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The Effect of the Implementation of Relationship-Based Care on Patient Satisfaction

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This is to certify that the doctoral study by

Laura Field

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Abstract

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MSN, Widener University, 1994

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Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

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Abstract

The purpose of this project was to evaluate the effects of relationship-based care (RBC) on patient satisfaction. RBC is a caring model that promotes a caring and healing environment by establishing and maintaining therapeutic relationships between patient, self, and coworker. The Centers for Medicare & Medicaid Services links Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores with reimbursement to hospitals. It is essential to not only achieve high patient satisfaction scores in order to ensure full financial reimbursement, but also to ensure high quality, patient-centered care. The current project assessed samples from 2 medical surgical groups, one system-wide and the other only patients from a single inpatient unit with sample sizes approximately 2,900 and 250 respectively. Data were collected retrospectively 3 times using the Press Ganey webpage at pre implementation, 6 months, and 12 months post RBC training. Results from an ANOVA indicated only a slight increase in post intervention HCAHPS scores with no statistical significant improvement. However, this increase indicates a positive trend, suggesting that the implementation of RBC may have assisted in improving patient responses. This evaluation has implications for the continued implementation for the enhancement of patient-centered care. These findings suggest that a nursing care model provides a collective belief to define a specific attitude to deliver care, facilitate professional development, and improve outcomes. By following RBC, nurses share a similar philosophy toward a caring environment.

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Dedication

I dedicate this project to my family, Chas, Ryan, Brennen, and Cailin. Their support is unending. Having a sense of humor was essential for the success of this project. Thank you all.

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I would like to thank my preceptor, Amy Glasofer for her guidance and encouragement. I could not have chosen a better mentor for this journey. In addition, AnneMarie Palatnik and Sue Politsky were amazing sources of motivation throughout my years at the Center for Learning. I would also like to thank David Kruidenier for his proofreading assistance and Mike Perekupta for his assistance with my statistical analysis. I'm glad they were all able to tolerate me for so long. I would like to thank my family for allowing me to fulfill my dream of obtaining my Doctorate in Nursing Practice. I want to thank my mother and father who are my biggest fans. They have both been my rock throughout the last five years of this journey. I would also like to thank Barbara Brinkman who believed in me and encouraged me to obtain my degree. She has guided me throughout this process and has offered much needed guidance for my success. I thank you all.

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Section 1: Nature of Project

Introduction

Patient satisfaction is a significant barometer in determining the quality of care in healthcare organizations. Patient satisfaction relates to the patient's perceptions of care and expectation attainment. High-quality care and caring behaviors equate to the financial success of healthcare organizations (Dingman, Williams, Fosbinder, & Warnick, 1999). One way of gauging patient satisfaction in the United States is the utilization of a standardized survey instrument and data collection tool given by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Consumers utilize HCAHPS scores to determine what healthcare institution would best match their needs. It is imperative for nurses to focus on courteous therapeutic communication while providing compassionate quality care, which emphasizes the connection with the patient to form a caring and healing environment. The implementation of a care model, such as relationship-based care, will improve the therapeutic relationship to produce an increase in patient satisfaction scores.

Background

Hospitals are focusing on improving patient satisfaction scores for various reasons. The Centers for Medicare & Medicaid Services (CMS) links HCAHPS scores with reimbursement to hospitals as a component of the Hospital Value-Based Purchasing (HVBP) program (Huppertz & Smith, 2014). Higher HCAHPS scores will produce a higher rate of reimbursement from CMS to healthcare providers (Press Ganey, 2014). HCAHPS scores account for 35% of an institution's value-based purchasing score and directly impact Medicare payments (Press Ganey, 2014). CMS incorporated the Institute of Medicine's (IOM) aims, one being the integration of patient centered care, as one of their strategies for improving quality of care (IOM, 2001). As a

result, hospital administrators are concentrating on ways to improve patient satisfaction and remain competitive in the ever-changing healthcare market. HCAHPS questions focus on nursing care, courtesy, listening, and communication skills to measure overall patient satisfaction (Levoy, 2009). Scores are available to consumers to educate themselves, compare healthcare facilities, and to determine what hospital will best meet their needs (Centers for Medicare & Medicare, 2014).

Nurses, coworkers, and organizational leaders have the authority and responsibility to be part of the transformation of improving patient satisfaction scores by identifying specific therapeutic behaviors and making a commitment to improve patient satisfaction. One method to achieve this goal is through the implementation of a care theory, which positively impacts the work environment regarding nursing care, patient satisfaction, and patient outcomes (Winsett & Hauck, 2011). A caring model guides the health care provider toward an understanding of the appreciation of the significance of patient communication and perceptions regarding the care patients' receive (Dingman et al., 1999).

Relationship-based care (RBC) is a caring model that promotes a caring and healing environment by establishing and maintaining therapeutic relationships between patients, coworkers, and self (Koloroutis, 2004). RBC, developed and trademarked by Creative Health Management, is based on Watson's (1988) theory of human caring, Swanson's (1993) middle range theory of caring, and Dingman's (1999) caring model. RBC incorporates the three relationships with six essential and interacting dimensions: teamwork, leadership, professional nursing practice, care delivery, resource-driven care, care delivery, and outcome measures (Koloroutis, 2004). Careful planning, continued education, and effective leadership are essential to the success of the implementation of RBC.

Patient-centered care models, such as relationship-based care, are becoming more prominent among leaders of healthcare organizations, research institutions, and public policy centers who believe that patients' affairs regarding healthcare should be the core of the healthcare experience (Cropley, 2012). RBC focuses on patient values and expectations while nurses engage and collaborate the care delivered. The success of healthcare institutions relies on the patients' perspective of the care they receive during their healthcare experience.

A special bond is created during a nurse's unique interaction with each patient, allowing them to act synergistically, to promote the well being of the patient. Tejero (2011) described this relationship as a nurse-patient dyad bonding and found that this relationship produces a strong positive correlation with patient satisfaction. Characteristics of this relationship include a nurse's ability to perform proficiently, display availability, and communicate knowledge (Williams & Irurita, 2004). The therapeutic and individualized relationship facilitates interpersonal communication, which results in improved patient satisfaction (Suhonem et al., 2012; Torero, 2011).

Caring models such as RBC are patient-centered models that focus on the therapeutic relationship between the nurse and patient. The successful implementation of caring models improves patient satisfaction leading to the loyalty of the consumer, increased revenue, market share, profitability, and improved outcomes (Dingman et al., 1999). RBC creates a caring and healing environment, which emphasizes the understanding of patient expectations, perceptions, and caring behaviors (Dingman et al., 1999).

The implementation of RBC as a caring model is the foundation for all practices in the healthcare facility utilized for this project. Virtua Healthcare System consists of three acute care hospitals with various health and wellness centers in the southern New Jersey area. RBC aligns

well with Virtua's mission, vision, and values. The implementation continues at varying levels throughout the institution.

Problem Statement

It is essential to achieve high patient satisfaction scores to receive full reimbursement and to maintain a competitive advantage. Improving patient satisfaction scores is imperative to the success of healthcare facilities. With shrinking reimbursement and lessening resources, it is essential that healthcare providers comprehend that the perceptions of quality are different for the healthcare provider and consumer (Levoy, 2009). Today, patients not only expect to have good outcomes, but they also desire and expect an individualized outstanding experience. Hospitals are concentrating on strategies to improve patient perception and satisfaction as measured by HCAHPS scores. Patient satisfaction is an individual's response to vital characteristics of the context, process, and outcome of their healthcare experience (Pascoe, 1983). Patients attribute their satisfaction with excellence of care, attainment of personal health goals and outcome, and quality (Suhonen et al., 2012). Nurses have the ability to explore patients' expectation during individualized nursing care. Because hospitals reimbursement from the Centers for Medicare and Medicaid is based on HCAHPS scores, hospitals need to improve their patient satisfaction scores to receive full payment to maintain financial success.

Purpose

The purpose of this project was to evaluate the effects of RBC on patient satisfaction. The project objective was to determine if the implementation of the care model, RBC, improves patient satisfaction as evidenced by the improvement of HCAHPS scores for patient's perception of their nurse, including listening carefully and treating the patient with courtesy and respect.

The project hypothesis was that there will be an increase in patient satisfaction scores after RBC is implemented in a healthcare facility.

Significance

By maximizing patient satisfaction and reimbursement, healthcare facilities can position themselves as a leading competitor in the healthcare arena. The utilization of HCAHPS gives an institution a partial vision of the patients' perception of quality nursing care. Exploring the link between the implementation of RBC and patient satisfaction is imperative to the future success of healthcare organizations. The project question was: Does the implementation of a RBC model improve patient satisfaction in an acute care facility as evidenced by improved HCAHPS scores?

Evidence Based Significance

There is little evidence supporting the relationship between the incorporation of patient-centered models and care models, such as RBC, into healthcare facilities and the effects on patient satisfaction. Exploring the correlation between the implementation of RBC and patient satisfaction is imperative to the future success of healthcare organizations.

However, RBC guides professional nursing practice and provides a foundation for evidence-based practice. The model emphasizes underlying threads of trust, respect, support, and therapeutic communication (Mathes, 2011). Evidence-based practice "integrates the best research evidence with clinical expertise and patient values" (Koloroutis, Felgen, Person, & Wessel, 2007, p. 657). According to Kettner, Moroney, and Martin (2013) evidence-based practice stresses the importance of using best available evidence when making clinical decisions. Improved caring relationships and therapeutic communication "contribute to positive outcomes for patients/families, healthcare providers, and healthcare systems" (Duffy & Hoskins, 2003, p.86). RBC improves communication between staff allowing them to collaborate on the delivery

of multidisciplinary, individualized quality care. There is a gap in the research literature demonstrating the application of caring theories and patient outcomes. Using the evidence received from the effects of caring theories will assist in the translation of research results to evidence-based practice to improve safety, quality, and outcomes (Duffy, 2003).

