give patients accurate estimation of time frames and communicate with them when a time frame may have to change or be extended.

An area that requires further research is how to measure AIDET with every patient interaction and especially patients with extended lengths of stays or patients who already have a therapeutic relationship with their physicians and nurses? Patients feel disrespected when the physician or nurse introduces himself or she with every visit, does not sit down, or does not listen to patient or family concerns because they are focusing on using the scripted tool of AIDET. Patients admitted to the hospital need to know their physicians, nurses, and healthcare team is there for them applying evidence based research, providing encouragement, support, empathy, and the resources available to embrace better patient outcomes.

Implementing comfort, caring, and change theories in health care and throughout this Capstone project was difficult because of individual personal needs, goals, and fear of change. Physicians, nurses, and support staff were educated on the importance of Dr. Kolcaba comfort theory, Dr. Watson's caring theory, and Kurt Lewin's change theory through the assistance of The Studer Group. The change, comfort, and caring theories promotes wellness through individually treating patients in an open, warm, comfortable, and patient centered environment increasing patient satisfaction, outcomes, and reimbursement.

The finding of the Capstone Project is summarized. Scripted communication of AIDET enhanced communication between the respondents regardless of age, race, gender, educational level, health, or emotional health. The average physician's communication score was 78.3% and the nurses were 77.3%. Additional questions were used to evaluate the application of AIDET between patients, physicians, and nurses who strive to treat patients with respect, listen carefully to them, and explain in an understandable manner. The physicians average communication score associated with courtesy and respect was 87.25%, listening carefully was 86.25%, and explaining in an understandable manner was 85.75%. The nurse's average communication score associated

with courtesy and respect was 86.75%, listening carefully 86.75%, and explaining in an understandable manner was 72.3%. Sixty one point eight percent of the respondents who experienced scripted communication process of AIDET would definitely recommend the hospital to others (Table I 15 & I 16).

Conclusion

The healthcare system is a complicated technological system that is eradicating diseases that once took the lives of many young and middle aged people. As technology increases patients are living longer and in some cases requiring expensive medical therapies. Unfortunately this is increasing health care costs and is wreaking havoc within a troubled system forcing people to go without health care (Dunn, 2011). This has led to an increase in health care costs and is driving crisis care. The Centers for Medicare and Medicaid services together with the AHRQ has created the HCAHPS survey. HCAHPS measures patient satisfaction while increasing focus on patient centered care, patient participation, and improved health care outcomes (Studer, 2010). Patient satisfaction is changing the health care reimbursement system from a pay for reporting system to a pay for performance system.

It is now more important than ever for hospitals to hardwire high performance by its physicians and nurses. HCAHPS will produce comparable data on patients' perspective of care so that consumers can make objective and meaningful comparisons among hospitals. Enhance public accountability in healthcare by increasing the transparency of quality hospital care. All while creating incentives for hospitals, physicians, and nurses to improve their quality care (Studer, 2010). Scripted communication tool of AIDET enhanced communication between the respondents regardless of age, race, gender, educational level, health or emotional health. The

average physician's communication score was 78.3% and the nurses was 77.3%. Meeting the rural hospitals goal of providing a patient centered environment where its physicians, nurses, and support staff are hardwired for excellence and quality assurance.

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Appendix A

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
1	<p>AIDET/TrueCare Standards Policy.</p> <p>Cheyenne Regional Medical Center Policy.</p> <p>2011.</p> <p><u>Will Use This Policy</u></p> <p>This is a CRMC Policy regarding scripted communication so it will be a big part of my project.</p>	Policy Implementation.	<p>Adopted with the assistance of The Studer Group.</p> <p>Power: None Noted</p>	<p>Implemented policy and behavior standards required for all staff working at Cheyenne Regional Medical Center.</p> <p>All staff including providers attends an orientation process learning about the importance of scripted therapeutic communication by the utilization of "AIDET" adopted from The Studer Group. Quarterly in-services and yearly regarding communication and therapeutic patient provider relationships.</p> <p>Staff, providers, CRMC, and CRPG creating supportive caring environments.</p>	<p>Scripted communication. Contracted services from The Studer Group.</p> <p>Supervisors and admin team monitor all communication throughout hospital.</p> <p>Funding sources: Contracted with The Studer Group.</p>	<p>Reducing patient anxiety by increasing patient satisfaction with the use of "AIDET".</p> <p>A= Acknowledge I= Introduce D=Duration E= Explanation T=Thanking.</p> <p>TrueCare Standards encourage staff and providers to act responsibility with all interactions throughout the hospital and clinics.</p>	<p>Evidence</p> <p>Level: VII</p> <p>Expert</p> <p>Opinion</p> <p>The Studer Group</p>	<p>Google Scholar:</p> <p>The Studer Group</p> <p>Cheyenne Regional Medical Center.org</p> <p>AIDET Communication Policy</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
2	<p>Why should I talk about emotion? Communication patterns associated with physician discussion of patient expressions of negative emotion in hospital admission encounters.</p> <p>Adams, K., Cimino, J.E.W, Arnold, R.M., Anderson, W.G. (2011).</p> <p><u>Will Use This Article</u></p> <p>Provider beliefs regarding communication and emotions.</p>	<p>Patient Education and Counseling.</p> <p>Qualitative Analysis of physician-patient admission encounters audio recorded between Aug 2008 and March 2009 at two hospitals.</p>	<p>Adult patients who are admitted within the University Hospital System August of 2008 to March of 2009.</p> <p>A codebook was iteratively developed to identify patients' verbal expressions of negative emotion. Physicians' were categorized responses by their immediate effect on further discussion of emotion.</p> <p>Power: Was not noted.</p>	<p>In the 79 patients' encounters with 27 physicians, the median expression of negative emotion was 1. Range was 0-14. Physician responses were 25% away, 43% neutral, and 32% toward.</p> <p>Neutral and toward responses elicited patient perspectives, concerns, social and spiritual issues, and goals for care. Toward responses demonstrated physicians' support, contributing to physician-patient alignment and agreement about treatment.</p>	<p>Non-verbal communication was not studied.</p> <p>Patient and provider may have been affected by recording.</p> <p>Unable to record all eligible encounters.</p> <p>Only two University hospitals were studied.</p> <p>Funding Sources: University of California.</p>	<p>Hospitalized patients frequently expressed negative emotion during physician admission encounters. Neutral and toward responses were associated with patient disclosure of information about social issues, concerns, and goals for care.</p> <p>Empathic and sympathetic responses conveyed support, aligned the physician and patient, and contributed to agreement about treatment plans. They help build rapport, enhance trust in the physicians and healthcare system. and increase adhere</p>	<p>Evidence</p> <p>Level: V</p> <p>Qualitative Study.</p>	<p>CINAHL:</p> <p>Physician-patient communication</p> <p>Hospital</p> <p>Emotional</p> <p>Empathy.</p>