Implications for Social Change

One transformation within healthcare is the concept of Hospital Value-Based Purchasing (HVBP). This change determines the rate of reimbursement based on patient satisfaction regarding the patient's perception of the care received during their stay at the hospital including care, communication with nurses and physicians, environment, and patient education received prior to discharge. The HCAHPS survey has three general goals, which are all endorsed by the National Quality Forum (NQF) in standardizing quality measurement and reporting (HCAHPS, 2014). The goals include:

1. The survey produces comparable data in the patient's perspective on care that allows objective and meaningful comparisons between hospitals on domains that are important to consumers.
2. Public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care.
3. Public reporting will serve to enhance public accountability in healthcare by increasing transparency of the quality of hospital care provided in return for the public investment (Centers for Medicare & Medicaid, 2014).

The implementation of RBC will create a caring and healing environment by forming therapeutic relationships between the patient and family, colleagues, and self to promote the best healthcare outcomes possible. The successful implementation of RBC facilitates safe, evidence-

based practice, and staff consumer satisfaction leading to a successful healthcare future (Rowen, 2007). This change of focus towards the patient and family empowers nurses to provide meaningful and relevant care and provides the patient with improved health outcomes (Hebda & Patton, 2012).

Definition of Terms

Relationship-based care: A caring model that emphasizes three relationships for the delivery of compassionate and humane care (Koloroutis, 2004). The three relationships are with the patient/family, colleagues, and self. RBC functions as a framework for the transformation of the organizational culture that shape caring behaviors (Koloroutis, 2004). These relationships allow the nurse to understand the patient's expectations pertaining to their physical, emotional, spiritual, and psychological needs (Koloroutis, Felgen, Person, & Wessel, 2007). By understanding patient expectations, nurses can focus on the patient instead of tasks to form a caring and healing environment.

Patient satisfaction: The equivalent between patient expectation of caring and the caring actually received (Greeneich, 1993). Patient satisfaction is an essential indicator to gauge the quality of care and the financial success of a healthcare provider (Dingman et al., 1999). I used HCAHPS scores to measure patient satisfaction.

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) *Survey:* A standardized tool to measure and assess patient satisfaction in areas of listening, explanations, environment, and cleanliness (HCAHPSonline, 2014). It allows consumers to make an educated decision regarding healthcare organizations and providers.

Assumptions and Limitations

There were several limitations to this program evaluation. One assumption of this project was that it was expected that all nurses in the units measured for this project embraced RBC, performed caring behaviors based on RBC, and demonstrated the dimensions of RBC. The design was a quantitative design, which does not allow for subjective information regarding human interactions concerning their healthcare experience (Terry, 2002). Social, internal, holistic, or emotional information could not be assessed. Because this project design was retrospective, it did not allow for control of the variables or reliability of the data (Portney & Watkins, 2009). I used a pre test post test design, which does not contain a control group or randomization, causing difficulty in attributing causation to the intervention (Terry, 2002). It was difficult to determine exactly when RBC was fully implemented in each unit and if the entire staff incorporated the behaviors into their daily professional practice. Leaders from each department were responsible for the implementation of RBC into their unit.

Summary

This section was a description of the project including a complete background of the need for the implementation of RBC as it relates to patient satisfaction, reimbursement, and current literature. The purpose, hypothesis, aim, objective, and project questions were included in this section. This section also included the definitions of associated terms, discussed how the project relates to social change in healthcare, and noted assumptions and limitations. There was limited information in the literature regarding how caring models affect patient satisfaction.

Section 2: Review of Scholarly Literature

Introduction

Because hospitals' reimbursement from the Centers for Medicare and Medicaid is based on HCAHPS scores, hospitals need to improve their patient satisfaction scores to receive full payment to maintain financial success. The purpose of this project was to evaluate the effect of RBC on patient satisfaction. Although there is a vast amount of literature regarding patient satisfaction focusing on improving HCAHPS scores, there are few researchers who linked caring theories to patient satisfaction improvements. This section is a review of literature regarding RBC, caring theories, and patient satisfaction.

While there are numerous articles explaining an institution's experience regarding the implementation of RBC, there were a limited amount of studies, which attempted to demonstrate an increase in patient satisfaction score with the implementation of RBC. I included one article, which utilized a patient-centered care model, not RBC specifically to determine if patient satisfaction scores improve.

Literature Search Strategy

The seven electronic databases used to perform a comprehensive literature review for this project included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, PubMed, EBSCO, Ovid Plus, Google Scholar, and Cochrane Library. Boolean terms, for example, *and* and *or* were useful to produce an increase in available articles. All articles were included despite the date due to the lack of literature on the topic of patient satisfaction and caring theories. Key search terms included the following: relationship-based care, caring theories, patient satisfaction, and HCAHPS. The review of the literature was organized in a narrow to broad sequence, separating topics of RBC, caring theories, patient satisfaction, and

HCAHPS. I also included a brief background in the utilization of various implementations of RBC as an introduction before the review of the literature was discussed in this paper.

Framework

Hospitals are focusing on patient-centered quality care mainly due to rising healthcare costs, medical liability, staffing shortages, and limited healthcare access (Cropley, 2012). RBC is a model that empowers patients, through education and coaching, to become a part of the collaborative team making informed decisions regarding their health. The improvement of the quality of care, according to the Institute of Medicine's (IOM, 2001) report, included the implementation of patient centered care to allow the patient to be the source of control. By empowering patients to be part of the care team and to promote patient control, patients' perceptions of their care may improve, leading to improved HCAHPS scores and improving reimbursement for hospitals.

Professional care models give nurses the "responsibility and authority for the provision of direct care" and allows the nurse to provide individualized skilled care to accomplish desired outcomes (ANCC, 2005). An individualized approach to care provided by the nurse, may improve the patients' perception of the care that he or she receives. The successful implementation of a nursing care model provides a collective belief to define a specific attitude toward the delivery of care, professional development, and constant improvement of patient, nurse, and organizational outcomes (Kaplow & Reed, 2008). By following the caring theory of RBC, nurses share a similar philosophy regarding the attainment of a caring and healing environment. These caring behaviors and attitudes demonstrate a deep commitment to patient satisfaction (Dingman et al., 1999).

RBC, trademarked by Creative Health Care Management, is a caring theory incorporating three crucial relationships: nurse with patient and family, nurse with colleagues, and nurse with self (Koloroutis, 2004). According to Koloroutis, the key to a caring and healing environment is the establishment of a caring, collaborative relationship between the nurse and the patient and family. At times, it may be difficult to establish this relationship because of the many distractions: monitors, electronic devices, critically ill patients, family members, and stressed employees (Schneider & Fake, 2010). In addition, six dimensions encompass RBC including leadership, teamwork, professional nursing practice, care delivery, resource driven practice, and outcomes measurement. These six dimensions are essential for creating a caring and healing environment.

The implementation of a patient-centered care model, such as RBC, provides a framework or guide to incorporate and hardwire caring behaviors for all communication, all departments, and all disciplines (Winsett & Hauck, 2011). Common themes of patient centered care models include individualized care, patient satisfaction, collaboration, and quality (Wolf et al., 2008). Patients and families are encouraged to be involved in their care while nurses provide knowledge, guidance, and nonjudgmental support.

Relationship-Based Care

Two very significant studies show contrasting results regarding the implementation of a caring theory to patient satisfaction. While Cropley (2012) assessed the impact of the implementation of RBC, Dingman (1999) evaluated the effect of implementing a general caring theory based on Watson's theory of human caring and Leininger's transcultural care theory on patient satisfaction. Both studies utilized a pre intervention and post intervention method to determine the impact on patient satisfaction. A dissimilarity of the two studies is such that while

Dingman used a survey tool developed by the Gallup Organization including a Likert-type scale with answers ranging from very satisfied to very dissatisfied, Cropley used HCAHPS scores (Cropley, 2012; Dingman, 1999).

In addition to patient satisfaction, Cropley (2012) also assessed the impact of RBC to length of stay and readmission rates in hospitalized patients in a small rural hospital in Texas. Cropley utilized secondary data from 2009 for the pre implementation data and 2010 for the post intervention data. According to Cropley, the data were reported in aggregate for monthly average HCAHPS scores relating to communication with nurses, responsiveness of hospital staff, pain management, and discharge information. Unfortunately, the study did not reveal a significant increase on patient satisfaction scores. One limitation to note is the short amount of time that the evaluation was performed after the implementation of RBC, resulting in an immature implementation. Utilizing a culturally hardwired model, may improve the likelihood of a positive result of improving patient satisfaction (Cropley, 2012).

Dingman et al. (1999) performed a study to evaluate the effect of the implementation of a caring theory on patient satisfaction in a 48-bed acute care hospital. Dingman et al. performed an analysis of variance and a leverage analysis regarding patient satisfaction characteristics to examine the results of nurse caring behaviors. Caring behaviors were attributed to improved patient satisfaction, which provides further evidence that caring is essential to the perception of patient satisfaction (Dingman et al., 1999). This finding is significant as evidence that the financial success of an institution is partly dependent upon high patient satisfaction scores (Huppertz & Smith, 2014). Recommendations included a plan for sustainability as increases in patient satisfaction plateaued after 6 months post intervention.

In a similar study, Winsett and Hauck (2011) examined patient satisfaction scores before and after an implementation of RBC using a caring behavior checklist to ensure full implementation. In addition to patient satisfaction and caring behaviors, researchers also measured staff turnover, staff satisfaction, and job performance. Caring behaviors included: responding to patient concerns, explaining procedures, validating, reassuring, conversing about non-healthcare issues, eye level conversations, touching, sustaining eye contact, and providing physical comfort measures (Winsett & Hauck, 2011). Using statistical software SPSS version 16, researchers found a range of 8.55 to 8.81 for a pre implementation score for patient satisfaction. Post implementation and during the training period scores showed no significant change, an increase from only 8.92 to 9.02, resulting in weak support for improved patient satisfaction.

It is worth mentioning a study in which researchers illustrated an improvement of parent satisfaction in a neonatal intensive care unit after an implementation of RBC (Faber, 2013). Similar to all previous articles presented, outcomes were evaluated using a pre test post test method. Various outcomes were addressed including perceptions of quality of care, parents' perception of the nursing staff, and nurses' perception of care. During the implementation, Farber explained how nurses were encouraged to form therapeutic relationships by the creation of primary care PODS in which nurses and parents collaborate care for the infant, perform morning huddles, and participate in daily rounds. The researcher reviewed six questions regarding caring in which pre test scores ranged from 1.85 to 3.29 and post test scores ranged from 3.43 to 4.57 which demonstrated a statistically significant increase in the parents' perceptions of care, and thus validating RBC.

Cropley's (2012) study in which patient satisfaction did not increase with the implementation of RBC is comparable to the study in which Wolf et al. utilized a randomized control group method in which 116 patients participated from a bariatric center (Wolf et al., 2008). Although RBC was not specifically implemented, a patient-centered care (PCC) model was utilized which focuses on similar concepts of RBC especially the patient and family as the core to caring. Usual care was provided to the control group participants while nurses educated in skills of PCC cared for study participants. The PCC group received a pre admission call, an individualized care plan, care partner identification, daily collaboration, partnership in decision-making, and a post discharge phone call (Wolf et al., 2008). No statistically significant difference was found in the groups and no significant differences were found for satisfaction or satisfaction with nursing care. However, it is important to note the participants in the PCC group were more open, communicative about feelings, and comfortable discussing negative experiences.

RBC focuses on the relationship with self, coworkers, and the patient and family. According to Koloroutis (2004), the relationship between nurses and patients and families is based on respect, personal concern for the patient, understanding expectations, protecting their dignity and well-being, and consistently encouraging feedback in all aspects of the patient's care. This is congruous with the findings of LeBlanc (2004) that engaging an open sense of communication during interactions yields a strong and significant positive correlation in regards to patient satisfaction. Likewise, Tejero (2011) found that the therapeutic dyad of nurse-patient relationship produced a higher level of patient satisfaction as evidenced by a high coefficient score indicating that the "higher the bonding factor score, the more therapeutic the interaction and the more satisfied the patient" (p. 1000). Swartz et al. (2008) also concluded that not only

does the patient benefit from a nurse-patient dyad, but that nurses have reported a reduction of stress and increased job satisfaction.

HCAHPS and Patient Satisfaction

HCAHPS is a 32-item survey with a set of 21 questions pertaining to communication with doctors and nurses, responsiveness of staff, pain management, communication about medication, discharge information, cleanliness of the environment, noise level, and transition of care (Appendix A, CMS, 2014). HCAHPS is the first national standard survey to measure patients' perception of their hospital experience. This allows hospitals to compare themselves with other hospitals across the nation. This public tool also enhances accountability and creates incentives for hospitals to improve the quality of the care they deliver. Results of the HCAHPS can be found on the *Hospital Compare* web page on www.medicare.gov/hospitalcompare. Because of HVBP program, hospitals are reimbursed from the CMS, according to their performance on HCAHPS. It is essential for hospitals to consistently improve the quality of care and patient satisfaction.

Huppertz and Smith (2014) suggested that the quantitative method of HCAHPS does not provide consumers with patients' anecdotal feedback, which can offer consumers information about their experiences. Likewise, Lagu and Lindenauer (2010) found that these limitations hindered consumer acceptance of HCAHPS and suggested that HCAHPS creators add a section for qualitative feedback. Furthermore, Huppertz and Smith reported that negative comments made on HCAHPS survey attempted to communicate a deeper level of dissatisfaction, which administrators may find helpful when learning to improve the quality of care.

Summary

This section emphasized the need for future examinations of strategies to improve patient satisfaction scores. Three of the studies found that relationship-based care does improve patient satisfaction; however, Faber (2013) included parent satisfaction in a neonatal care unit. Cropley (2012) did not produce a positive impact on patient satisfaction scores. Likewise, Wolf (2008) did not find a positive impact on patient satisfaction although a patient-centered care model was implemented instead of RBC. Finally, Tejero (2011) found that therapeutic relationships between the nurse and patient were also predictive of improved patient satisfaction. There was not strong support for the effect of RBC on patient satisfaction.

Section 3: Methodology

Introduction

The purpose of this project was to evaluate the effects of RBC on patient satisfaction. This section is an outline of the methodology of the project including the implementation process, setting, sample, and data collection. This section includes an explanation of the HCAHPS instrument utilized to determine patient satisfaction and how data was analyzed.

Setting

This project took place at Virtua Healthcare Systems, located in southern New Jersey. In addition to a system-wide evaluation of RBC, Voorhees 7A medical surgical unit was selected to participate in this program evaluation. Virtua consists of three community, acute care facilities. In April of 2013, Creative Health Care Management, an international healthcare consulting firm and the creators of RBC, performed a 5-day immersion program for administrative staff, educators, and managers at Virtua. Nursing staff were not included at this time. The program consisted of the foundations of RBC, the three relationships, six dimensions, and various strategies to incorporate RBC into the Virtua Healthcare System. The chief nursing officer is passionate about RBC because forming healthy interpersonal relationships is essential to connecting to one another to form a caring and healing environment (Personal Communication, Tracy Carlino, September 13, 2013).

Voorhees 7A was selected as an exemplar for a nursing unit that has fully incorporated RBC into their practice. The unit is a 24-bed medical/surgical unit with a staff of 35 registered nurses. The nursing director has a strong vision of how RBC works and has successfully inspired the nursing staff to see the benefits of the model (Personal Communication, Karen

Goldsmith, December 1, 2014). Some activities that have transformed the nursing staff toward the RBC model included:

- Improve educational programs such as pressure ulcers, wound care, falls, patient and family education
- Staff recognition activities including professional advancement
- Infection prevention program- foley, central lines, hand washing
- Team building- "Get To Know" posters
- Community service involvement – holiday giving project, March of Dimes
- Communication board
- HCAHPS awareness program- "Race to the Top"
- Social media development including 7A Facebook page
- Exercise fitness challenge to promote care of self and teamwork
- Evidence based practice involvement including patient flow issues, hospital pull-through time, product education, and new product review
- Encourage staff competency improvement
- Resource utilization and waste awareness

(Personal Communication, Karen Goldsmith, December 1, 2014)

Implementation of Relationship-based Care

The implementation consisted of monthly classes for all nursing staff held by senior educators in addition to a monthly huddle to discuss each nursing unit's specific objectives and goals. The objectives for the class included defining the three relationships and six dimensions of RBC, discussing appropriate behaviors to facilitate a caring and healing environment, and identifying strategies for the implementation of RBC (Field & Glasofer, 2013). The

interdisciplinary team focused on improving the care delivery to patients, improving healthy relationships between self, patients, and coworkers, and facilitating the ownership of nurses' professional practice. The class consisted of various speakers, power point presentations, interactive conversations, videos, and a question and answer session for a variety of teaching strategies.

In addition to the RBC foundation class, on-line learning tools consisting of power point presentations, monthly RBC reminders, templates, videos, and many resource materials, were available to all employees to further their understanding of relationship-based care. Monthly RBC huddles, at various locations of the campus, offered a venue for employees to discuss their experiences with the implementation process as well as seeking assistance to overcome barriers to its implementation. All senior educators involved in the transformation of RBC were also available to attend staff meeting to assist in the facilitation of RBC if barriers arise or managers want to enhance the present implementation on the nursing units.

Sample

Two samples were utilized for this project. Group one consisted of all medical-surgical patients who received and returned surveys. Group two consisted of only patients who have received and returned surveys from Voorhees 7A medical surgical nursing unit. The sampling procedure included a random sampling of all eligible patients on a monthly basis. Virtua sends a list of all discharged patients to Press Ganey. Patients who receive the survey must be 18 years or older, have had an overnight stay or longer, and be discharged alive from the hospital. Surveys are excluded from a hospice discharge, prisoner, foreign address, high publicity patients, and patients discharged to nursing homes (CMS, 2008). Within one week, Press Ganey, an approved survey vendor sends a random sample of surveys to those patients along with a cover

letter (Appendix B). Press Ganey receives the list of eligible discharges, administers the survey, and submits the HCAHPS data in a standardized format to Virtua on a quarterly basis to create a rolling quarterly data file. After three weeks of the mailing of the surveys, if there is no response, Press Ganey sends a follow-up letter to remind the individual to return the completed survey (Appendix C).

On average, there are approximately 500 system-wide surveys received each month to Virtua from Press Ganey. The nursing unit 7A has approximately 17 surveys returned per month. There were three samples utilized for this project, pre-implementation, and post-implementation at 6 months and 12 months periods. A total of seven nurses from 7A medical/surgical nursing unit attended the relationship-based care classes in October 2013. This information was required to determine the dates for pre-implementation and the dates for post implementation.

Variables

The independent variable was RBC. The dependent variable was patient satisfaction, which was measured by HCAHPS scores, in which the patient's perceptions were reported for how often their nurse treated them with respect and courtesy, and listened carefully to them.

This project was limited by scope to the assessment of the program at one particular hospital system. Furthermore, this evaluation was also limited in terms of time, as an implementation of a caring model may take longer to assure a culturally hardwired, mature model (Cropley, 2012). As a result, time was a limitation of the evaluation (Leedy & Omrod, 2010). In addition, the evaluation used quantitative data, which does not allow for subjective information regarding human interactions concerning their healthcare experience (Terry, 2002). Social, internal, holistic, or emotional information could not be assessed.

Because this was a program evaluation, it did not allow for control of the variables or reliability of the data (Portney & Watkins, 2009). Confounding variables could not be controlled during this evaluation. However, this evaluation was a primary attempt to demonstrate a fundamentally descriptive work to decrease the gap in the literature regarding the effect of relationship-based care on patient satisfaction. Future projects would be beneficial to decrease the extraneous variables by comparing units that have fully implemented relationship-based care and units who have not implemented the model. This type of project would increase the likelihood that the findings are an accurate assessment of the project and not due to extraneous factors (Burns & Grove, 2009). However, for this project, all departments were educated regarding RBC at the same time.