No.	Article Citation	Study Design	Sample Size & Statistical	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
3	<p>Further examination of the impact of patient participation on physicians' communication style.</p> <p>Cegala, D.J., Chisolm, D.J., Nwomeh, B.C. (2011).</p> <p>Patient Education and Counseling.</p> <p><u>Considering use</u></p> <p>Article is good but is limited to pediatric patients and their parents or guardians</p>	<p>Audio tapes of 7 pediatric surgeons and 68 of their patients' parents/guardians were coded and examined for physician information exchange.</p>	<p>The audiotapes of 7 pediatric surgeons and 68 of their patients' parent/guardians were coded and examined for physicians' information exchange and support utterances as they interacted with parent/guardians with varying degrees of participation.</p> <p>Multilevel regression.</p> <p>Power</p> <p>R=.58, p<.001, two tailed for volunteered communication by physicians</p>	<p>The results of a multilevel regression analysis showed, consistent with related research, that the same physicians were more informative overall the provided more information in response to parents' questions when interacting with high participation parents.</p> <p>Participation was not associated with physicians' volunteered information, general explanations, or support utterances.</p>	<p>Small sample sized and a single setting. A larger sample of physicians' and parent would lend more confidence in the results, and data collection at multiple sites would bolster generalizability to the pediatric surgery context. Plus the lack of comparability to other specialist.</p> <p>Funding:</p> <p>NCH Research Institute and Thomas Boles Fund, both of Nationwide Children's Hospital, Columbus, OH.</p>	<p>The results of the multilevel regression analysis showed that surgeons were more responsive to parents/guardians who were more interactive.</p> <p>Surgeons may provide detailed information to patients who are active in the pre-op visit. This increases the validity of informed consent, and surgical procedure.</p>	<p>Evidence Level: VII</p> <p>Regulator/expert committees</p>	<p>CINAHL:</p> <p>ELSEVIER</p> <p>Patient participation</p> <p>Patient centered</p>
4	<p>Health Capital Topics</p> <p>January, 2011</p> <p><u>Not going to use:</u></p> <p>Although informative article I am not going to use it.</p>	<p>Not a research article. Informative article on The Healthcare Reform and the impact it has on hospitals.</p> <p>Tax -exempt hospitals.</p> <p>This article for lay public regarding future health care and tax-exempt hospitals.</p>	<p>Again not a research article</p> <p>Informative article separating out tax-exempt hospitals.</p> <p>Power:</p> <p>No power noted.</p>	<p>To promote the goals of lowering healthcare costs and increasing the quality of patient care, two payment systems are going into effect with a goal to directly tie reimbursement to performance.</p>	<p>Bias more informative article stressing the importance of the change in reimbursement system that will effect reimbursement.</p> <p>Funding Source:</p> <p>Health Capital- General source on healthcare within the U.S.</p>	<p>A written financial assistance policy which creates criteria for eligibility for financial assistance. Creating basis for calculating amounts charge to patients. And what steps will be taken for non-payment.</p>	<p>Evidence Level: VII</p> <p>Expert Opinion.</p>	<p>Google Scholar</p> <p>Behavior Modification Techniques.</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the	Data Bases Investigate
5	<p>How to increase employee retention and drive higher patient satisfaction.</p> <p>Hotko, B. (2011).</p> <p>The Studer Group.</p> <p><u>Will Use:</u></p> <p>This article supports the stance on scripted communication by The Studer Group.</p>	<p>Conducting hourly nursing rounds on inpatients within a hospital that is contracted with The Studer Group.</p>	<p>Importance of hourly nursing rounds in the hospital for in patients. Increases communication and reduces anxiety for patients and family members. Introduction of office staff by utilizing "AIDET" to improve clinic outcomes by reducing patient anxiety levels and identifying patient and clinical issues before they reach a critical level.</p> <p><u>Power:</u></p> <p>No power noted.</p>	<p>Patient and employee satisfaction by encouraging hourly rounding and building of patient and family relationships.</p> <p>Process improvement areas and sharing them.</p>	<p>Rounding for Outcomes.</p> <p>Staff required no matter what they are doing rounding on their patients hourly.</p> <p><u>Funding source:</u></p> <p>Contract with The Studer Group.</p>	<p>Rounding on patients is essential to build relationships and reduce patient anxiety levels.</p> <p>Nursing, providers, administrators, and support staff will learn what is working and what is not. Better anticipation of patient needs.</p> <p>Identification process improvement areas (What systems can be working better).</p>	<p>Evidence Level I: VII</p> <p>Expert Opinion from The Studer Group.</p>	<p>Google Scholar</p> <p>The Studer Group</p> <p>Hourly rounding.</p> <p>Communication.</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the	Data Bases Investigate
6	<p>Patient trust in physicians and adoption of lifestyle behaviors to control, height, blood pressure.</p> <p>Jones, D.E., Carson, K.A., Bleich, S.N., Cooper, L.A. (</p> <p>Patient Education and Counseling.</p> <p><u>Not using this study.</u></p> <p>Although shows the importance of communication it is more dx focused.</p>	<p>Longitudinal analysis of data from a randomized controlled trial of interventions. The goal was to enhance patients with HTN compliance to medications and lifestyle modifications.</p>	<p>The goals of this study were to assess the relationship between patients and their providers. Trust that builds between the provider and patient leading to lifestyle modification and acceptance of disease process.</p> <p>To participate in this study the patient had to have HTN.</p> <p><u>Power:</u></p> <p>95% CI = 1.38-3.74 behavior modification of trying to lose weight when they trusted their physician.</p>	<p>The longitudinal analysis of data from a randomized controlled trial of interventions. The goal was to enhance patients with HTN compliance to medications and lifestyle modifications.</p> <p>There were 200 patients seen by 41 physicians at 14 different urban primary care practices in Baltimore, Maryland and followed for 12 months.</p>	<p>Larger patient samples with ethnically and socially diverse populations. Use of more objective measures of lifestyle modification and medication adherence.</p> <p><u>Funding source:</u></p> <p>Grants from the National Heart, Lung, and Blood Institute.</p>	<p>It was found that 70% of patients reported they had complete trust in their physician and were trying to make the suggested lifestyle modifications.</p> <p>Trust in one's physician predicts attempts to lose weight among patients with HTN and may contribute to attempts to consume salt and increase exercise.</p>	<p>Evidence Level I: II</p> <p>Randomized control trial of interventions.</p>	<p>CIN AHL</p> <p>Adherence</p> <p>African-Americans</p> <p>Blood Pressure Control</p> <p>Hypertension</p> <p>Trust</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
7	<p>Curtains Up! Using forum theatre to rehearse the art of communication in healthcare education.</p> <p>Middlewich, Y., Kettle, T.J., Wilson, J.J. (2011).</p> <p>Nurse Education in Practice.</p> <p><u>Will Use This Article.</u></p>	Teaching and developing communication skills in healthcare education is becoming more than ever important so that best proactive can be achieved.	<p>Teaching communication skills to students within the educational setting. Using didactic approaches.</p> <p>To be included in the study students had to be in a program within healthcare education.</p> <p>Power: Power was not noted.</p>	<p>Teaching students in the healthcare field to develop high level communication skills. Didactic approaches help students practice communication styles and opportunities to learn from the didactic approaches.</p> <p>Students in the healthcare field are required to develop technical skills and learn effective communication styles. Effective communication styles are important in developing patient relationships and impacting healthcare outcomes.</p>	<p>Not really a research article that was funded. Suited more as a discussion on the importance of teaching communication styles and learning various styles to impact optimal outcomes.</p> <p>Funding Source: None listed was an article written by University Lectures in the healthcare setting.</p>	The article focuses on using experiential theatrical techniques to allow students to explore and practice multiple ways of communicating without resorting to scripted answers for given situations.	<p>Evidence Level: VII</p> <p>University Lectures in the Healthcare setting.</p>	<p>CINAHL: ELSEVIER Forum theatre Communication Higher Education Healthcare.</p>
No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
8	<p>Patient trust in physicians and adoption of lifestyle behaviors to control high blood pressure.</p> <p>Jones, D.E., Carson, K.A., Bleich, S.N., Cooper, L.A. (2011).</p> <p>Patient Education and Counseling.</p> <p><u>Will Use This Article.</u> Important in the study of behavior</p>	Longitudinal analysis of data from a randomized controlled trial of interventions to enhance hypertensive patients' adherence to medications and recommended lifestyle modifications.	<p>Two hundred patients were seen by 41 urban primary care practices in Baltimore, Maryland and followed for 12 months.</p> <p>Secondary analysis of longitudinal data collected during the Patient-Physician Partnership study.</p> <p>To be included in the study you had to be receiving care in one of the 41 urban primary care practices in Baltimore, Maryland, and be a patient for at least 1 yr.</p> <p>Power: CI= 1.38-3.74 of patient who tried to lose weight with support of their provider.</p>	<p>Seventy percent of patients reported complete trust in their physician. In adjusted analyses revealed higher odds of reporting attempts to lose wt. (CI= 1.38-3.74) than did patients with less trust in their physician.</p> <p>Patients' who felt trust in the physician was significantly with attempts to lose weight, cut salt, and exercise.</p>	<p>Larger patient samples with ethnically and socially diverse populations. Use of more objective measures of lifestyle modification and medication adherence.</p> <p>Funding Source: National Heart, Lung, and Blood Institute.</p> <p>Funding Source: National Heart, Lung, and Blood Institute.</p>	<p>The results of this study identified the importance of patient trust in physicians as an important factor of adherence to recommended lifestyle modifications for HTN control.</p> <p>Reinforces the fact that physician behavior, communication styles, and trust are important factors in the development of rapport with patients.</p>	<p>Evidence Level: II</p> <p>Evidence obtained from a randomized controlled trial.</p>	<p>CINAHL: Provider communication Hypertension Behavior modification. Trust</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
9	<p>Patient Satisfaction: How patient health conditions influence their satisfaction.</p> <p>Otani, K., Waterman, B., Dunagan, C.W. (2012).</p> <p>Journal of Healthcare Management.</p> <p><u>Will use this article in my study</u></p>	<p>BJC Healthcare in St. Louis, Missouri provided the data for this study.</p> <p>Five hospital included in this study. The study was a telephone survey study company specializing in patient satisfaction</p>	<p>Patient Satisfaction Company making calls to patients from 5 community hospitals. This is an adult population study. A probability sampling method with stratification by department and hospital was used. Patients were initially contacted 7 to 14 days post discharge. Those who didn't respond were contacted until they completed the survey or refused to fill out the survey. To be part of the survey had to be admitted to one of the five community hospitals for at least 24 hours.</p> <p>Power: Was not noted.</p>	<p>The results of this patient satisfaction survey multiple linear regression analyses. The analyses included six attributes, the severity indicator, the scatter term, the interaction effect variables and the control variables.</p> <p>Nursing care was found to be the most influential, followed by staff care, admission process, physician care, and the room. Food was not found to be statistically significant.</p> <p>The severity of illness itself was not statistically significant in either model but there was an interaction effects with physician care, staff care, and food.</p>	<p>This study was a cross sectional. With the study design, it is possible to establish an association, but not appropriate to claim a cause and effect relationship.</p> <p>The information from the study was from large hospitals in one geographic area</p> <p>Funding: IRB Purdue University Study.</p>	<p>The results of the study revealed practical implications for healthcare managers. The six attributes of admission process, nursing care, physician care, staff care, food, and room were not equally influential.</p> <p>Nursing care and staff care showed their consistent influence in both models. The admission process, food, and room showed much less influence than nursing care or staff care. So improving nursing and staff care will improve patient satisfaction</p>	<p>Evidence Level: I</p> <p>Systematic Review.</p>	<p>CINAHL: Patient satisfaction</p> <p>Healthcare</p> <p>Health conditions</p>
10	<p>Court's Ruling: What's ahead for healthcare.</p> <p>Remington Report.</p> <p>This is a very important article for the changes in the reimbursement system. <u>I will be using to outline the changes to the healthcare system.</u></p>	<p>Not a research article. It is an article on the immediate requirements of laws that are changing regarding reimbursement.</p>	<p>Not a research article but important article in the understanding the various changes going into effect with the health care system.</p> <p>Very informative article that outlines the upcoming changes in the healthcare and reimbursement system.</p> <p>Power: Power is not noted. More of an informative article.</p>	<p>Informing article on the law changes regarding employer responsibility regarding healthcare, Medicare, Medicaid, and healthcare insurance providers.</p>	<p>No evidence basis or study. Just focused on the changes mandated by law regarding healthcare. Very confusing for older population and those who are not involved in the health care?</p> <p>Funding: Not noted is informative outline of healthcare changes.</p>	<p>Although these laws go into effect soon they are also very important to the population and providers due to all changes.</p> <p>Changes to the reimbursement system instead of pay for reporting will be pay for performance system.</p>	<p>Evidence Level: VII</p> <p>Expert Opinion</p>	<p>Google Scholar:</p> <p>Healthcare</p> <p>Healthcare Organizations</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
11	<p>Doubling down on the patient experience. Many hospitals are taking a two-pronged approach to make sure HCAHPS scores help, rather than hurt, Medicare payments</p> <p>Bush, H. (2011). Hospitals & Health Networks.</p> <p><u>I will be using this article very important in the reimbursement process and patient satisfaction.</u></p>	Not a research article but an article focusing on CMS starting to use HCAHPS surveys to calculate value-based purchasing payments for 2013. Hospitals are launching educational programs to prepare employee	<p>The leaders at Carolinas HealthCare System, a 28-hospital system based in Charlotte, N.C are currently training its employees on tactics to improve performance on the HCAHPS survey. They are doing this by building a HCAHPS scorecard that employees will be able to track their performance in real time.</p> <p>To be included in these articles have to be a patient in one of the 28 hospitals within Charlotte, NC.</p> <p>Power: None noted Not noted.</p>	<p>Communication is one of the largest categories on the HCAHPS survey. Half of all the 18 core questions directly relate to how patients perceive their interactions with staff, nurses, and providers.</p> <p>Hospitals are trying to standardize the way clinicians and staff interacts with patients and families by increasing training on the importance of communication and scripted communication with the use of "AIDET". The use of AIDET and scripted communication is believed to help reduce patient anxiety.</p>	<p>The limitations of the article are that it isn't really a research article. However has a lot of important information related HCAHPS and patient satisfaction?</p> <p>Engaging staff and incoming staff to practice scripted communication and work as a team.</p> <p>Funding: Carolinas HealthCare System. 28-Hospital system based in Charlotte, N.C.</p>	<p>Leading by example doesn't mean forcing staff and providers to comply with scripted communication styles. It encourages providers by picking champions to take up to 30 hours of class time on leadership principles that emphasize values of curiosity, accountability and authenticity. Staff all undergoes a training course called "Simply the best", a day long course that stresses the importance of patient service and team work.</p>	<p>Evidence Level: VII Expert advice from CMS regarding HCAHPS scores.</p>	<p>Google Scholar: Patient satisfaction Patient experience Communication Performance</p>
12	<p>Welcome to the Emergency Room, I'll be your doctor today. Are scripted communication tools for clinicians effective?</p> <p>Bush, H. (2011). Hospitals & Health Networks.</p> <p><u>Considering the use in my study.</u> Important aspect in scripting provider communication. But it's not really research article.</p>	Not really a study design but an interesting article on the use of scripted communication such as AIDET by The Studer Group.	<p>As CMS revamps the reimbursement process from pay for reporting to pay for performance. Hospitals are scrambling to educate its staff and providers about on the importance of patient communication and working as team to reduce patient anxiety which will lead to better patient outcomes and satisfaction.</p> <p>Not a research study but important rebuttal regarding scripted communication.</p> <p>Power: None noted.</p>	<p>AIDET- is scripted communication that stands for Acknowledge, Introduce, Duration, Explanation, and Thanking the patient which was developed by The Studer Group to reduce patient anxiety levels. Human resource departments and hospital administrators believe scripted communication helps build relationships through careful listening.</p> <p>There are many providers and staff that are very cynical about scripted communication and how it isn't a long term solution to improving patient communication.</p>	<p>Use of scripted communication requirement and providers and staff who continue to fight the system which is much bigger than they.</p> <p>Lack of examples of scripted communication not working to build patient provider relationships.</p> <p>Funding: Health forum Inc.</p>	<p>Providers and staff buy into scripted communication which will ease patient and family anxiety. Lead to better patient outcomes and patient satisfaction within the facility which results in better reimbursement.</p> <p>Staff and providers acting difficult about communication styles because of the belief that it isn't a long term solution to focusing on patient satisfaction and reimbursement. Some argue health care field is turning into the hospitality focused.</p>	<p>Evidence Level: VII Regulatory opinions regarding reimbursement changes in healthcare setting.</p>	<p>Google Scholar Patient Satisfaction Patient provider communication Scripted communication in healthcare</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
13	<p>Advanced Practice Nursing Model for Comprehensive Care With Chronic Illness. Model for Promoting Process Engagement.</p> <p>Cumbie, S. A., Conley, V.M., Burman, M. E. (2004). Advances in Nursing Science.</p> <p><u>Considering use in my project.</u> Patient focused and engaging regarding care they receive.</p>	<p>The purpose of the article is to describe the utilization of theory to develop client-focused approach for advanced practice nursing management and engagement of patients who have chronic illnesses.</p>	<p>Client-centeredness is defined by article as the extent to which clinicians select and deliver interventions mindful of responsive to individual and family characteristic, such as affective states, beliefs, goals, and resources. Focusing on patient centeredness will build rapport with client and help providers understand client and his/her needs and values.</p> <p>Power: None noted.</p>	<p>Chronic care is stressful to clients and family members. Chronic illness management often needs that to be flexible and individualized to the client and disease process. This isn't always an option with standardizing care outcome management tactics that CMS is imposing.</p> <p>APN's are uniquely trained providers who are educated in theory and are able to focus on the entire patient and social system that makes up a patient and their belief system. APN's are able to manage chronic disease states by identifying and relating to the client</p>	<p>The limitations to this study are that further study needs to be done regarding APN care. The article suggests linking with Montana State University to do a pilot study which will allow investigator to make refinements in the client-centered intervention approach that may be necessary to create model of care.</p> <p>Funding: University of Wyoming W. Whitney School of Nursing.</p>	<p>APN'S WORK WITH PATIENT TO MAKE DECISIONS ABOUT CLIENT PROBLEMS, HOW TO MANAGE THEM, WHETHER TO PRESCRIBE MEDICATIONS AND WHAT MEDICATIONS TO PRESCRIBE, WHAT TEACHING PROCESSES NEED TO BE DONE WITH PATIENT'S OR FAMILY MEMBERS TO INCREASE PATIENT BUY IN AND OUTCOMES OF DISEASE PROCESSES.</p>	<p>Evidence Level: VI Single descriptive study.</p>	<p>CINAHL: Advanced Practice Nursing Chronic illness Client-Centered model of nursing care. Theory development. Theory synthesis</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
14	<p>Disentangling physician sex and physician communication style: Their effects on patient satisfaction in a virtual medical visit.</p> <p>Mast, M.S., Hall, J.A, Rotor, D.L. (2007). Patient Education and Counseling.</p> <p><u>Will use this article very important on communication style no one fits all.</u></p>	<p>This study aimed to investigate of physician sex and physician communication style on patient satisfaction. In real patient visits, physician sex and physician communication style are confounded variables.</p>	<p>An experimental design, analogue patients (167 students) interacted with computer-generated virtual physicians on the computer screen. Patient's satisfaction during the visit was assessed.</p> <p>To be included in this study had to be part of the 167 students who interacted with a virtual physician.</p> <p>Power: None noted</p>	<p>The findings of the study that depending on the sex composition of the dyad, physician communication style affected analogue patient's satisfaction differently. Patients were found to be more satisfied with a physician who adopted caring as opposed to a non-caring communication style.</p> <p>Males preferred to see male physicians. In the male dyad there was not a caring factor that leads to patient satisfaction. Females preferred to see female physicians who adopted caring communication styles.</p>	<p>Is that this study focuses on only one type of medical problem which was headaches in a very homogeneous group of people.</p> <p>Also the exclusive use of university students as analogue patients.</p> <p>The setting is very experimental.</p> <p>Funding: University of Neuchâtel Johns Hopkins University</p>	<p>The sex of the physician and sex of the patient moderate how different physician communication styles affect patient satisfaction. Females prefer to see female physician who adopt caring behaviors. While males prefer to see male providers there wasn't the caring factor to the communication style that lead to their patient satisfaction.</p> <p>There isn't a once size fits all communication style with patients.</p>	<p>Evidence Level: VI Single descriptive study or qualitative study.</p>	<p>CINAHL: ELSEVIER Physician-patient communication. Patient-centered care</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
15	<p>Patient perspectives of patient-provider communication after adverse events.</p> <p>Duclos, C.W., Eichler, M., Taylor, L., Quintela, J., Main, D.S., Pace, W., Staton, E.W. (2005).</p> <p>International Journal for Quality in Health Care.</p> <p><u>Considering using this article.</u></p>	<p>The study was to explore patient perceptions of the patient-provider communication after an actual adverse medical event.</p> <p>Conducted at three sites in Colorado.</p>	<p>There were four patient groups using a semi-structured guide. Transcripts were analyzed using an editing approach to identify themes.</p> <p>Participants were recruited from a statewide post-injury program. Twenty-two patients initially agreed to participate. 16 adults participated, representing 13 cases.</p> <p>Power: <u>None noted.</u></p>	<p>There were complex issues and processes that were involved in resolution attempts. Effective communication was an important factor in whether professional relationships continued after and adverse event. The communication nature and quality influenced whether patients defined the event as an honest mistake or error. There were two types of trauma identified with the adverse event. Physical and emotional were expected and found in most cases. The third trauma was the financial aspect which was found to be the most important aspect of damage from and adverse event.</p>	<p>Study of patients who experienced an adverse event with slight help financially may alter their responses.</p> <p>There was gender bias although both sexes were approached to participate in the study females primarily responded. Varying levels of adverse events and their effects on pt.</p> <p>Funding: AHRQ grant U18 HSI18878, Wilson D. Pace, PI.</p>	<p>Provider communication is very important and timeliness and quality were important influences on patients' responses to adverse events. Approaching the patient and collaborating together will help the patient emotionally, physically, and financially. It also decreases the frustration and anger experienced by the patient.</p> <p>So health organizations, providers, investigators, and policymakers should consider the patient experience</p>	<p>Evidence Level: VI</p> <p>Single descriptive Study.</p>	<p>Google Scholar:</p> <p>Medical Errors</p> <p>Patient perspective</p> <p>Patient-provider communication.</p> <p>Qualitative Research.</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
16	<p>Interprofessional education: effects on professional practice and health care outcomes (review).</p> <p>Zwarenstein, B. S., Goldman, M., Barr H., Freeth, D., Hammick, M., Koppel, I. (2009).</p> <p>The Cochrane Collaboration.</p> <p><u>Considering using this article.</u></p>	<p>There was a searched Cochrane Effective Practice and Organization of Care Group specialized register, MMEDLINE and CINAHL, for the years of 1999 to 2006.</p>	<p>The selection criteria included Randomized and controlled trials controlled before and after studies and interrupted time series. Patient/client and/or healthcare process outcomes. Two reviewers independently assess the eligibility of potentially relevant studies, and extracted data from, and assessed the quality of the studies.</p> <p>Power: None noted.</p>	<p>Four of these studies indicated that IPE produced positive outcomes in the following areas: Emergency department culture and patient satisfaction. Working as a team to reduce clinical errors. Care provided to in the management of domestic violence victims, mental health competencies in related to the care provided to patients. In addition, two of the six studies reported mixed patient outcomes which are positive and neutral and the two studies reported that the IPE interventions had no impact with professional practice or with patient care.</p>	<p>There was a risk of bias as one study was high quality. The four RCTs concealment of allocation was done in two studies and not clear in two studies; blinded or objective assessments of primary outcomes are done in all the studies.</p> <p>Funding: Was not noted since it was a review of randomized and controlled studies.</p>	<p>In some of the studies communication skills training program did not improve patient satisfaction scores. Interprofessional teamwork training programs on collaborative behavior in ER's showed statistically significant improvement in quality of observed team behaviors between the experimental and controlled group.</p>	<p>Evidence Level: I</p> <p>Randomized and controlled trials.</p>	<p>CINAHL:</p> <p>Scripted</p> <p>Communication in the health care setting.</p> <p>Communication</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
17	<p>The customer's always right: Steps you can take to ensure customer satisfaction.</p> <p>Johnson, A. (2010). <i>Journal of Emergency Medical Service.</i></p> <p><u>Will use in my project because focused on patient satisfaction when emergency services are needed.</u></p>	<p>Not really a study but an interesting article on patient satisfaction regarding service provided by EMS. The evidence of patient satisfaction is well documented in healthcare. So should be logical to assume EMS would as well.</p>	<p>There is very little formal research conducted on EMS customer satisfaction. However, in 2008, Professional Research Consultants Published The National EMS Patient Perception Bench Mark Study. They surveyed 1,000 EMS patients from 20 different agencies. Of those surveyed, 86.6% rated the overall quality of care to be excellent.</p> <p>Power: Was not noted not really research article but informative on patient satisfaction</p>	<p>What was interesting is that the patients who rated 86.6% of the EMS services as excellent or very good. Were the same patients who rated their care in the ER as 58.3% versus 29.2%? As HCAHPS takes over the hospital system it only makes sense that EMS will also have to focus on patient satisfaction. The difficulty with EMS patient satisfaction is that the EMS experience can be scrutinized from the beginning of the 911 call to arrival of the first responders, paramedic arrival, assessment, privacy, dignity, transport of care into the ER.</p>	<p>One of the big limitations in this study was the limited amount of information regarding patient satisfaction with EMS. Also adopting a patient satisfaction tool that is capable of measuring important aspects of patient satisfaction by the multitude of aspects regarding the complicated system</p> <p>Funding: Emergency Medical Services organization.</p>	<p>Patient satisfaction is very important aspect to our healthcare system. With the initiation of HCAHPS it will become more important. Most EMS systems believe patients and family value their life-saving skills above all else. But frankly life-saving skills are used on then 1% of patients. And interpersonal skills are assessed 100% of the time. Patient follow up is extremely important aspect to patient satisfaction whether is in house or third party.</p>	<p>Evidence Level: VII Report from expert opinion in the EMS system.</p>	<p>Google Scholar Communication Patient satisfaction Emergency Medical Service patient satisfaction.</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
18	<p>Practical approaches for building a patient-centered culture.</p> <p>Frampton, S. (2008). <i>Plain Tree and the Picker Institute.</i></p> <p><u>Will Use in my study Patient and provider focused.</u></p>	<p>There were 150 practices in place at patient-centered hospitals across the country. The practices studied were chosen from a series of site visits and conference calls undertaken in early 2008.</p>	<p>150 practices in place at patient centered hospitals that were chosen. The practice studied were organized around those aspects of the patient experience prioritized by patients themselves, as indicated by focus group data collected and analyzed by Plane tree. These practices were chosen because monitor their performance. To participate in the study had to be using a patient satisfaction tool and assessing regularly.</p> <p>Power: None noted.</p>	<p>The survey was focus on both patients and staff for maximum effectiveness. The practices described here should also be considered for their potential to enhance the staff experience. Communicating effectively with patients and families is a cornerstone of providing quality health care. The communication with the provider is the pathway to patient centered care. Patients directly judge the way their provider interacts with them. The environment also sets the stage for optimal exchange and the patient provider connection.</p>	<p>Scripted communication styles to be in the moment with patients and families. Environments that are not supportive or sterile are not conducive to effective communication.</p> <p>Funding: Plain Tree and the Picker Institute</p>	<p>Focusing a patient centered care must call attention to the patient needs. The clinic environment must be a warm secure and open. Providers must pay attention to their patients. Entities are using scripting tools to help providers and staff effectively communicates with their patients. Patient and family communication boards are important as well as a note pad for patients to take note or write questions down for the provider.</p>	<p>Evidence Level: VI Evidence from a single descriptive study.</p>	<p>Google Scholar: Patient centered care</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
19	<p>Structuring communication relationships for interprofessional teamwork (SCRIPT): a cluster randomized controlled trial. Zwarenstein, M., Reeves, S., Russell, A., Kenaszchuk, C., Conn, L. G., Miller, K.L., Lingard, L., Thorpe, K.E (2007).</p> <p><u>Considering the use of this article. Not quite sure since it's a whole different type of healthcare system.</u></p>	Interprofessional approaches are important to promote effective collaboration in health care. Systematic reviews find scant evidence of benefit. The protocol describes the first cluster randomized controlled trial	The study is a multi-centered mixed-methods cluster randomized controlled trial involving twenty clinical teaching teams. In general internal medicine divisions or five Toronto tertiary care hospitals. They were randomly assigned wither to receive an intervention designed to improve interprofessional collaborative communication. To be included in this study had to be part teaching team or patient with team rounding. Power: None noted	Creating a culture of interprofessional collaborative communication will generally create an exchange of information between professions. The intervention is designed to promote joint problem solving. Collaboration communication in our model in both intentional and opportunistic. It is purposeful as health care professionals will determine the information that is exchanged. The general internal medicine projected that this type of information exchange is meant for problem solving methods and improving patient centered care.	Harm from the study is minimal because there wasn't any patient contact. The various categories of patient care such as prescription drug coverage. Confidentiality of individual and patient level is important and can sometimes be correlated with admissions rates. Funding: Toronto Tertiary Hospitals	Important finding from our qualitative data is that opportunities for interprofessional collaborative communication occur during informal, unplanned interactions, outside of formal structured meetings. Interpersonal collaboration is important to communication between health care providers and patients. When the healthcare team is working together no matter their educational level they provide optimal care that is often patient centered.	Evidence Level: II Evidence was obtained from a well-designed RCT.	CINAHL: Scripted communication Patient satisfaction Healthcare Team work.
20	<p>Clinical Development: A framework for effective communication skills. Hamilton, S.J., Martin, D.J. (2007).</p> <p>Nursing Time.net</p> <p><u>Will use in my project focuses on nursing unique aspect of applying theory to communicating with patients.</u></p>	The use of effective communication skills in nursing have been extensively researched and documented over the years. Nurses often facilitate therapeutic provider communication.	Communication skills framework is multi-dimensional and challenging because everyone is so unique. There are five communication skills interact with pts., establish intention of interaction, decide on the intervention to be used, assess the impact of intervention, and evaluate the implications of communication. Power: None noted.	Nurses interact with patients using a full range of communication skills. Nurses and providers need to be in the moment with their patients to help the patient and family feel the provider is there to help physically and emotionally. Nurses often make patients feel better because they allow them to space to express any fears, anxieties, concerns or worries they may have. While providers are often pressed for time they do not always all the necessary time for the patient to express what they are feeling.	A limitation of this study is that it was primarily focused on nurses. Although nurses are important part of the health care team does not compare providers against providers. I am curious how effective providers who were nurses before providers communicate with their patients? Funding: None noted.	Nurses are taught to be resourceful and often draw on a variety of physical and psychological skills to provide care to patients and family members. They are taught various interpersonal skills and often adaptable as they practice in clinics, inpatient sector, outpatient sector, and specialty areas. Not only do they work hard using their theory in communicating with patients.	Evidence Level: VI Single descriptive study or qualitative study.	Google Scholar Communication Patient Communication Scripted Communication.