Instrument

The HCAHPS survey is a standardized tool utilized nationally since 2006 to provide public sharing of comparable data for acute care hospitals (Appendix A, CMS, 2014). Questions are asked regarding the patient's care experience including communication with nurses, communication with doctors, responsiveness of staff, cleanliness and quietness of the facility, pain control, discharge information, and communication about medications. There were demographic questions used for screening patients and adjusting the mix of patients.

To determine the survey's statistical data, the CMS along with the Agency for Healthcare Research and Quality (AHRQ) to improve public reporting of clinical measures, performed a 3-state, 24 hospital, pilot field study (CMS, 2003). Sample members, adult patients with an overnight short-term, acute care hospital stay, were mailed an introductory letter 1 week prior to receiving the survey and a follow-up postcard 4 weeks later if no response was received. A variety of core hospitals were utilized for a mixed random population for the pilot study. The

survey consists of 32 items to determine the perceived satisfaction of the patient's hospital experience.

Composites had an internal consistency reliability of *.89* for communication with nurses exhibiting a high hospital level reliability (CMS, 2003). For reliability to be useful, a score of *.7* is acceptable (Polit, 2010). Covariance statistics supported the use of the questions regarding communication with nurses as a composite. The two questions used in this project regarding listening and respect were highly related to the patients' perceptions of their overall rating of the hospital with an alpha score of *.79* and *.73* respectively (CMS, 2008). Construct validity occurs through the establishment of content and predictive validity of measurement of an instrument (Burns & Grove, 2009). Construct validity relates to the way a measure relates to other measures, indicating if communication with nurses is an important quality for patients, then the hospitals with high composite scores, will also have a high overall rating. For a composite to be useful, a score of is acceptable (Polit, 2010). According to Burns & Grove (2009) because a correlation coefficient of *1.00* indicates perfect reliability and *0.00* indicates no reliability, a value of *.76* demonstrates a strong reliability for communication with nurses in correlation with patients' overall rating of the hospital.

The tool measures the frequency of specific care experiences using a response scale as always (4), usually (3), sometimes (2), or never (1). In addition, there are two global questions rating the overall experience of the patient and rating the hospital on a scale of 1-10 with 10 signifying the best hospital care. The last question asks if the patient would recommend the hospital using a scale of "definitely yes" to "definitely no." The two questions most appropriate for this project were descriptive of a caring model such as relationship-based care and were "reflective of direct nursing relationships" (Cropley, 2012, p. 334). The first question relates to

how often nurses treat the patient with courtesy and respect, which are essential to the caring and healing environment of relationship-based care and for the personal healing relationship it forms (Koloroutis, 2004). The second question relates to how often nurses listen carefully to the patient.

RBC is a caring model, which focuses on the caring behaviors of nurses. Caring characteristics, reported by eighty cultures, encompass words such as respect, concern, attention, and presence (Leininger, 1994). These words relate to the two selected HCAHPS questions regarding listening, respect, and courtesy. To accomplish a trusted relationship with a patient and family, it is essential for the nurse to listen to their patient's unique needs and expectations (Koloroutis, 2004). Koloroutis explains that the nurse acts a guide to usher a patient's path through unknown situations and to help the patient and family understand pertinent information to allow for knowledgeable decision-making. Therefore, respect and courtesy are essential components of RBC.

Data Collection

This project began approximately 1-year after the initial RBC class. HCAHPS scores were collected for the two questions prior to the initial class to obtain a baseline pre RBC implementation score and post RBC HCAHPS scores at 6 months and 12 months. Careful identification of the project design provides maximum control over factors that could impede the project's desired outcomes (Burns & Grove, 2009).

To determine if RBC improves patient satisfaction scores, two questions was examined regarding nursing communication. Question 1: <u>During this hospital stay, how often did nurses treat you with courtesy and respect?</u> Question 2: <u>During this hospital stay, how often did nurses listen carefully to you?</u> Answers include: (1) Never, (2) Sometimes, (3) Usually, and (4)

Always. The only scores that were collected were the two questions regarding nurse communication. The student had access to all pertinent data including but not limited to 7A nursing unit HCAHPS scores for each question and the system-wide HCAHPS data. The mean scores for each question were used for both 7A and system-wide. Results were received quarterly to each institution and posted on Virtua's webpage. The student was instructed on the proper use of the extrapolation of data from the Press Ganey site. Press Ganey has a password protected website which allows users at any time to access and view up-to-date data. Data from the Press Ganey reports, for pre implementation and 6 and 12 month post RBC intervention was obtained using a personal laptop computer in a convenient setting.

Data Analysis

An analysis of variance (ANOVA) was used for the statistical analysis as it is the most appropriate tool for this program evaluation. An ANOVA is a "statistical technique used to examine differences among two or more groups by comparing the variability between the groups with the variability within the groups" (Burns & Grove, 2009, p. 688) The ANOVA was utilized "to determine if the observed differences among the set of means are greater than would be expected by chance alone" (Portney & Watkins, 2009, p. 451). In this program evaluation, the ANOVA was computed to explore differences among pre implementation and post implementation for both questions for a system-wide calculation and for the specific unit calculation. In addition, the use of an ANOVA was utilized to determine if the difference in scores was a significant change or insignificant change in HCAHPS scores. An ANOVA design was utilized for the statistical analysis using statistical software SPSS version 17 (SPSS Inc., Chicago, Illinois) to determine if there was a significant improvement of scores after the implementation of RBC system-wide and unit-based.

Protection of Human Rights

There was no risks to patients as this project was retrospective and utilized secondary data to determine outcomes. In addition, all data obtained through HCAHPS were reported as aggregate. No individual participant's information was reported independently or included any identifying information.

Summary

Healthcare organizations are becoming increasingly concerned with patient satisfaction as it relates to outcomes and reimbursement. The purpose of this project was to evaluate the effect of RBC on patient satisfaction system-wide and on a fully implemented nursing unit. This section has offered the plan of the project in relation to the implementation of RBC and use of HCAHPS as an evaluation to determine patient satisfaction. Methodology was discussed noting the use of ANOVA as the most appropriate statistical design. The survey offered a valid and reliable tool for the comparative data on areas of greatest concern to patients. The evaluation of unit specific scores and system-wide scores for both questions was examined independently at pre implementation and 6 months and 12 months post implementation to determine if there was a statistically significant increase in patient satisfaction scores for both the healthcare system and the specific nursing unit. This information would allow the student to determine if the implementation of RBC effected a patient's perception of satisfaction.

Section 4: Findings, Discussion, and Implications

Introduction

The purpose of this project was to evaluate the effects of RBC on patient satisfaction. The project objective was to determine if the implementation of the care model, RBC, improves patient satisfaction as evidenced by the improvement of HCAHPS scores for patient's perception of their nurse, including how often the nurse treated the patient with courtesy which is question 1 and how often the nurse listened carefully to the patient which is question 2. System-wide HCAHPS scores regarding patients' perception of nurses were compared at three time points. A similar comparison of one specific nursing unit, 7A, was also completed. This chapter is a summary of the findings, discussion, implications, and suggestions for future projects.

Findings

An analysis was performed in order to investigate potential differences in HCAHPS scores regarding their interactions with nurses before and after the implementation of RBC. The time periods of interest were: pre implementation, 6 months after implementation, and 12 months after implementation. Two separate analyses were performed, focusing on two distinct goals for both system-wide and 7A. In addition, demographic information was also collected for age and gender for both groups and both questions.

Data were gathered using HCAHPS surveys conducted during the described time frames, and patients responded on a Likert scale using a response scale as always (4), usually (3), sometimes (2), or never (1). Question 1: <u>During this hospital stay, how often did nurses treat you with courtesy and respect?</u> Question 2: <u>During this hospital stay, how often did nurses listen carefully to you?</u> An ANOVA was performed to investigate potential differences between pre implementation and post implementation. The test used the null hypothesis that there was no

difference in patients' HCAHPS scores between the three time periods. A significant result would have indicated that a difference occurred in patients' satisfaction of their interactions with their nurses. The results are discussed below.

Gender & Age Summary

The system-wide and 7A groups shared many commonalities. In terms of gender, both groups were made up of more females than males, 51%-57% females, and 43%-47% males, with the difference being slightly larger in the system-wide data. The age breakdown of both groups saw the largest portion in the 65-79 year range at 32% to 39%, with the smallest portion of the group falling in the 18-34 year range at 3% to 6%. The similarities in sample demographics allow a researcher to compare the data more accurately in terms of responses to HCAHPS. If significant differences existed, an age or gender bias would be a definite possibility. See Table 1 for a summary of these data.

Table 1

Description of Demographics for System-Wide

	Pre (n=5796)	6 mo (n=2461)	12 mo (n=3256)
Gender Female	57%	54%	55%
Male	43%	46%	45%
Age 18-34	3%	3%	3%
35-49	10%	9%	8%
50-64	26%	26%	25%
65-79	37%	37%	39%
80+	24%	25%	25%

Table 2

Description of Demographics for 7A

	Pre (n=235)	6 mo (n=96)	12 mo (n=103)
Gender Female	56%	53%	51%
Male	44%	47%	49%
Age 18-34	6%	6%	6%
35-49	8%	10%	6%
50-64	26%	29%	25%
65-79	35%	32%	38%
80+	25%	23%	25%

HCAHPS Scores

In order to achieve mean scores for the ordinal survey data, point values were assigned to each response. A response of always was assigned a 4, usually a 3, sometimes a 2, and never was assigned a 1. Summing all of the responses and dividing by the sample sizes in each period calculated a mean score for each time period. Because the numbers did not have a great deal of variance, it was difficult to see an effect or change in HCAHPS scores.