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
21	<p>The Impact of a program in mindful communication on primary care physicians.</p> <p>Beckman, H.B., Wendland, M, Mooney, C., Krasner, M.S., Quill, T.E., Suchman, A.L., Epstein, R.M. (2012).</p> <p>Academic Medicine.</p> <p><u>Will use in my project because of the importance providers feel in communication with other healthcare providers, patients, and family members?</u></p>	<p>In 2008, the authors conducted in depth semi structured interviews with primary care physicians who completed a 52-hour mindful communication program.</p>	<p>The sample size was 70 primary care providers who participated in the mindful communication study that was 52-hours as a continuing education class which consisted of 8 weekly sessions. The course included meditation and self-awareness.</p> <p>To be included in this study you had to participate in this continuing education class that was 52 hours and 8 weeks long.</p> <p>Power: None noted</p>	<p>The results of Mindful Communication program participants some shared concerns of professional isolation and desire to share experiences. Statistics showed that 75% of physicians expressed that they hoped this program would help them become connected with their peers. Stress reduction and learning mindfulness techniques are believed to help reduce burnout and be in the moment with their patients. Providing an atmosphere that is supportive and emotionally safe will help patients and providers effectively communicate. Taking time for personal development is important.</p>	<p>There was a small sample size and was in one geographic community. Participation was also voluntary. So results might be greater if all providers were required to take a course similar to this one to reduce burnout and isolation.</p> <p>Funding: Physicians Foundation</p>	<p>There were three themes identified from this study. The first one was that sharing personal experiences with colleagues reduced professional isolation. Second is that mindfulness skills improved the providers ability to be presence and attentive to patient concerns and respond more effectively. The third theme and most importantly is developing a better self-awareness that was positive and attend to their own needs without feeling guilty.</p>	<p>Evidence Level: VII Expert opinion mindful communication</p>	<p>CINAHL Communication Therapeutic patient provider communication</p>
22	<p>Nurses joining family doctors in primary care practices: perceptions of patients with multimorbidity.</p> <p>Fortin, M., Hudon, C., Gallagher, F., Ntetu, A.L., Maltais, D., Soubhi, H. (2010).</p> <p>BMC Family Practice.</p> <p><u>Considering use in my project because of the nursing aspect of communication.</u></p>	<p>Among the many strategies used to reform primary care, the participation of nurses in primary care practices appears to offer promising avenues to better meet the needs of vulnerable patients.</p>	<p>The methods used were 18 primary (health) care patients with multimorbidity participated in semi-directed interviews. The interviews were to explore the perceptions and expectation of the involvement of nurses in primary care practices. These interviews were audio-recorded and transcribed. There was a thematic analysis.</p> <p>To be included in this small study had to be patients in this practice were interviews were taking place.</p> <p>Power: None noted</p>	<p>This is a qualitative descriptive clinical study conducted. There was an interview guide that was developed by the research team. Most of these questions were open ended. Patients focused in this study shows there are many patients with severe comorbidities being followed by primary care providers. The study found that patients with several co-morbidities are open to the participation of nurses in primary care practices. Patients feel a greater accessibility with their provider. However patients clearly identify the roles of the nurse and the provider.</p>	<p>The limitations were a small sample size. The study was limited to a single, geographic region, deliberately addressing a particular group that is affected by chronic illnesses and familiarity with primary care services.</p> <p>Funding: Pfizer Canada, Martin Fortin is funded by the Canadian Institutes of Health Research</p>	<p>The patients who are suffering from chronic illnesses are very receptive to the involvement of nurses in primary care practices. Most patients who have chronic illnesses have expectations of greater accessibility to services, for themselves and for new patients taken on by the primary health care team. However patients expect a clear definition of each other roles and fields of practice.</p>	<p>Evidence Level: VI Evidence obtained from a single descriptive interview study.</p>	<p>CINAHL Communication Nursing professionals Multimorbidity</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
23	<p>Improving patient safety through provider communication strategy enhancements. Dingley, C., Daugherty, K., Dering, M.K., Persing, R. (2011). <u>Will definitely use because of the important safety aspects of communication and provider, nursing, and facility huddles.</u></p>	<p>The study design was a pre-test/post-test design. The study setting was Denver Health Medical Center and three of its care settings the Medical Intensive care unit, Acute Care Unit, and The Behavioral Health Unit.</p>	<p>The statistical methods were a pre-test/post-test designed. The study incorporated baseline data collection and implementation of team communication interventions. Data collection and analysis over a 24 months. There was a goal that was to develop a user friendly toolkit that accomplished feedback.</p> <p>To be part of this study you had to be a patient of 477- bed medical center of the Denver Health and Hospital Authority.</p> <p>Power: None noted</p>	<p>There were communication interventions. The situational briefing guide is a standard communication tool that is a guide for staff and providers. Staff and providers are encouraged to use this guide to identify patient needs. Team huddles were implemented on the units of study. It was found that team huddles encouraged communication processes and identification of patient issues and problematic areas. Multidisciplinary rounds and goal sheets were implemented and completely patient centered. Rounds are open and collaborative communication.</p>	<p>Physician engagement in an academic hospital is difficult due to the various personnel involved in patient care. Continuing education and the importance of a program such as this will help with the buy in to this type of communication processes. Also communicating with appropriate staff.</p> <p>Funding: Agency for Healthcare Research and Quality, Partnerships in Implementing Patient Safety Grants.</p>	<p>The strategies to enhance teamwork and communication can be successfully implemented in the acute care setting. Can create an environment that is efficient and effective in patient centered communication. Creating a toolkit can help staff and patients in the communication process will help lead to better patient understanding and outcomes. Further studies will be needed to discover the effectiveness of the interventions.</p>	<p>Evidence Level: V Evidence obtained from systematic reviews of qualitative studies.</p>	<p>CINAHL Communication enhancements Patient Safety Patient communication</p>
24	<p>Spirituality and medicine: science and practice. Davidson, R.J. (2008). Ann Family Medicine. <u>Considering the use of this article because I think it is important aspect to patient satisfaction.</u></p>	<p>This is more of an article on spirituality and medicine. The article stresses the importance of spiritual care at the end of life which is a topic of critical importance for compassionate and humane treatment.</p>	<p>This article talks about the importance of previous articles who have studied the importance of the physician being attentive to the spiritual dimension of a patient's life context. There are several key questions raised by this article. How can we assess such qualities as being present? How does being present by clinician affect the patient?</p> <p>I also feel a provider must feel like spirituality is important to even consider it.</p> <p>Power: None noted.</p>	<p>During the past decade there is a focus on advances in the understanding of mind brain relations. Science has begun to dissect the complex mechanism by which the brain influences the biologic human system. The relationship between the provider and patient can be affected in various ways by the patient's emotions, psychological state, and general level of patient's wellbeing. Two of the sited articles by the author address the spiritual qualities of the healer, including compassion, presence, and true listening all affect patient care and provider presence.</p>	<p>A major limitation of this study is that it really isn't a research study. Although it does take into consider aspects of spirituality and patient care</p> <p>Funding: Waisman Laboratory for Brain Imaging and Behavior, Laboratory for Affective neuroscience, and Center for Creating a Healthy Mind, University of Wisconsin-Madison</p>	<p>As the author notes the brain circuits transformed by meditation play a key role in modulating peripheral biologic systems that may be consequential for health. These circuits in the brain can be reset by compassionate care which may have a downstream impact on the peripheral biologic system that affects health and illness. As medicine progresses spiritual care must be focused on because it can play such an important part of health for the patient.</p>	<p>Evidence Level: VII Expert committees on the importance of provider being aware of a patient's spirituality.</p>	<p>Google Scholar Spirituality in communication Spirituality in healthcare Spirituality in the healthcare environment.</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
25	<p>Patient satisfaction metrics: Customer service or quality care? Nurses support better quality care but balk at using scripts to get there.</p> <p>Nelson, R. (2012). American Journal of Nursing.</p> <p><u>I will definitely use this in my project very important.</u></p>	<p>This isn't necessarily a research article but an article on scripting for patient satisfaction. Nurses have always said the quality of patient care is undoubtedly a top priority for nurses.</p>	<p>The Centers for Medicare and Medicaid Services (CMS) will make incentive payments to acute care hospitals on the basis of how well they perform on certain quality measures or on how much their performance improves from baseline levels. The better an institution performs or the more it improves during a fiscal year the higher the reimbursement will be.</p> <p>Power: None noted.</p>	<p>Scripted communication has changed over the years but recently because of the push from CMS and the reimbursement process. There are numerous consultants and plans for service excellence that promote the use of scripting for optimal communication. Although scripting can be useful there is an element of patient centered care that might be lost in the script. Often scripting can become rote or filled with subliminal messages which is concerning to nurses because scripting can lead patients into answering a certain way despite their honest opinion of how their stay is going.</p>	<p>Since this article is not a research article it brings about some nursing concerns. One concern is if scripting communication will tell the whole story. In Portland Oregon there was a study that showed only 74% of patients believed their pain was controlled. In reality pain cannot be always controlled.</p> <p>Funding: Academy of Medical-Surgical nurses.</p>	<p>Several researchers are suggesting that quality rating do deserve further attention. The attention does not always have to be focused on communication. The staffing of the hospital and work environment also played a significant role in patient satisfaction. Also what about patients who are critically ill they are not always capable of communicating via scripting. With the critically ill it is sometimes very important to make sure patients have the best opportunity for outcomes.</p>	<p>Evidence Level: VII Expert opinion from the president of the academy of Medical-Surgical Nurses.</p>	<p>CINAHL Scripting communication Quality Patient Care.</p>
26	<p>Nurse practitioners and managed care: Patient satisfaction and intention to adhere to nurse practitioner plan of care.</p> <p>Hayes, E. (2007). Journal of the American Academy of Nurse Practitioners.</p> <p><u>Will definitely use because of the important aspect of NP communication and patient satisfaction.</u></p>	<p>Post visit questionnaires and narrative comments about patient satisfaction with NP communication, overall satisfaction with visit. Was a three part descriptive, correlation, and exploratory study</p>	<p>The 18 NPs (all women) were asked during their interviews in the second study phase if they were willing to participate in a study. All the 18 NPs were willing to participate. Two NPs were not able participate in the study because of administrative space and inability to support the research study.</p> <p>To be included in this study had to be a patient of the NP participating in the study. As well as a facility who supported the study. Power: None noted.</p>	<p>The purpose of this study was to explore patient satisfaction, intention to adhere to NP plan of care, and the impact of managed care on NPs' patient in their various settings. There were post visit questionnaires and narrative comments about patient satisfaction with NP communication, overall satisfaction with visit, recall of the plan, and the follow through of the plan. The effect of managed care was also studied regarding the NP's plan of care and the patient responsibility to follow through.</p>	<p>Some of the limitations of the study are the correlations between patient background and outcome variables. The differences in the means scores between groups while small were skewed and tend to show a need for further investigation.</p> <p>Funding: Faculty Research Grant, university of Massachusetts, Amherst, Massachusetts.</p>	<p>Patients were overall satisfied with the NP communication and visit. Most of them adhered to the NP recommended plan of care but less responded to the recommended lifestyle changes. Most patients reported they trusted their NPs, valued their opinions, and believed the NP had their best interest at hand. Many patients made mention that they felt that their NPs took a lot of time to listen to their concerns. Most patients state they have a lot of frustration with managed care.</p>	<p>Evidence Level: VI Evidence obtained from a single descriptive study</p>	<p>CINAHL Nurse practitioners Managed Care Patient Satisfaction Adherence intention.</p>

No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
27	<p>Patient satisfaction with Nurse Practitioner care in primary care settings.</p> <p>Gagan, M.J. (2010).</p> <p>Research paper.</p> <p><u>I will not be using this article with my project.</u></p>	<p>A descriptive correlational study was conducted using a 15 item satisfaction survey distributed to participants by the clinic receptionist after a visit with the NP. The demographic data, reason for visit and wait.</p>	<p>The setting was two clinical sites in the same medium sized city were used for data collection. The first site was a University site the other site was a primary care office. The patient satisfaction and acceptance were measured using modified 15 item version of the Thrasher and Pur-Stephenson patient satisfaction survey.</p> <p>Power: 179 Responses, 15.598 SD of 4.71 and range 12-25</p>	<p>The object of the study was to determine the level of satisfaction with care and acceptance of the role of a NP in New Zealand. Patients filled out the study one hundred and ninety three completed the patient satisfaction surveys were received with some missing data. There wasn't any attempt to fill in the missing data. There was positive correlation between age and satisfaction. There wasn't any correlation between waiting times and patient satisfaction. No difference based on gender. Many patients had a good understanding of the role of a NP and felt comfortable.</p>	<p>There were two problems of the study the first was the failure to use fully trained research assistants to distribute and collect questionnaires or answer participates questions. The next problem identified was the satisfaction tool. There was a failure to reverse the questions to avoid column answering</p> <p>Funding: None noted.</p>	<p>Was that although the role of NP is rather new in New Zealand it hasn't been fully evaluated. This study was addressing two important aspects of evaluation, satisfaction, and acceptance. The study found that patients worldwide are satisfied with the care they receive from NPs and NPs role is accepted by various people despite their educational levels, ethnicity, or reasons for the health care visit.</p>	<p>Evidence Level: VII</p> <p>Research paper that's goal is to determine the level of satisfaction with care and acceptance of the role of Nurse Practitioner.</p>	<p>CINAHL</p> <p>Patient satisfaction</p> <p>Primary care</p> <p>Nurse Practitioners</p>
No.	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Straights/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
28	<p>Nurse practitioners' communication styles and their impact on patient outcomes: An integrated literature review.</p> <p>Charlton, C.R., Dearing, K.S., Berry, J.A., Johnson, M.J. (2008).</p> <p>Journal of the American Academy of Nurse Practitioners.</p> <p><u>Will definitely use very important communication styles by NP's and natient outcomes.</u></p>	<p>The databases searched included Academic Search Elite, Cumulative Index to Nursing and Allied Health Literature. The goal was to define the act of imparting or transmitting information verbally and nonverbally</p>	<p>There was an electronic search conducted to identify studies from 1999 to 2005 using all the major research databases. The articles were weaned to be articles that are limited to peer-reviewed research articles, English language, and patient outcomes evaluated.</p> <p>Power: None noted.</p>	<p>There were seven articles that were evaluated. The articles were primarily NPs acting as the primary care provider and discussed the patient outcomes for the studies. Communication styles were looked at very closely. The style of communication that NP uses can positively or negatively influence patient outcomes. The negative outcomes were not studied in this article. The positive outcomes were patient satisfaction, increased adherence to treatment plans, and improved patient health.</p>	<p>The studies analyzed were not conclusive, partly because researcher does not use consistent definitions or outcomes measures.</p> <p>Funding: None noted</p>	<p>The communication style of the NP uses to interactive with the patient leads to positive outcomes. The bio psychosocial styles of communication were identified as being equal to that of patient centered communication. But regardless of what communication style is used there is a relationship between NPs using patient centered communication and its impact on outcomes.</p>	<p>Evidence Level: V</p> <p>Evidence obtained from systematic reviews of descriptive and qualitative studies</p>	<p>CINAHL</p> <p>Nurse Practitioner</p> <p>Communication styles</p> <p>Patient centered outcomes</p>