HCAHPS System-Wide Scores

System-wide data saw a slight increase in scores in the time periods between pre and post implementation. Question 1 and 2 received slightly higher scores at both 6 and 12 months periods, 3.85 to 3.86, and 3.7 to 3.73 respectively. See Table 3 for results.

Table 3

System-Wide HCAHPS Scores

	Pre	6 Months	12 Months
Question 1: Courtesy & Respect	3.8504 n=5796	3.8655 n=2461	3.8652 n=3256
Question 2: Listening	3.7265 n=5788	3.7377 n=2455	3.7367 n=3251

HCAHPS Scores 7A

When comparing 7A HCAHPS scores between pre and post implementation, the responses to question one, courtesy and respect as well as question two, listening experienced a slightly greater increase than the system-wide data. Question 1 received the highest score 12 months after implantation, 3.87 to 3.92, while question 2 peaked in the 6 month post implementation period, 3.78 to 3.81. The differences, while not necessarily statistically significant, indicated that the program could have assisted in the improvement of the already high HCAHPS scores. See Table 4 for results.

Table 4

7A HCAHPS Scores

	Pre	6 Months	12 Months
Question 1: Courtesy & Respect	3.8766 n=235	3.9167 n=96	3.8298 n=114
Question 2: Listening	3.7897 n=233	3.8125 n=96	3.9298 n=114

Analysis – System-Wide

A standard ANOVA was done to examine the effect of implementation in system-wide data. The analysis focused on two specific questions regarding courtesy/respect and listening. The ANOVA was performed on each question's data in order to look for differences in HCAHPS scores between the time periods of pre implementation, 6 months post implementation, and 12 months post implementation.

Question 1 – Courtesy/Respect

The analysis of variance was performed to test the null hypothesis that there is no difference in mean response scores relating to courtesy/respect between the three time periods. The p-value for the ANOVA was greater than 0.05, at 0.145, with 2 degrees of freedom and an F-score of 1.931. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding courtesy and respect from their nurses. A summary of the data is presented in table 5.

Table 5

Courtesy and Respect (Q1) Scores System-Wide
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.3420	1.931	0.145
Within Groups	11,509	0.1772		
Total	11,511			

Question 2 - Listening

Once again, an ANOVA was performed to test the null hypothesis that there was no

difference in mean response scores relating to nurse listening between the three time periods. Since the p-value was greater than 0.05, (P = 0.243 with 2 degrees of freedom and an F-score of 1.160) there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding listening from their nurses. A summary of the data is presented in Table 6.

Table 6

Listening Scores (Q2) System-Wide
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.3291	1.160	0.243
Within Groups	11,492	0.2838		
Total	11,494			

Question 1 – Courtesy/Respect 7A

The results of the ANOVA showed a p-value greater than 0.05, at 0.27961, with 2 degrees of freedom and an F-score of 1.27812. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding courtesy and respect from their nurses. A summary of the data is presented in Table 7.

Table 7

Courtesy and Respect (Q1) Scores 7A
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.16727	1.27812	0.27961
Within Groups	431	0.13087		
Total	433			

Question 2 – Listening 7A

The results of the ANOVA for differences in perceptions regarding listening once again indicated a p-value greater than 0.05, at 0.8678, with 2 degrees of freedom and an F-score of 0.14184. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding listening from their nurses. The results are shown in table 8.

Table 8

Listening (Q2) Scores 7A
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.02942	0.14184	0.8678
Within Groups	428	0.2.20743		
Total	430			

Discussion

The purpose of this project was to evaluate the implementation of RBC at an acute care facility in southern New Jersey. The evaluation of the program was based on the effect on HCAHPS scores for all medical surgical patients and patients from 7A. The scores were examined at three different times, including 1 year prior to implementation, and 6 and 12 months following the implementation. The findings showed no statistically significant improvements for both questions relating to listening, courtesy, and respect for both system-wide and 7A as evidenced by p-values greater than 0.05. However, there were slight improvements in scores, which could indicate a possible upward trend. This was a similar finding to Cropley's (2012) study and Winsett & Haucks's (2011) study, which also demonstrated no statistically significant effects on patient satisfaction scores however, scores increased slightly.

Patient satisfaction can be difficult to measure as it has multidimensional aspects regarding an individual's perception of their healthcare experience. RBC may positively improve patient satisfaction in a manner that is not reflective of HCAHPS scores. Furthermore, many nurses at Virtua have improved the caring and healing environment by focusing on their relationships with self, co-workers, and patients and families. Caring behaviors are as unique to each individual nurse, as they are received by each individual patient. If a nurse demonstrates exemplary caring behaviors, one might question if that experience will increase a patients satisfaction during their hospital stay. It is possible that the use of another survey, a caring assessment or patient experience survey, would be a better method to evaluate this implementation of RBC. Perhaps patient satisfaction and caring behaviors are two separate entities, which cannot be linked together. Most importantly, Virtua continues to utilize RBC as a guide to incorporate patient-centered care for the enhancement of a positive patient experience.

It was the expectation of the education department that managers and staff members would disseminate the foundations of RBC. The educational department provided tools including power point presentations, class notes, videos, and self-learning packets, as well as a SharePoint site with various resources for the enhancement of the implementation class as a way to disseminate the information. However, it is unknown to what degree of implementation occurred on each unit and how each nurse demonstrated RBC behaviors to their patients.

This implementation was a 1-day educational program with the expectation that nurses would disseminate the information to the staff and incorporate the behaviors into their daily delivery of care to enhance the patient-centered experience. It was also expected that the six dimensions of RBC were being incorporated into the nurses care delivery. This evaluation examined HCAHPS scores to evaluate if RBC was successful. However, observing caring behaviors performed by nurses could be another method to assess the implementation.

Quality relationships contribute to best practice in healthcare, leading to a "patient-centered, collaborative care environment" (Cropley, 2012, p. 338). Patients have a choice in healthcare and expect to be treated as part of the healthcare team with courtesy and respect. There is the possibility that RBC does not improve patient satisfaction as evidenced by the improvement of HCAHPS scores. However, other surveys to evaluate the implementations of care models should be considered.

Strengths, Limitations, and Implications

Implementing a care model to a large healthcare facility can be an overwhelming undertaking. However, the implementation in its infancy phase sets the stage for healthcare professionals to comprehend the significance of caring and the importance of understanding

patients perception of caring. The sample size for both system-wide and 7A were more than adequate adding to the strength of the evaluation.

There were several limitations to this program evaluation. The design was a quantitative design, which does not allow for subjective information regarding human interactions concerning their healthcare experience (Terry, 2002). Therefore, social, internal, holistic, or emotional information could not be assessed. Because this project design was retrospective, it did not allow for control of the variables or reliability of the data. Having a control group could have decreased the difficulty in attributing causation of the implementation. In addition, using an already high scoring unit, such as 7A, did not allow for a significant increase in scores. It was difficult to determine exactly when RBC was fully implemented in each unit and if the entire staff incorporated the behaviors into their daily professional practice. Leaders from each department were responsible for the implementation of RBC into their unit.

This project was limited by scope to the assessment of the program at one particular hospital system. This evaluation was also limited in terms of time, as an implementation of a caring model may take longer to assure a culturally hardwired, mature model (Cropley, 2012). As a result, time was a limitation of the evaluation (Leedy & Omrod, 2010).

Because this is a program evaluation, it did not allow for control of the variables or reliability of the data (Portney & Watkins, 2009). However, this evaluation was a primary attempt to demonstrate a fundamentally descriptive work to decrease the gap in the literature regarding the effect of RBC on patient satisfaction. Future projects would be beneficial to decrease the extraneous variables by comparing units that have fully implemented RBC and units who have not implemented the model. This type of project would increase the likelihood that the findings are an accurate assessment of the project and not due to extraneous factors (Burns &

Grove, 2009). However, for this project, all departments were educated regarding RBC at the same time.

This evaluation has implications for the continued implementation of a caring model for the betterment of patient-centered care. Patients' affairs regarding healthcare should continue to be the core of the healthcare experience (Cropley, 2012). The success of healthcare institutions relies on the patients' perspective of the care they receive during their healthcare experience. Patients expect to be listened to and treated with respect and courtesy. The successful implementation of RBC facilitates safe, evidence based practice, and staff consumer satisfaction leading to a successful healthcare future (Rowen, 2007). Patient-centered care empowers nurses to provide meaningful and relevant care and provides the patient with improved health outcomes (Hebda & Patton, 2012).

Recommendation for Future Work

In regards to program evaluations, future projects would be beneficial to decrease the extraneous variables by comparing units that have fully implemented RBC and units who have not implemented the model. This type of project would increase the likelihood that the findings are an accurate assessment of the project and not due to extraneous factors (Burns & Grove, 2009). In addition, using a unit with low HCAHPS scores would allow the evaluator to see a better improvement in scores. It was difficult to see an increase in scores since they were already high at the pre implementation stage. An implementation of a caring model may take years to be fully incorporated into the culture of a healthcare system. Therefore, it would be beneficial to repeat this evaluation at 2 years and 3 years after implementation.

Caring behaviors must be an integral part of the delivery of patient-centered care (Dingman et al., 1999). Future work should be performed to observe the delivery of care by

nurses to examine their caring behaviors, which have been incorporated into their care delivery. Perhaps these two questions retrieved from the HCAHPS survey are not the best measure of patient satisfaction as a different measurement strategy might yield different results.

Nurses need evidence to understand how essential their role is in influencing patient satisfaction (Wolf et al., 2008). Having a caring model provides nurses with a common framework or structure to guide their nursing practice for the delivery of evidenced based practice. Based on the results of this program evaluation, the following implementation recommendations are suggested:

- Descriptive information for the implementation plan, including unique nursing behaviors and activities, should be included to each unit leader to improve communication and complete implementation
- The implementation of RBC must become a fundamental part of the strategic plan, incorporating the cultural change of the facilities philosophy.
- A sustainability plan should be part of the program development with mandatory follow-up reports from each department
- Managers need to model caring behaviors
- Investigate other methods to measure patient satisfaction for relationship-based care

Analysis of Self

I have learned the process of all aspects of the development of a successful evidence-based program and feel confident in my leadership skills to design, implement, and evaluate a program for the improvement of the care delivery system, especially evidence-based practice.