No	Article Citation	Study Design	Sample Size & Statistical Methods	Purpose/Results/Findings	Limitations	Conclusions/Strengths/ Nursing Implications	Quality of the Evidence	Data Bases Investigated
29	<p>Better communication in the emergency department.</p> <p>Burley, D. (2011).</p> <p>Emergency Nurse</p> <p><u>I will definitely use because of its importance in history taking and development of a medical interventions and plans regarding current situation.</u></p>	<p>There is little research more of a literature review undertaken by the author to discover limitation in effective history taking and communication processes among ENPs. Plus identifies good practice in ER care.</p>	<p>The method to this article is to identify history taking and communication processes in the emergency room by ENP's. The author used the British Nursing Index, CINAHL, and Medline Data in the literature review.</p> <p>Power: None Noted</p>	<p>The ENP was introduced to the ER in the 1980's. ENPs see, treat, refer, and discharge patients autonomously. They take histories, document histories. They must communicate effectively with patients, family members, and other medical professionals who are involved in patient care. Often patients who present to ER have complex needs. The ENP role continues to expand to make ER care more flexible and less taxing on physicians. However, ER's are beginning to feel the pressure of increasing patients which is causing ENP's and physicians to spend less time with pts.</p>	<p>The limitation to the study is that there is little research and primarily Literature review. The other limitation is the varying communication styles of the providers, patients, families, and other medical professionals.</p> <p>Funding: None Noted</p>	<p>There were three themes emerged from the review. They are interruptions, overload, and barriers. These stressors can lead to decrease patient care focus and increase in medical error. Barrier building that reduces effected communication, history taking, reduced understanding, and poor command of language setting. The author recommends increasing the number of staff and training them in managing pressure, communicating effectively with patients.</p>	<p>Evidence Level: VI</p> <p>Evidence obtained from a single descriptive study</p>	<p>CINAHL</p> <p>Communication styles and barriers</p> <p>Workload</p> <p>Interruptions</p> <p>History taking</p>
30.	<p>Nurse Practitioner/Patient communication styles in clinical practice.</p> <p>Berry, J.A. (2009).</p> <p>The Journal for Nurse Practitioners.</p> <p><u>Considering using article but want will see. Article is good but very similar to the last article.</u></p>	<p>Nurse practitioners spend an estimated two thirds of patient-encounter clinical time an intrapersonal communication. There is little information on NP communication styles.</p>	<p>A literature search was completed via Ovid, CINAHL, Medline, and the Cochrane Library. 53 NP/patient transcripts for communication style. Transcript analysis showed that only a minority of NP's actually used patient centered communication.</p> <p>Power: None Noted</p>	<p>NP's used the information-giving variable as the basis for analysis. The study defined a patient-centered communication style as those interactions where the patient information-giving at least as much or more than information seeking with patients. It was 16 NPs used patient centered communication while 37 used provider centered communication style. But of all the communication styles the NP's used negative talk the least.</p>	<p>The limited research study. Primarily a lit review and study group was very small. Also there was a lack of random subject selection which affects the external validity of findings to NP's in primary care providers.</p> <p>Funding: None noted</p>	<p>There were differing levels of experience of the NP's in the study. The patients who were studied had seen the NP at least once before or had developed a relationship prior to study. The patients were all adult patients with varying chronic illnesses. The conclusion of this study is that more research needs to be done to identify the element of patient centered communication. It was also discovered that more research needs to be done regarding providers and patients.</p>	<p>Evidence Level: V</p> <p>Systematic literature review.</p>	<p>CINAHL</p> <p>NP/patient communication</p> <p>Provider-centered communication</p> <p>Provider/patient communication</p>

No.	Article Citation	Study Design	Sample Size & Statistical	Purpose/Results/Findings	Limitations	Conclusions/Recommendations/ Nursing Implications	Quality of the Evidence	Quality of the Evidence
31	<p>Physicians Again are Opting to Sell Practices to Hospitals.</p> <p>Fitzgerald, S (2012).</p> <p>Nashville Medical News.</p> <p><u>Considering using article because trend of physicians and advanced practice providers leaving private practice.</u></p>	<p>Not really a research article more of an article that explains reimbursement changes and pressures of practicing in a private practice environment. How large hospitals are offering incentives for physicians and advanced care providers to join them.</p>	<p>Survey of results from the Medical Group Management associated that revealed physician compensation and revenue are negatively affected by hospital ownership of a practice. But inversely the stresses of being privately owned are much greater.</p> <p>Power None Noted</p>	<p>Physicians and advanced practice providers are facing pressure and are willing to sell their practices to the local hospital because of rising costs, declining reimbursements, claim hassles, growing need for continued electronic sophistication, family time, and a more predictable schedule, and stress.</p>	<p>Only one survey from The Medical Group Management Associated.</p>	<p>With the increasing costs associated with health care remaining in private practice is very difficult for physicians and advanced health care providers. Consequently are being employed by hospitals that are requiring its providers to alter their care delivery models.</p>	<p>Evidence Level: V</p> <p>Evidence Grade: Systematic Lit review</p>	<p>Evidence Level: Ok</p> <p>Evidence Grade: Good outcomes and system improvement.</p>
No.	Article Citation	Study Design	Sample Size & Statistical	Purpose/Results/Findings	Limitations	Conclusions/Recommendations/ Nursing Implications	Quality of the Evidence	Quality of the Evidence
32	<p>Chronic illness and Patient Satisfaction.</p> <p>Carlin, C.S., Christianson, J.B., Keenan, P., Finch, M. (2012).</p> <p>Health Research and Educational Trust.</p> <p><u>Using article because to the chronic illness is encountered daily by physicians and nurses.</u></p>	<p>Structural equation modeling was used to examine how relationships among patient characteristics, three constructs representing patient experience with the health care system, and overall satisfaction with care vary across patients by number of chronic illnesses.</p>	<p>Telephone survey in 14 U.S. geographical areas. Random digital dial telephone survey of adults with one or more chronic illnesses.</p> <p>Power None Noted</p>	<p>Patients with more chronic illnesses report higher overall satisfaction. The total effects of better patient-provider interaction and support for patient self-management are associated with higher satisfaction for all levels of chronic illness. It was found that older, female, or insured patients are more satisfied: highly educated patients are less satisfied.</p>	<p>Single measure to assess satisfaction with care. Simple measure of complexity-number of chronic conditions for individuals using ambulatory services.</p>	<p>Providers seeking to improve their patient satisfaction scores could do so by considering patient characteristics when accepting new patients or deciding who to refer to other providers for treatment.</p>	<p>Evidence Level: V</p> <p>Evidence Grade: Structural equation modeling by telephone survey in 14 U.S geographic areas</p>	<p>Evidence Level: Good</p> <p>Evidence Grade: Fair Random digital telephone survey study.</p>

Appendix B

Logic Model Development

Strategies
Application of Dr. Watson’s Caring Theory.
Uninterrupted time with patients.
Sensitivity to self and others.
Spiritual, emotional, and human care-giving factors.
Promoting teaching and learning.
Supportive Protective Environment.
Application of the CBI with the Studor Satisfaction survey to patients receiving care in the outpatient internal medicine clinic.

Assumptions
Applying the caring theory will enable every patient despite their cultural beliefs to communicate effectively with health care providers.
Patient willingness to share intimate detail of their lives.
Positive patient outcomes.

Influential Factors
Open communication.
Respect
Basic Human Needs.
Patient Provider Value Systems.
Dr. Watson’s Caring Theory.
Protective Confidential Environment.

Problem or Issue
Does caring impact therapeutic patient provider relationships and patient outcomes?

Community Needs/Assets
Shortage of primary health care providers.
Implementation of medical homes.
Facility location and ease of

Desired Results (outputs, outcomes, and impact)
Positive therapeutic relationships
Patient Autonomy
Patient Responsibility
Positive Patient Outcomes
Healthier Community.
Patient/Provider satisfaction.

4

3

1

2

5

Appendix C

CITI Collaborative Institutional Training Initiative

Human Research Curriculum Completion Report

Printed on 8/4/2012

Learner: Shannon Cook (username: cook427)

Institution: Regis University

Contact Information 725 Rodeo Ave

725 Rodeo Ave.

Cheyenne, Wyoming 82009 United States

Department: Nursing

Phone: 307-514-5263

Email: cook427@regis.edu

Social Behavioral Research Investigators and Key Personnel:

Stage 1. Basic Course Passed on 08/04/12 (Ref # 8401289)

Required Modules

Date

Completed

Introduction 08/04/12

Appendix D



Cheyenne Regional
Medical Center

214 EAST 23RD STREET
CHEYENNE, WY 82001
307-634-2273
WWW.CRMWCWY.ORG

December 12, 2012

Institutional Review Board, Regis
University
Main Hall, Room 452, Mail Code H4
Denver, CO 80221
Email: irb@regis.edu

RE: Shannon Cook, FNP-C, Doctoral Research


To whom it may concern:

This letter is to serve as notice that Cheyenne Regional Medical Center supports the project proposed by Shannon Cook, FNP-C, entitled 'Scripted Communication through the use of "AIDET"'. Cheyenne Regional is pleased to support Ms. Cook in her academic endeavors. We anticipate the results of Ms. Cook's research, and we are pleased that she is using our patient survey's to better understand the interplay between provider communication and patient satisfaction.

For this study, Cheyenne Regional understands that Ms. Cook will be reviewing patient satisfaction surveys. Cheyenne Regional understands that the study does not involve patient identifiers or require any patient contact. We anticipate that if the scope of the study is to change that Ms. Cook will notify Cheyenne Regional in advance of the change to determine if additional institutional safe guards need to be followed.

If you have any additional questions or concerns, please contact Aimee Dendrinis, Compliance Counsel at (307) 432-6624 or aimee.dendrinis@crmcwy.org.

Thank you,


Carlene Crall

Vice-President and Chief Human Resources Officer, Chief Compliance Officer

Appendix E



Academic Affairs
Academic Grants

3333 Regis Boulevard, H-4
Denver, Colorado 80221-1099

303-458-4206
303-964-5528 FAX
www.regis.edu

IRB – REGIS UNIVERSITY

March 28, 2013

Shannon Cook
725 Rodeo Ave
Cheyenne, WY 82009

RE: IRB #: 13M13-039

Dear Ms. Cook:

The amendment to your original IRB "Scripting Communication for Patient Satisfaction" was approved on March 27, 2013. You have one year from this date of approval to complete the project. It is the responsibility of the investigator to maintain the submitted surveys (since submissions are done confidentially and without subject identifiers) for a period of three years after the conclusion of the research. The Office of Academic Grants does not retain copies of individual IRB documentation, including approval letters, past three years from approval date.

We wish you the best on your project!

Sincerely,

A handwritten signature in blue ink that reads "Patsy McGuire Cullen".