I am passionate about the attainment of a caring and healing environment as well as healthy relationships between the patient, colleagues, and self. I am empowered to explore various strategies that will enhance the satisfaction of patients through competent and knowledgeable care, kindness, respect, and courtesy. I have learned and appreciated the process of determining the best evidence-based practice for a variety of patient populations.

I have learned the importance of the continuation of nursing education for the enhancement of the profession of nursing. It is a lifelong endeavor, which requires constant awareness of the evolving healthcare environment. Achieving my doctorate of nursing practice is not the end point but rather a starting point to apply knowledge to application through the attainment and sustainability of evidence based practice. My professional goal is to obtain my doctorate of nursing practice but my personal goal is to transfer and share my knowledge to novice nurses for the enhancement of the nursing profession. Thanks to my practicum, I have become a confident leader, understanding the importance of providing leadership, vision and inspiration.

Summary

This program evaluation found that the implementation of RBC does not statistically improve patient satisfaction scores as evidenced by HCAHPS scores. These findings were similar to the finding in the literature stated in this evaluation. However, there was an upward trend in HCAHPS scores for both 7A and system-wide for both questions, which could indicate a possible positive effect of relationship-based care. One principal limitation was the presence of extraneous variables. Future recommendations were made especially the need for further evaluations at 2 and 3 years when the model has been culturally hard-wired into the fabric of the nurse care delivery system. Despite the fact that scores were not found to be statistically

significant, HCAHPS scores increased slightly showing a trend toward a positive effect on patient satisfaction. Moreover, I feel strongly that RBC, as a patient-centered care model, is the crux to delivering quality, individualized, caring behaviors, which is essential for the advancement of the nursing profession.

Chapter 5: Scholarly Product

Patient satisfaction is a significant barometer in determining the quality of care in healthcare organizations. High-quality care and caring behaviors equate to the financial success of healthcare organizations (Dingman, Williams, Fosbinder, & Warnick, 1999). One way of gauging patient satisfaction in the United States is the utilization of a standardized survey instrument and data collection tool given by the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Therefore, it is imperative for nurses to focus on courteous therapeutic communication while providing compassionate quality care, which emphasizes the connection with the patient to form a caring and healing environment.

Background

The Centers for Medicare & Medicaid Services (CMS) links HCAHPS scores with reimbursement to hospitals as a component of the Hospital Value-Based Purchasing (HVBP) program (Huppertz & Smith, 2014). Higher HCAHPS scores will produce a higher rate of reimbursement from CMS to healthcare providers (Press Ganey, 2014). CMS incorporated the Institute of Medicine's (IOM) aims, one being the integration of patient-centered care, as one of their strategies for improving quality of care (IOM, 2001). As a result, hospital administrators are concentrating on ways to improve patient satisfaction and remain competitive in the ever-changing healthcare market. RBC is a caring model that promotes a caring and healing environment by establishing and maintaining therapeutic relationships between patients, coworkers, and self (Koloroutis, 2004). RBC, developed and trademarked by Creative Health Management, is based on Watson's (1988) theory of human caring, Swanson's (1993) middle range theory of caring, and Dingman's (1999) caring model. RBC incorporates the three relationships with six essential and interacting dimensions: teamwork, leadership, professional

nursing practice, care delivery, resource-driven care, care delivery, and outcome measures (Koloroutis, 2004). Patient-centered care models, such as RBC, are becoming more prominent among leaders of healthcare organizations, research institutions, and public policy centers who believe that patients' affairs regarding healthcare should be the core of the healthcare experience (Cropley, 2012).

The successful implementation of caring models improves patient satisfaction leading to the loyalty of the consumer, increased revenue, market share, profitability, and improved outcomes (Dingman et al., 1999). Therefore, because hospitals reimbursement from the Centers for Medicare and Medicaid is based on HCAHPS scores, hospitals need to improve their patient satisfaction scores to receive full payment to maintain financial success. The purpose of this project was to evaluate the effects of RBC on patient satisfaction.

By maximizing patient satisfaction and reimbursement, healthcare facilities can position themselves as a leading competitor in the healthcare arena. Improved caring relationships and therapeutic communication "contribute to positive outcomes for patients/families, healthcare providers, and healthcare systems" (Duffy & Hoskins, 2003, p.86).

Literature Review

Although there is a vast amount of literature regarding patient satisfaction focusing on improving HCAHPS scores, there is limited literature regarding studies that link caring theories to patient satisfaction improvements. In addition, there are numerous articles explaining an institution's experience regarding the implementation of RBC, there are a limited amount of studies, which attempt to demonstrate an increase in patient satisfaction score with the implementation of RBC.

The improvement of the quality of care, according to the Institute of Medicine's (IOM) 2001 Report, *Crossing the Quality Chasm*, includes the implementation of patient centered care to allow the patient to be the source of control (IOM, 2001). The implementation of a patient-centered care model provides a framework or guide to incorporate and hardwire caring behaviors for all communication, all departments, and all disciplines (Winsett & Hauck, 2011). Common themes of patient-centered care models include individualized care, patient satisfaction, collaboration, and quality (Wolf et al., 2008).

Two very significant studies show contrasting results regarding the implementation of a caring theory to patient satisfaction. While Cropley (2012) assessed the impact of the implementation of RBC, Dingman (1999) evaluated the effect of implementing a general caring theory based on Watson's theory of human caring and Leininger's transcultural care theory on patient satisfaction. Both studies utilized a pre intervention and post intervention method to determine the impact on patient satisfaction. A dissimilarity of the two studies is such that while Dingman utilized a survey tool developed by the Gallup Organization including a Likert-type scale with answers ranging from very satisfied to very dissatisfied, Cropley used HCAHPS scores (Cropley, 2012; Dingman, 1999).

Dingman et al. (1999) performed a study to evaluate the effect of the implementation of a caring theory on patient satisfaction in a 48-bed acute care hospital. Caring behaviors were attributed to improved patient satisfaction, which provides further evidence that caring is essential to the perception of patient satisfaction (Dingman et al., 1999

In a similar study, Winsett & Hauck (2011) examine patient satisfaction scores before and after an implementation of RBC utilizing a caring behavior checklist to ensure full implementation. Post implementation and during the training period scores showed no

significant change, an increase from only 8.92 to 9.02, therefore resulting in weak support for improved patient satisfaction. In summation, there is not strong support for the effect of RBC on patient satisfaction.

Methodology

This project took place at Virtua Healthcare Systems, located in southern New Jersey. In addition to a system-wide evaluation of RBC, Voorhees 7A medical surgical unit was selected to participate in this program evaluation. Virtua consists of three community, acute care facilities. In April of 2013, Creative Health Care Management, an international healthcare consulting firm and the creators of RBC, performed a 5-day immersion program for administrative staff, educators, and managers at Virtua. The program consisted of the foundations of RBC, the three relationships, six dimensions, and various strategies to incorporate RBC into the Virtua Healthcare System. Voorhees 7A was selected as an exemplar for a nursing unit that has fully incorporated RBC into their practice. The unit is a 24-bed medical/surgical unit with a staff of 35 registered nurses.

Implementation of Relationship-based Care

The implementation consisted of monthly classes for all nursing staff held by senior educators in addition to a monthly huddle to discuss each nursing unit's specific objectives and goals. The interdisciplinary team focused on improving the care delivery to patients, improving healthy relationships between self, patients, and coworkers, and facilitating the ownership of nurses' professional practice. The class consisted of various speakers, power point presentations, interactive conversations, videos, and a question and answer session for a variety of teaching strategies.

Sample

Two groups were used for this project. Group one consisted of all medical-surgical patients who received and returned surveys. Group two consisted of only patients who received and returned surveys from Voorhees 7A medical surgical nursing unit. The sampling procedure included a random sampling of all eligible patients on a monthly basis. Within one week, Press Ganey, an approved survey vendor sent a random sample of surveys to those patients along with a cover letter. Press Ganey received the list of eligible discharges, administered the survey, and submitted the HCAHPS data in a standardized format to Virtua on a quarterly basis to create a rolling quarterly data file.

There were three samples utilized for this project, pre implementation, and post implementation at 6 months and 12 months periods. A total of seven nurses from 7A medical/surgical nursing unit attended the RBC classes in October 2013. This information is required to determine the dates for pre implementation and the dates for post implementation.

Instrument

HCAHPS survey is a standardized tool utilized nationally since 2006 to provide public sharing of comparable data for acute care hospitals (Appendix A, CMS, 2014). Composites had an internal consistency reliability of *.89* for communication with nurses exhibiting a high hospital level reliability (CMS, 2003). Furthermore, the two questions used in this project regarding listening and respect were highly related to the patients' perceptions of their overall rating of the hospital with an alpha score of *.79* and *.73* respectively (CMS, 2008).

The tool measures the frequency of specific care experiences using a response scale as always (4), usually (3), sometimes (2), or never (1). The two questions most appropriate for this project were descriptive of a caring model such as RBC and are "reflective of direct nursing

relationships" (Cropley, 2012, p. 334). The first question relates to how often nurses treat the patient with courtesy and respect, which are essential to the caring and healing environment of RBC and for the personal healing relationship it forms (Koloroutis, 2004). The second question relates to how often nurses listen carefully to the patient.

Data Collection

This project began approximately 1-year after the initial RBC class. HCAHPS scores were collected for the two questions prior to the initial class to obtain a baseline pre implementation score and post RBC HCAHPS scores at 6 months and 12 months. To determine if RBC improves patient satisfaction scores, two questions were examined regarding nursing communication. Question 1: During this hospital stay, how often did nurses treat you with courtesy and respect? Question 2: During this hospital stay, how often did nurses listen carefully to you? The only scores that were collected were the two questions regarding nurse communication. The mean scores for each question were utilized for both 7A and system-wide.