Patsy McGuire Cullen, PhD, CPNP
Chair, Institutional Review Board
Associate Professor and Director
Department of Accelerated Nursing
Loretto Heights School of Nursing
Rueckert-Hartman College for Health Professions
Regis University

cc: Dr. Cris Finn

Appendix F

SAMPLE

Print Date

RE: Your hospital stay ending Precode 4

Dear FIRST + LAST,

Our goal at Cheyenne Regional Medical Center is to provide our patients with the highest quality health care that we can. To accomplish this we need to know what we are doing right and what needs improvement. We depend on our patients and their families to keep us informed. The enclosed patient satisfaction survey asks about the care you received during your hospital stay that ended on the date listed above.

This survey is part of an ongoing national project that will provide meaningful comparisons on issues of hospital care that are important to all consumers. The overall hospital results will be publicly reported and available to consumers at www.hospitalcompare.hhs.gov. These results will help consumers make choices about hospital care and will help hospitals improve the care they provide.

Questions 1-25 in the enclosed survey are part of a national initiative sponsored by the United States Department of Health and Human Services to measure the quality of care in hospitals. Your participation is voluntary and will not affect your health benefits.

By sharing your thoughts and feelings about your health care experience, you can help us make our care better for future patients and their families. Please take a few minutes to complete this survey and return it in the postage paid envelope. Feel free to express your opinions.

Thank you for helping to improve health care for all consumers. If you have any questions about this survey, please call (307)773-8002.

Sincerely,

A handwritten signature in black ink that reads "John Lucas MD". The signature is written in a cursive, flowing style.

John L. Lucas, M.D.
Chief Executive Officer

454914 14wvse

The number on the bottom of the survey is used to tell us if you returned your survey so we don't send you reminders.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0998-0981. The time required to complete this information collected is estimated to average 8 minutes for questions 1-25 on the survey, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: Centers for Medicare & Medicaid Services, 7500 Security Boulevard, C1-25-05, Baltimore, MD 21244-1850.

Thank you! Your answers may be shared with the hospital for quality improvement and may be used for research purposes. Return to: 710 Rush Street, South Bend, IN 46601

SAMPLE

Appendix G Hospital Consumer Assessment of Healthcare Providers and Systems

SAMPLE



OMB Control Number: 0338-0081

PHYSICIAN

	very poor	poor	fair	good	very good
1. Time physician spent with you.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Physician's concern for your questions and worries.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. How well physician kept you informed.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Friendliness/courtesy of physician.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Skill of physician.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

DISCHARGE

	very poor	poor	fair	good	very good
1. Extent to which you felt ready to be discharged.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Speed of discharge process after you were told you could go home.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Instructions given about how to care for yourself at home.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

PERSONAL ISSUES

	very poor	poor	fair	good	very good
1. Staff concern for your privacy.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How well your pain was controlled.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Degree to which hospital staff addressed your emotional needs.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Response to concerns/complaints made during your stay.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Staff effort to include you in decisions about your treatment.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Comments (describe good or bad experience): _____

OVERALL ASSESSMENT

	very poor	poor	fair	good	very good
1. Your rating of Volunteered.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. How well staff worked together to care for you.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Likelihood of your recommending this hospital to others.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Overall rating of care given at hospital.....	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

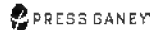
Comments (describe good or bad experience): _____

ADDITIONAL INFORMATION

- After discharge, did you receive a phone call from your nurse or another hospital staff member regarding your stay?
 Yes No Cannot Remember
- Did staff introduce themselves upon entering your room?
 Never Usually Sometimes Always
- Were you visited daily by the nurse manager or charge nurse?
 Never Usually Sometimes Always

Patient's Name: _____ Telephone Number: _____

THANK YOU. Please return the completed survey in the postage-paid envelope.



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 QJ4546-2001-01-2001

128456782

Survey questions 1 to 22 and the About Your Questions form were created by the U.S. Department of Health and Human Services.

SAMPLE

SURVEY INSTRUCTIONS: You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient. Answer all the questions by completely filling in the circle to the left of your answer. You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this: No → If No, Go to Question 1

Please answer the questions in this survey about your stay at Cheyenne Regional Medical Center. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES

- During this hospital stay, how often did nurses treat you with courtesy and respect?
 Never Sometimes Usually Always
- During this hospital stay, how often did nurses listen carefully to you?
 Never Sometimes Usually Always
- During this hospital stay, how often did nurses explain things in a way you could understand?
 Never Sometimes Usually Always
- During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
 Never Sometimes Usually Always I never pressed the call button

YOUR CARE FROM DOCTORS

- During this hospital stay, how often did doctors treat you with courtesy and respect?
 Never Sometimes Usually Always
- During this hospital stay, how often did doctors listen carefully to you?
 Never Sometimes Usually Always
- During this hospital stay, how often did doctors explain things in a way you could understand?
 Never Sometimes Usually Always

THE HOSPITAL ENVIRONMENT

- During this hospital stay, how often were your room and bathroom kept clean?
 Never Sometimes Usually Always
- During this hospital stay, how often was the air around your room quiet at night?
 Never Sometimes Usually Always

YOUR EXPERIENCES IN THIS HOSPITAL

- During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
 Yes No → If No, Go to Question 12
- How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
 Never Sometimes Usually Always
- During this hospital stay, did you need medicine for pain?
 Yes No → If No, Go to Question 16
- During this hospital stay, how often was your pain well controlled?
 Never Sometimes Usually Always
- During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?
 Never Sometimes Usually Always

Please use black or blue ink to fill in the circles completely.
 Example:

Return To: 710 Park Street, Suite 600, 3140801

(continued...)

SAMPLE

15. During this hospital stay, were you given any medicine that you had not seen before?

- Yes
- No → If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

- Never
- Sometimes
- Usually
- Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

- Never
- Sometimes
- Usually
- Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

- Own home
- Someone else's home
- Another health facility → If Another, Go to Question 21

19. During the hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

- Yes
- No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

- Yes
- No

GENERAL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays if your answers to 21. Using any particular form (e.g., where it is the worst) may be possible one 19 is the best; hospital possible, what minor would you use to rate this hospital during your stay?

- 0 Worst hospital possible
- 0 1
- 0 2
- 0 3
- 0 4
- 0 5
- 0 6
- 0 7
- 0 8
- 0 9 Best hospital possible

22. What do you consider your hospital to be in terms of health?

- Excellent/++
- Probably/++
- Probably/++
- Definitely/++

ABOUT YOU

23. In general, how would you rate your overall health?

- Excellent
- Very good
- Good
- Fair
- Poor

24. What is the highest grade or level of school that you have completed?

- Some high school, but did not graduate
- High school graduate or GED
- Some college or 2-year degree
- 4-year college graduate
- Master's or other college degree

25. Are you of Spanish, Hispanic or Latino origin or descent?

- No, not Spanish/Hispanic/Latino
- Yes, Puerto Rican
- Yes, Mexican, Mexican American, Chicano
- Yes, Cuban
- Yes, other Spanish/Hispanic/Latino

26. What is your race? Please choose one or more.

- White
- Black or African American
- Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaska Native

27. What language do you usually speak at home?

- English
- Spanish
- Chinese
- Russian
- Vietnamese
- Some other language (please print): _____

ADDITIONAL QUESTIONS ABOUT YOUR STAY

Now that we have asked you to tell us about what happened during your stay, we want to ask you about how well we did on our needs.

22A-5786

INSTRUCTIONS: Fill in the circle that best describes your experience. If a question does not apply to you, please skip to the next question. Space is provided for you to comment on 'Y' or 'U' experiences.

ADMISSION

1. Speed of admission process.....

very	good	fair	poor	
1	2	3	4	5
2. Courtesy of the person who admitted you.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

ROOM

1. Pleasantness of room decor.....

very	good	fair	poor	
0	0	0	0	0
2. Room cleanliness.....

0	0	0	0	0
---	---	---	---	---
3. Courtesy of the person who cleaned your room.....

0	0	0	0	0
---	---	---	---	---
4. Room temperature.....

0	0	0	0	0
---	---	---	---	---
5. Noise level in and around room.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

MEALS

1. Temperature of the food (cold foods cold, hot foods hot).....

very	good	fair	poor	
0	0	0	0	0
2. Quality of the food.....

0	0	0	0	0
---	---	---	---	---
3. Courtesy of the person who served your food.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

NURSES

1. Friendliness/courtesy of the nurses.....

very	good	fair	poor	
0	0	0	0	0
2. Promptness in responding to the call button.....

0	0	0	0	0
---	---	---	---	---
3. Nurses attitude toward your requests.....

0	0	0	0	0
---	---	---	---	---
4. Amount of attention paid to your special or personal needs.....

0	0	0	0	0
---	---	---	---	---
5. How well the nurses kept you informed.....

0	0	0	0	0
---	---	---	---	---
6. Skill of the nurse.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

TESTS AND TREATMENTS

1. Waiting time for tests or treatments.....

very	good	fair	poor	
0	0	0	0	0
2. Explanations about what would happen during tests or treatments.....

0	0	0	0	0
---	---	---	---	---
3. Courtesy of the person who took your blood.....

0	0	0	0	0
---	---	---	---	---
4. Courtesy of the person who started the IV.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

VISITORS AND FAMILY

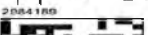
1. Visitor relations and comfort for visitors.....

very	good	fair	poor	
0	0	0	0	0
2. Staff attitude toward your visitors.....

0	0	0	0	0
---	---	---	---	---

Comments (describe good or bad experience): _____

(continued...)



SAMPLE

Appendix H

SWOT Analysis for Capstone Project

<p><u>Strengths</u></p> <ul style="list-style-type: none"> - Benefits patients and the community. - Standardizes communication. - Promotes team work. - Hardwires high performance. - Promotes patient centered care. - Stimulates critical thinking about patient centered care and outcomes. - Standard survey tool HCAHPS. - No additional funding required. - Demonstrates the value of the DNP role. 	<p><u>Weaknesses</u></p> <ul style="list-style-type: none"> - Small sample size. - Rural hospital. - Dangers of scripted communication. - Conservative population. - Decreased patient participation. 	<p><u>Strategies to Overcome Weaknesses</u></p> <ul style="list-style-type: none"> - Recruit the maximum number of eligible patients. - Demonstrate the value to patients and the community. - Contract with The Studer Group to hardwire high performance. - Contract with Press Ganey to assist with survey process. - Obtain IRB approval.
---	---	---

<p><u>Threats</u></p> <ul style="list-style-type: none"> - Limited patient participation. - Limited provider participation. - Limited employee participation. - Limited volunteer participation. - Ranking of rural hospitals against non-rural hospitals 	<p><u>Strategies to Overcome Weaknesses</u></p> <ul style="list-style-type: none"> - Educate the community about the importance of the patient participation to become a patient centered hospital. - Educate patients, providers, employees, and volunteers per The Studer Group through orientation, workshops, and in-services. - Prove benefits to patient, community, and improve healthcare.
---	--

Table H 1

SWOT Analysis for Capstone Project

<p><u>Opportunities</u></p> <ul style="list-style-type: none"> - Provide data regarding the impact scripted communication has on decreasing patient anxiety and increasing patient participation of care. - Increase patient satisfaction and performance using standard HCAHPS. - Increase reimbursement to promote health care services in Laramie County and throughout Wyoming. - Create safe patient centered environment where patients are at the center of their care. - Decrease health care costs in Laramie County and Wyoming by less crisis care.
--

Table H 2

Study Goals for Capstone Project

Goal	Type of Goal
Communication assessed in patients who have been admitted to the hospital.	Short-Term
Scripted Communication (AIDET) use by physicians.	Short-Term
Scripted Communication (AIDET) use by nurses.	Short-Term
Patient perception of communication by the Physicians and Nurses.	Long-Term
Patient Satisfaction measured by HCAHPS and Recommendation of hospital	Long-Term

Table H 3

Timeline for Capstone Project

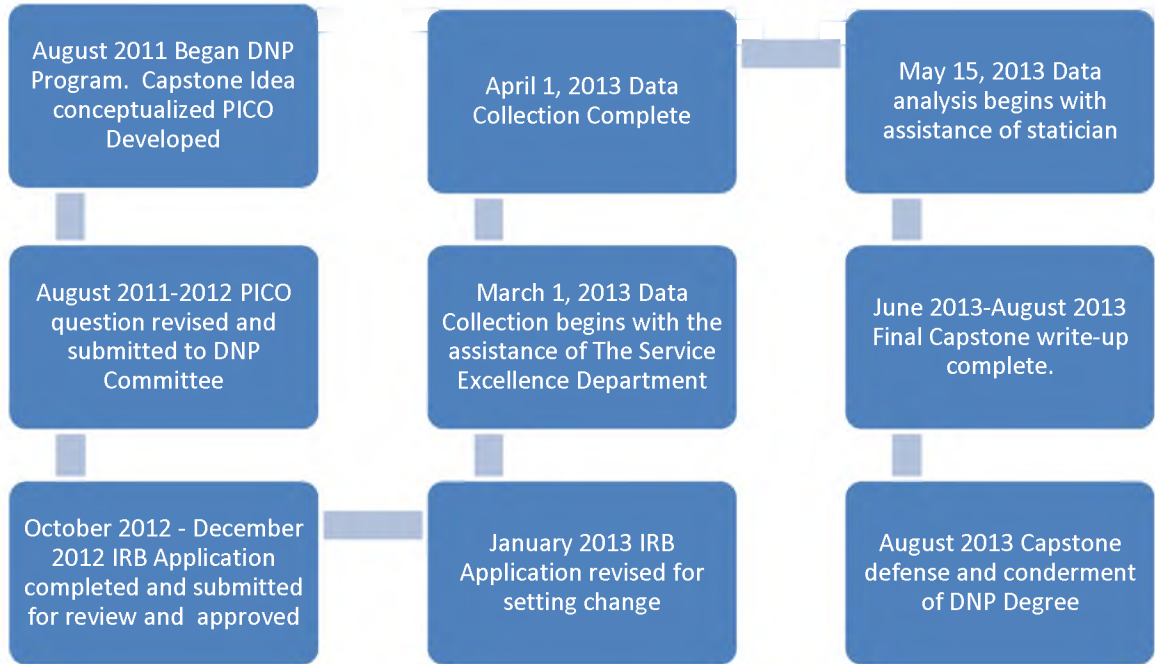


Table I4

Ethnicity of Respondents

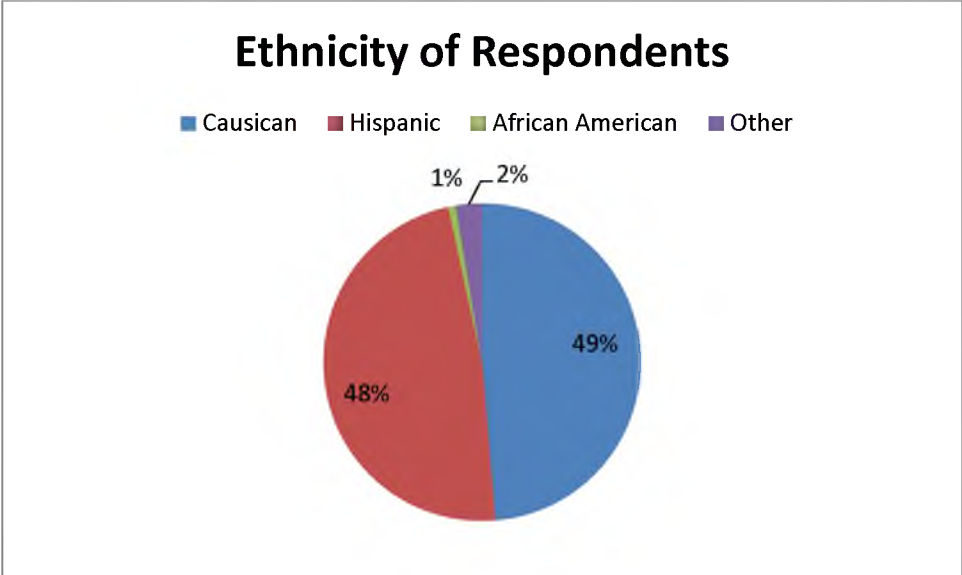


Table I5

Respondents Educational Level

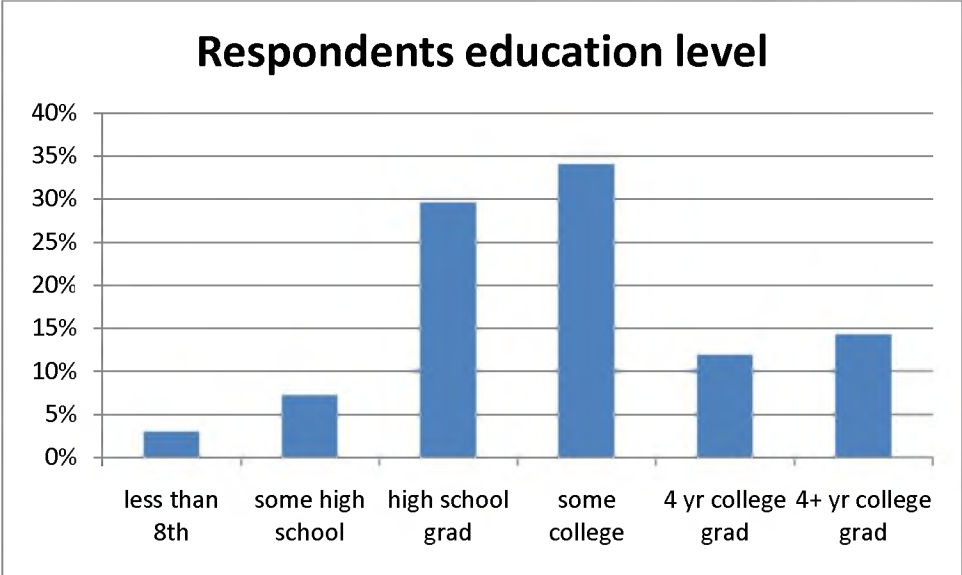
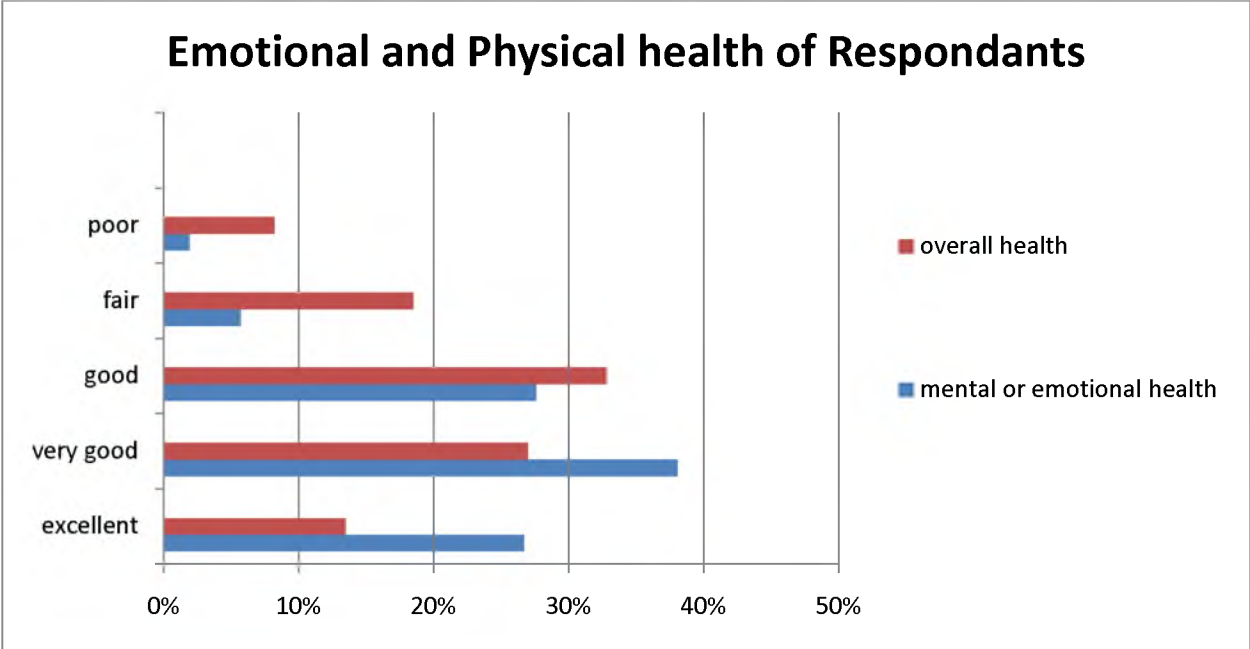