Data Analysis

An analysis of variance (ANOVA) was used for the statistical analysis, as it was the most appropriate tool for this program evaluation. The ANOVA was utilized "to determine if the observed differences among the set of means are greater than would be expected by chance alone" (Portney & Watkins, 2009, p. 451). In this program evaluation, the ANOVA was computed to explore differences among pre implementation and post implementation for both questions for a system-wide calculation and for the specific unit calculation. In addition, the use of an ANOVA determined if the difference in scores is a significant change or insignificant change in HCAHPS scores.

Findings

An analysis was performed in order to investigate potential differences in HCAHPS scores regarding their interactions with nurses before and after the implementation of RBC. The time periods of interest were: pre implementation, 6 months after implementation, and 12 months after implementation. Two separate analyses were performed, focusing on two distinct goals for both system-wide and 7A. In addition, demographic information was also collected for age and gender for both groups and both questions.

Data were gathered using HCAHPS surveys conducted during the described time frames, and patients responded on a Likert scale using a response scale as always (4), usually (3), sometimes (2), or never (1). Question one: During this hospital stay, how often did nurses treat you with courtesy and respect? Question two: During this hospital stay, how often did nurses listen carefully to you? A standard analysis of variance (ANOVA) was performed to investigate potential differences between pre implementation and post implementation. The test used the null hypothesis that there is no difference in patients' HCAHPS scores between the three time periods. A significant result would indicate that a difference occurred in patients' satisfaction of their interactions with their nurses. The results are discussed below.

Gender & Age Summary

The system-wide and 7A groups shared many commonalities. In terms of gender, both groups were made up of more females than males, 51%-57% females, and 43%-47% males, with the difference being slightly larger in the system-wide data. The age breakdown of both groups saw the largest portion in the 65-79 year range at 32% to 39%, with the smallest portion of the group falling in the 18-34 year range at 3% to 6%. The similarities in sample demographics allow a researcher to compare the data more accurately in terms of responses to HCAHPS. If

significant differences existed, an age or gender bias would be a definite possibility. See Table 1 for a summary of these data.

Table 1

Description of Demographics for System-Wide

	Pre (n=5796)	6 mo (n=2461)	12 mo (n=3256)
Gender Female	57%	54%	55%
Male	43%	46%	45%
Age 18-34	3%	3%	3%
35-49	10%	9%	8%
50-64	26%	26%	25%
65-79	37%	37%	39%
80+	24%	25%	25%

Table 2

Description of Demographics for 7A

	Pre (n=235)	6 mo (n=96)	12 mo (n=103)
Gender Female	56%	53%	51%
Male	44%	47%	49%
Age 18-34	6%	6%	6%
35-49	8%	10%	6%
50-64	26%	29%	25%
65-79	35%	32%	38%
80+	25%	23%	25%

HCAHPS Scores

In order to achieve mean scores for the ordinal survey data, point values were assigned to each response. A response of always was assigned a 4, usually a 3, sometimes a 2, and never was assigned a 1. Summing all of the responses and dividing by the sample sizes in each period calculated a mean score for each time period. Because these numbers did not have a great deal of variance, it was difficult to see an effect or change in HCAHPS scores.

HCAHPS System-Wide Scores

System-wide data indicated a slight increase in scores in the time periods between pre and post implementation. Question 1 and 2 received slightly higher scores at both 6 and 12 months period, 3.85 to 3.86, and 3.7 to 3.73 respectively. See Table 3 for results.

Table 3

System-Wide HCAHPS Scores

	Pre	6 Months	12 Months
Question 1: Courtesy & Respect	3.8504 n=5796	3.8655 n=2461	3.8652 n=3256
Question 2: Listening	3.7265 n=5788	3.7377 n=2455	3.7367 n=3251

HCAHPS Scores 7A

When comparing 7A HCAHPS scores between pre and post implementation, the responses to question 1, courtesy and respect as well as question 2, listening experienced a slightly greater increase than the system-wide data. Question 1 received the highest score 12

months after implantation, 3.87 to 3.92, while question 2 peaked in the 6 month post implementation period, 3.78 to 3.81. The differences, while not necessarily statistically significant, showed that the program could have assisted in the improvement of the already high HCAHPS scores. See Table 4 for results.

Table 4

7A HCAHPS Scores

	Pre	6 Months	12 Months
Question 1: Courtesy & Respect	3.8766 n=235	3.9167 n=96	3.8298 n=114
Question 2: Listening	3.7897 n=233	3.8125 n=96	3.9298 n=114

Analysis – System-Wide

A standard ANOVA was done to examine the effect of implementation in system-wide data. The analysis focused on two specific questions regarding courtesy/respect and listening. The ANOVA was performed on each question's data in order to look for differences in HCAHPS scores between the time periods of pre implementation, 6 months post implementation, and 12 months post implementation.

Question 1 – Courtesy/Respect

The analysis of variance was performed to test the null hypothesis that there was no difference in mean response scores relating to courtesy/respect between the three time periods. The p-value for the ANOVA was greater than 0.05, at 0.145, with 2 degrees of freedom and an F-score of 1.931. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding courtesy and respect

from their nurses. A summary of the data is presented in table 5.

Table 5

Courtesy and Respect (Q1)Scores System-Wide
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.3420	1.931	0.145
Within Groups	11,509	0.1772		
Total	11,511			

Question 2 - Listening

Once again, an ANOVA was performed to test the null hypothesis that there was no difference in mean response scores relating to nurse listening between the three time periods. Since the p-value was greater than 0.05, (P = 0.243 with 2 degrees of freedom and an F-score of 1.160) there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding listening from their nurses. A summary of the data is presented in Table 6.

Table 6

Listening Scores (Q2) System-Wide
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.3291	1.160	0.243
Within Groups	11,492	0.2838		
Total	11,494			

Question 1 – Courtesy/Respect 7A

The results of the ANOVA showed a p-value greater than 0.05, at 0.27961, with 2 degrees of freedom and an F-score of 1.27812. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding courtesy and respect from their nurses. A summary of the data is presented in Table 7.

Table 7

Courtesy and Respect (Q1) Scores 7A
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.16727	1.27812	0.27961
Within Groups	431	0.13087		
Total	433			

Question 2 – Listening 7A

The results of the ANOVA for differences in perceptions regarding listening once again reported a p-value greater than 0.05, at 0.8678, with 2 degrees of freedom and an F-score of 0.14184. Since the p-value was greater than 0.05, there was insufficient evidence to claim that there was a significant difference in HCAHPS scores regarding listening from their nurses. The results are shown in table 8.

Table 8

Listening (Q2) Scores 7A
ANOVA comparison among 3 time points

Source	df	MS	F	P-Value
Between Groups	2	0.02942	0.14184	0.8678
Within Groups	428	0.2.20743		
Total	430			

Discussion

The purpose of this project was to evaluate the implementation of RBC at an acute care facility in southern New Jersey. The evaluation of the program was based on the effect on HCAHPS scores for all medical surgical patients and patients from 7A. The scores were examined at three different times, including 1 year prior to implementation, and 6 and 12 months following the implementation. The findings showed no statistically significant improvements for both questions relating to listening, courtesy, and respect for both system-wide and 7A as evidenced by p-values greater than 0.05. However, there were slight improvements in scores, which could indicate a possible upward trend. This was a similar finding to Cropley's (2012) study and Winsett and Haucks's (2011) study, which also demonstrated no statistically significant effects on patient satisfaction scores however, scores increased slightly.

Patient satisfaction can be difficult to measure as it has multidimensional aspects regarding an individual's perception of their healthcare experience. RBC may positively improve patient satisfaction in a manner that is not reflective of HCAHPS scores. Furthermore, many nurses at Virtua have improved the caring and healing environment by focusing on their

relationships with self, co-workers, and patients and families. Caring behaviors are as unique to each individual nurse, as they are received by each individual patient. If a nurse demonstrates exemplary caring behaviors, one might question if that experience will increase a patients satisfaction during their hospital stay. It is possible that the use of another survey, a caring assessment or patient experience survey, would be a better method to evaluate this implementation of RBC. Perhaps patient satisfaction and caring behaviors are two separate entities, which cannot be linked together. Most importantly, Virtua continues to utilize RBC as a guide to incorporate patient-centered care for the enhancement of a positive patient experience.

It was the expectation of the education department that managers and staff members would disseminate the foundations of RBC. The educational department provided tools including power point presentations, class notes, videos, and self-learning packets, as well as a SharePoint site with various resources for the enhancement of the implementation class as a way to disseminate the information. However, it is unknown to what degree of implementation occurred on each unit and how each nurse demonstrated RBC behaviors to their patients.

This implementation was a 1 day educational program with the expectation that nurses would disseminate the information to the staff and incorporate the behaviors into their daily delivery of care to enhance the patient-centered experience. It was also expected that the six dimensions of RBC were being incorporated into the nurses care delivery. This evaluation examined HCAHPS scores to evaluate if RBC was successful. However, observing caring behaviors performed by nurses could be another method to assess the implementation.

Quality relationships contribute to best practice in healthcare, leading to a "patient-centered, collaborative care environment" (Cropley, 2012, p. 338). Patients have a choice in healthcare and expect to be treated as part of the healthcare team with courtesy and respect.

There is the possibility that RBC does not improve patient satisfaction as evidenced by the improvement of HCAHPS scores. However, other surveys to evaluate the implementations of care models should be considered.

Strengths, Limitations, and Implications

Implementing a care model to a large healthcare facility can be an overwhelming undertaking. However, the implementation in its infancy phase sets the stage for healthcare professionals to comprehend the significance of caring and the importance of understanding patients perception of caring. The sample size for both system-wide and 7A were more than adequate adding to the strength of the evaluation.