Table I6

Emotional and Physician Health of Respondents



AIDET Communication by Physicians Showing Courtesy and Respect

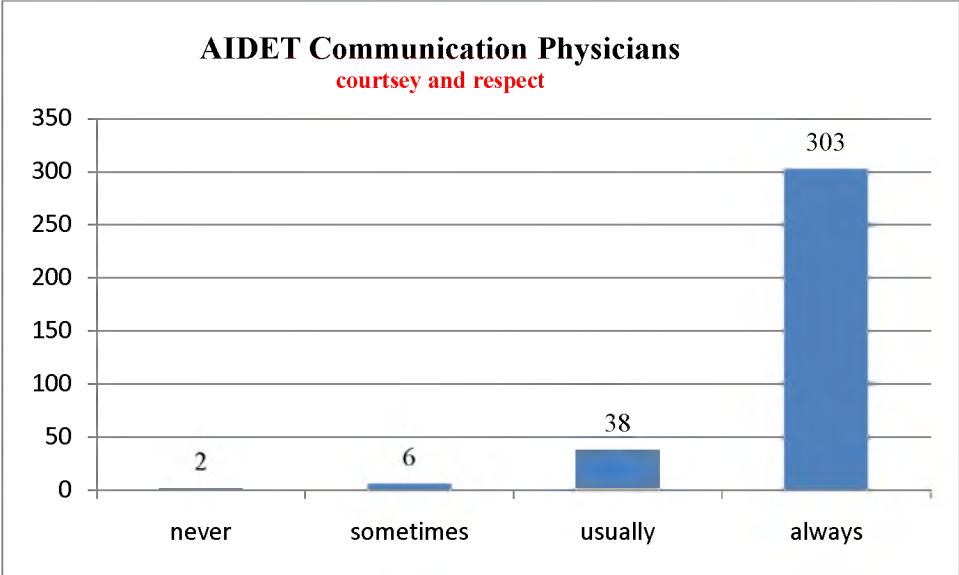


Table I8

AIDET Communication of Physicians Listening Carefully to Patients

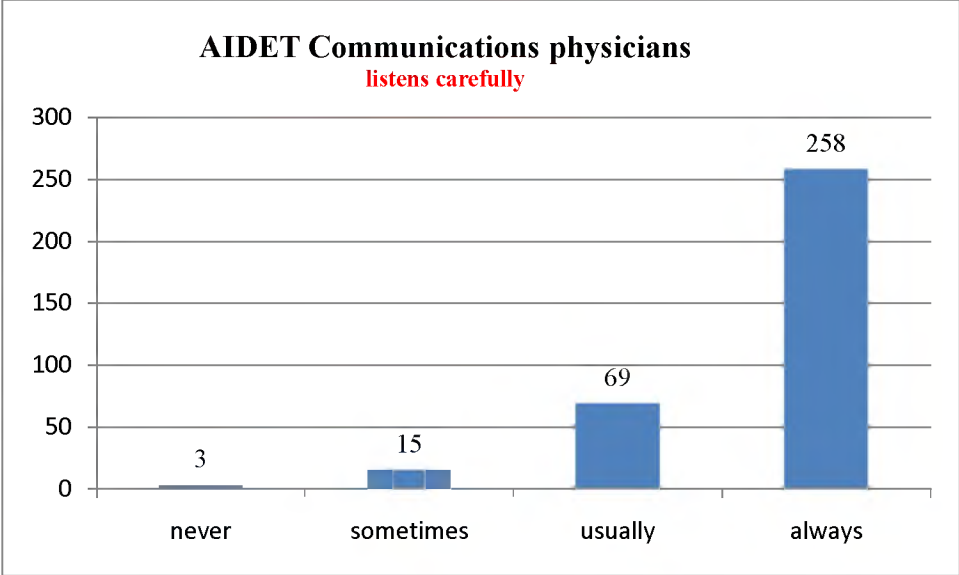


Table I9

AIDET Physician Communication Explains in an Understandable Manner to Patients

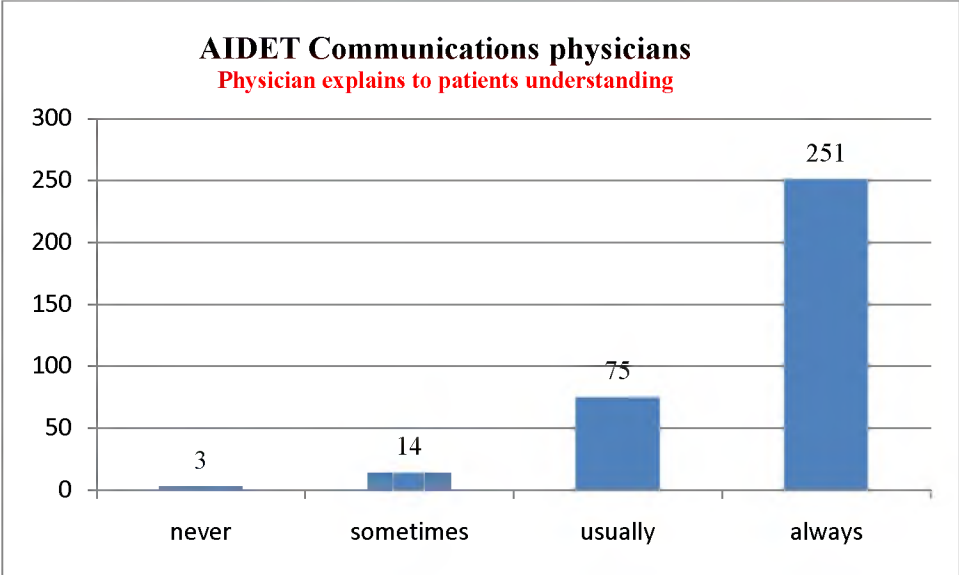


Table I10

Communication with Physicians Who Utilize AIDET

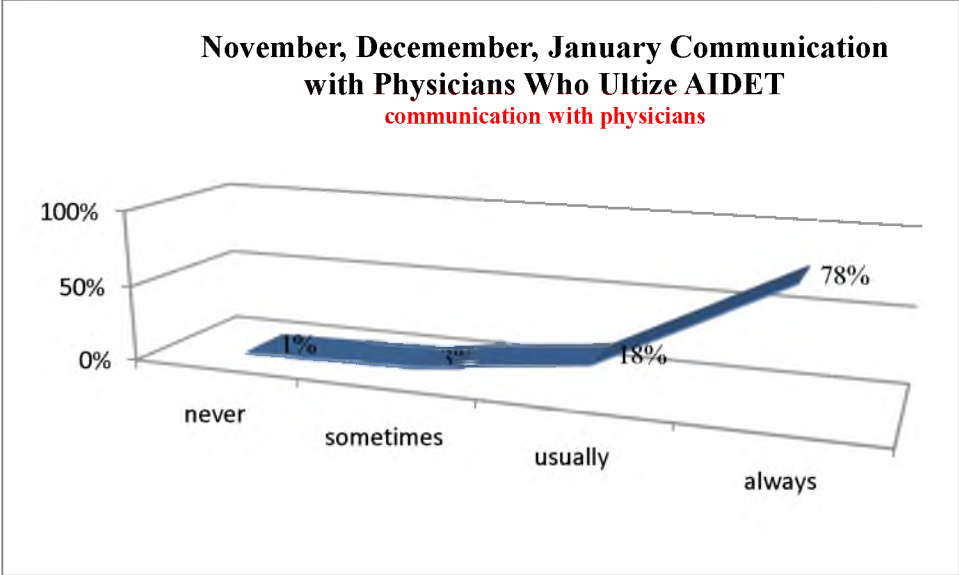


Table I11

AIDET Communication by Nurses Showing Courtesy and Respect

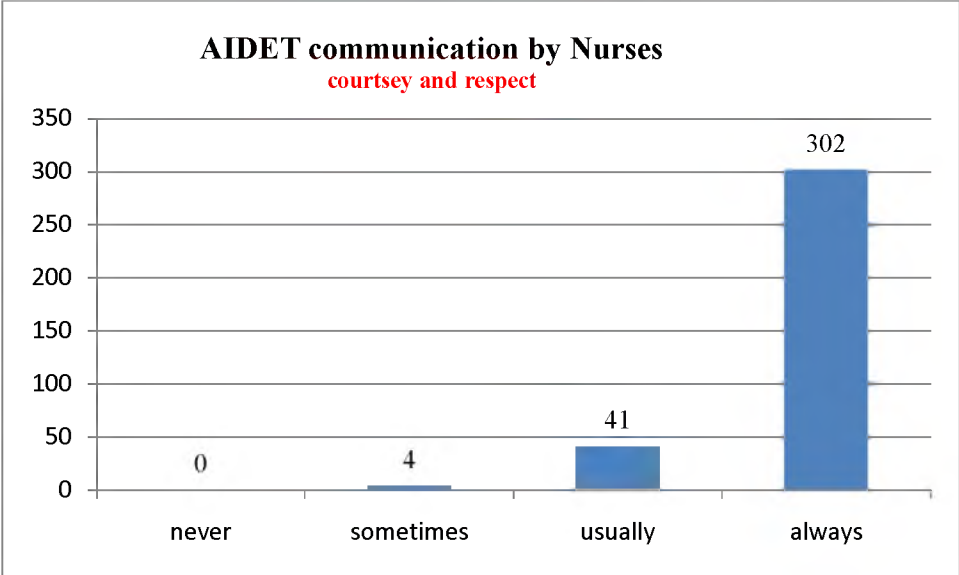


Table I12

AIDET Communication Nurses Carefully Listening to Patients

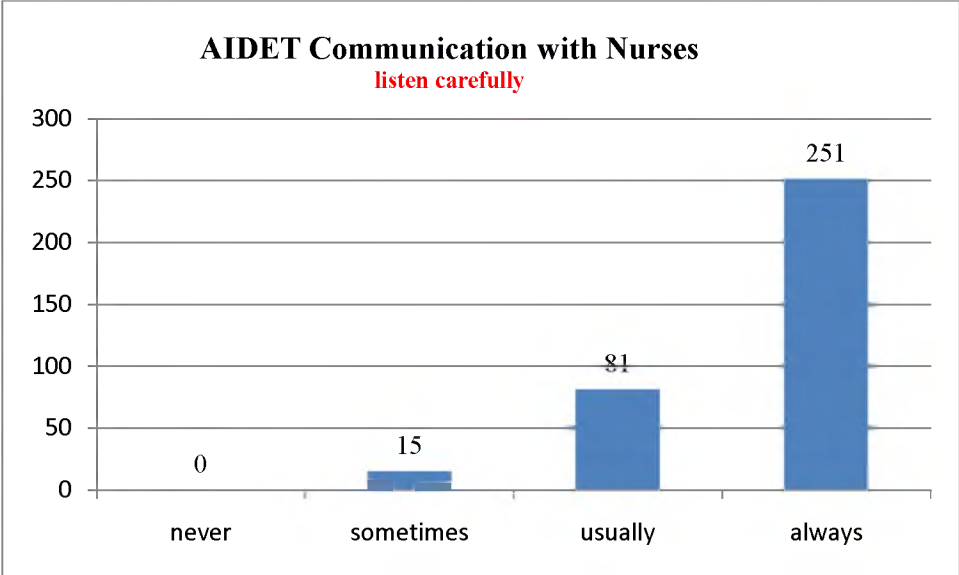


Table I13

AIDET Nurses Communication Explains in an Understandable Manner to Patients

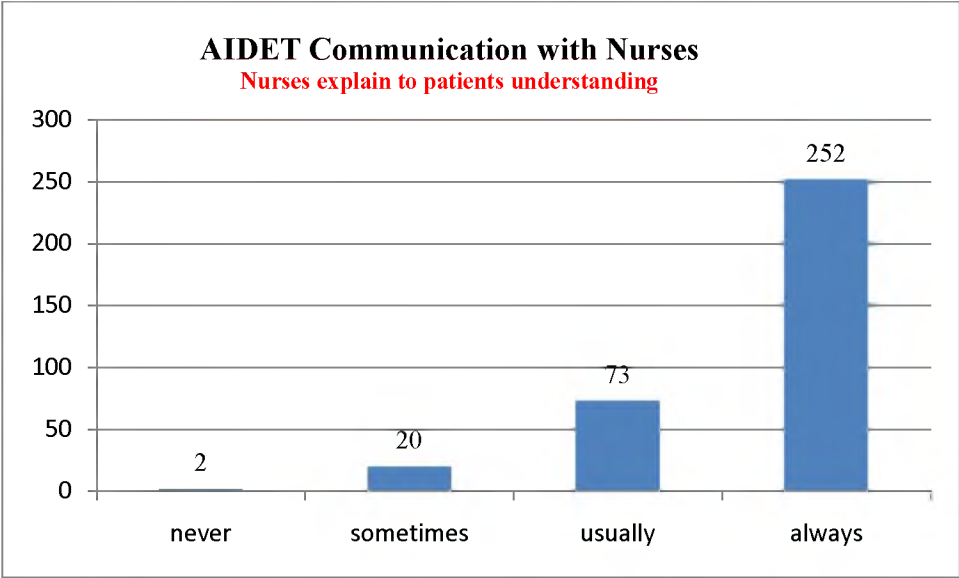


Table I14

Communication with Nurses Who Utilize AIDET

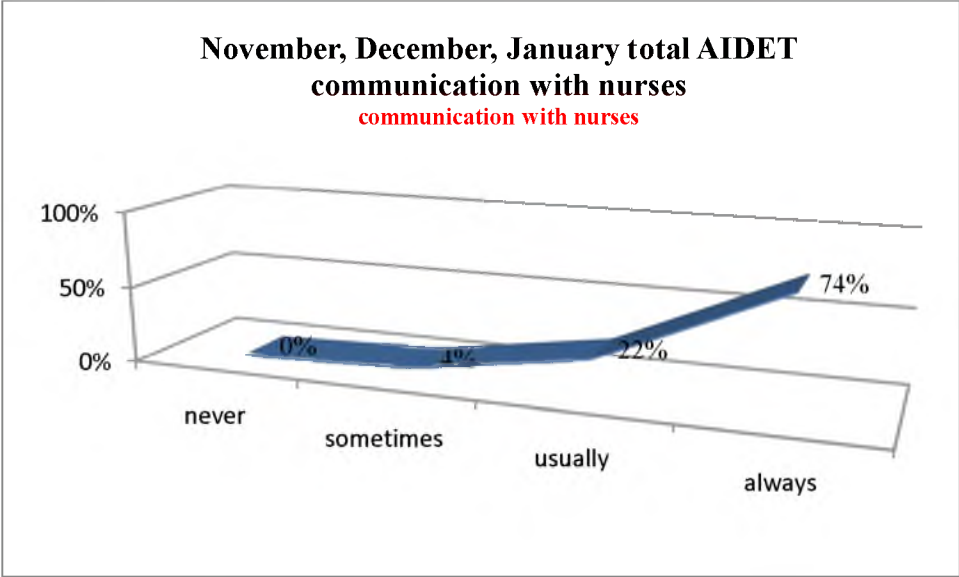


Table I15

November, December, January Recommendation of the Hospital

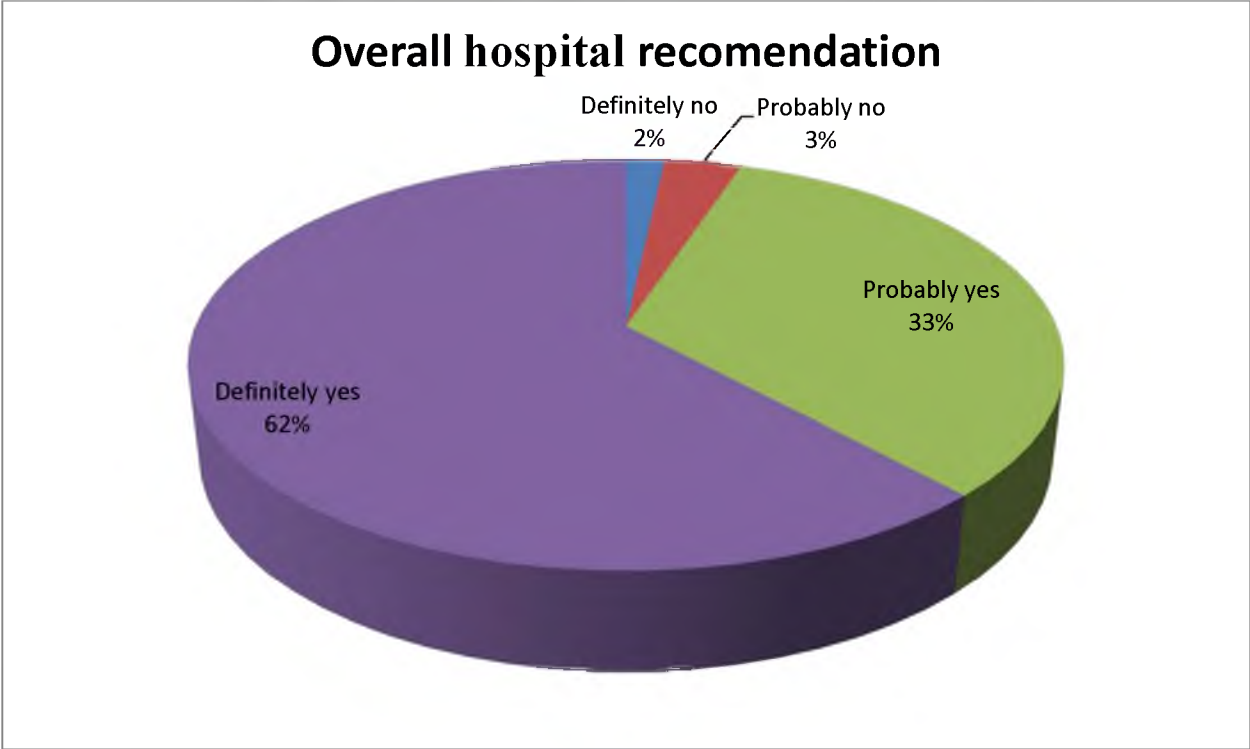


Table I16

November, December, January Recommendation of the Hospital