There were several limitations to this program evaluation. The design was a quantitative design, which does not allow for subjective information regarding human interactions concerning their healthcare experience (Terry, 2002). Therefore, social, internal, holistic, or emotional information could not be assessed. Because this project design was retrospective, it did not allow for control of the variables or reliability of the data. Having a control group could have decreased the difficulty in attributing causation of the implementation. In addition, using an already high scoring unit, such as 7A, did not allow for a significant increase in scores. It was difficult to determine exactly when RBC was fully implemented in each unit and if the entire staff incorporated the behaviors into their daily professional practice. Leaders from each department were responsible for the implementation of RBC into their unit.

This project was limited by scope to the assessment of the program at one particular hospital system. This evaluation was also limited in terms of time, as an implementation of a caring model may take longer to assure a culturally hardwired, mature model (Cropley, 2012). As a result, time was a limitation of the evaluation (Leedy & Omrod, 2010).

Because this is a program evaluation, it did not allow for control of the variables or reliability of the data (Portney & Watkins, 2009). However, this evaluation was a primary attempt to demonstrate a fundamentally descriptive work to decrease the gap in the literature regarding the effect of RBC on patient satisfaction. Future projects would be beneficial to decrease the extraneous variables by comparing units that have fully implemented RBC and units who have not implemented the model. This type of project would increase the likelihood that the findings are an accurate assessment of the project and not due to extraneous factors (Burns & Grove, 2009). However, for this project, all departments were educated regarding RBC at the same time.

This evaluation has implications for the continued implementation of a caring model for the betterment of patient-centered care. Patients' affairs regarding healthcare should continue to be the core of the healthcare experience (Cropley, 2012). The success of healthcare institutions relies on the patients' perspective of the care they receive during their healthcare experience. Patients expect to be listened to and treated with respect and courtesy. The successful implementation of RBC facilitates safe, evidence based practice, and staff consumer satisfaction leading to a successful healthcare future (Rowen, 2007). Patient-centered care empowers nurses to provide meaningful and relevant care and provides the patient with improved health outcomes (Hebda & Patton, 2012).

Recommendation for Future Work

In regards to program evaluations, future projects would be beneficial to decrease the extraneous variables by comparing units that have fully implemented RBC and units who have not implemented the model. This type of project would increase the likelihood that the findings are an accurate assessment of the project and not due to extraneous factors (Burns & Grove,

2009). In addition, using a unit with low HCAHPS scores would allow the evaluator to see a better improvement in scores. It was difficult to see an increase in scores since they were already high at the pre implementation stage. An implementation of a caring model may take years to be fully incorporated into the culture of a healthcare system. Therefore, it would be beneficial to repeat this evaluation at 2 years and 3 years after implementation.

Caring behaviors must be an integral part of the delivery of patient-centered care (Dingman et al., 1999). Future work should be performed to observe the delivery of care by nurses to examine their caring behaviors, which have been incorporated into their care delivery. Perhaps these two questions retrieved from the HCAHPS survey are not the best measure of patient satisfaction as a different measurement strategy might yield different results.

Nurses need evidence to understand how essential their role is in influencing patient satisfaction (Wolf et al., 2008). Having a caring model provides nurses with a common framework or structure to guide their nursing practice for the delivery of evidenced based practice. Based on the results of this program evaluation, the following implementation recommendations are suggested:

- Descriptive information for the implementation plan, including unique nursing behaviors and activities, should be included to each unit leader to improve communication and complete implementation
- The implementation of RBC must become a fundamental part of the strategic plan, incorporating the cultural change of the facilities philosophy.
- A sustainability plan should be part of the program development with mandatory follow-up reports from each department
- Managers need to model caring behaviors

- Investigate other methods to measure patient satisfaction for relationship-based care

Summary

This program evaluation found that the implementation of RBC does not statistically improve patient satisfaction scores as evidenced by HCAHPS scores. These findings were similar to the finding in the literature stated in this evaluation. However, there was an upward trend in HCAHPS scores for both 7A and system-wide for both questions, which could indicate a possible positive effect of relationship-based care. One principal limitation was the presence of extraneous variables. Future recommendations were made especially the need for further evaluations at 2 and 3 years when the model has been culturally hard-wired into the fabric of the nurse care delivery system. Despite the fact that scores were not found to be statistically significant, HCAHPS scores increased slightly showing a trend toward a positive effect on patient satisfaction. Moreover, I feel strongly that RBC, as a patient-centered care model, is the crux to delivering quality, individualized, caring behaviors, which is essential for the advancement of the nursing profession.

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HCAHPS Survey

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 checking the box 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:

  ☐ Yes
  ☑ No ➔ ***If No, Go to Question 1***

You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.
Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

2. During this hospital stay, how often did nurses listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always
9 ☐ I never pressed the call button

YOUR CARE FROM DOCTORS

5. During this hospital stay, how often did doctors treat you with courtesy and respect?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

6. During this hospital stay, how often did doctors listen carefully to you?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

7. During this hospital stay, how often did doctors explain things in a way you could understand?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

THE HOSPITAL ENVIRONMENT

8. During this hospital stay, how often were your room and bathroom kept clean?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

9. During this hospital stay, how often was the area around your room quiet at night?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

YOUR EXPERIENCES IN THIS HOSPITAL

10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 12**

11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

12. During this hospital stay, did you need medicine for pain?

1 ☐ Yes
2 ☐ No ➔ **If No, Go to Question 15**

13. During this hospital stay, how often was your pain well controlled?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

1 ☐ Never
2 ☐ Sometimes
3 ☐ Usually
4 ☐ Always

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

- [1] ☐ Yes
- [2] ☐ 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?**

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ Always

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

- [1] ☐ Never
- [2] ☐ Sometimes
- [3] ☐ Usually
- [4] ☐ 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?**

- [1] ☐ Own home
- [2] ☐ Someone else's home
- [3] ☐ Another health facility ➔ **If Another, Go to Question 21**

19. **During this 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?**

- [1] ☐ Yes
- [2] ☐ 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?**

- [1] ☐ Yes
- [2] ☐ No

OVERALL 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 in your answers.

21. **Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?**

- [0] ☐ 0 Worst hospital possible
- [1] ☐ 1
- [2] ☐ 2
- [3] ☐ 3
- [4] ☐ 4
- [5] ☐ 5
- [6] ☐ 6
- [7] ☐ 7
- [8] ☐ 8
- [9] ☐ 9
- [10] ☐ 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?

- [1] ☐ Definitely no
- [2] ☐ Probably no
- [3] ☐ Probably yes
- [4] ☐ Definitely yes

UNDERSTANDING YOUR CARE WHEN YOU LEFT THE HOSPITAL

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.

- [1] ☐ Strongly disagree
- [2] ☐ Disagree
- [3] ☐ Agree
- [4] ☐ Strongly agree
- [5] ☐ I was not given any medication when I left the hospital

ABOUT YOU

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?

- [1] ☐ Yes
- [2] ☐ No

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

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

28. In general, how would you rate your overall mental or emotional health?

- [1] ☐ Excellent
- [2] ☐ Very good
- [3] ☐ Good
- [4] ☐ Fair
- [5] ☐ Poor

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

- [1] ☐ 8th grade or less
- [2] ☐ Some high school, but did not graduate
- [3] ☐ High school graduate or GED
- [4] ☐ Some college or 2-year degree
- [5] ☐ 4-year college graduate
- [6] ☐ More than 4-year college degree

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

- [1] ☐ No, not Spanish/Hispanic/Latino
- [2] ☐ Yes, Puerto Rican
- [3] ☐ Yes, Mexican, Mexican American, Chicano
- [4] ☐ Yes, Cuban
- [5] ☐ Yes, other Spanish/Hispanic/Latino

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

- [1] ☐ White
- [2] ☐ Black or African American
- [3] ☐ Asian
- [4] ☐ Native Hawaiian or other Pacific Islander
- [5] ☐ American Indian or Alaska Native

32. What language do you <u>mainly</u> speak at home?

- [1] ☐ English
- [2] ☐ Spanish
- [3] ☐ Chinese
- [4] ☐ Russian
- [5] ☐ Vietnamese
- [6] ☐ Portuguese
- [9] ☐ Some other language (please print): _____

THANK YOU

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

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

Appendix B: Sample Initial Cover Letter for the HCAHPS Survey

[SAMPLED PATIENT NAME] [ADDRESS]
[CITY, STATE ZIP]

[HOSPITAL LETTERHEAD]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at www.medicare.gov/hospitalcompare. These results will help consumers make important choices about their 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.

We hope that you will take the time to complete the survey. Your participation is greatly appreciated. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [OPTIONAL: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR] [HOSPITAL NAME]

Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.

Appendix C: Sample Follow-up Cover Letter for the HCHAPS Survey

[SAMPLED PATIENT NAME] [ADDRESS]
[CITY, STATE ZIP]

[HOSPITAL LETTERHEAD]

Dear [SAMPLED PATIENT NAME]:

Our records show that you were recently a patient at [NAME OF HOSPITAL] and discharged on [DATE OF DISCHARGE]. Approximately three weeks ago we sent you a survey regarding your hospitalization. If you have already returned the survey to us, please accept our thanks and disregard this letter. However, if you have not yet completed the survey, please take a few minutes and complete it now.

Because you had a recent hospital stay, we are asking for your help. This survey is part of an ongoing national effort to understand how patients view their hospital experience. Hospital results will be publicly reported and made available on the Internet at www.medicare.gov/hospitalcompare. These results will help consumers make important choices about their 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. Please take a few minutes and complete the enclosed survey. After you have completed the survey, please return it in the pre-paid envelope. Your answers may be shared with the hospital for purposes of quality improvement. [OPTIONAL: You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.]

If you have any questions about the enclosed survey, please call the toll-free number 1-800-xxx-xxxx. Thank you again for helping to improve health care for all consumers.

Sincerely,

[HOSPITAL ADMINISTRATOR] [HOSPITAL NAME]

Note: The OMB Paperwork Reduction Act language must be included in the mailing. This language can be either on the front or back of the cover letter or questionnaire, but cannot be a separate mailing. The exact OMB Paperwork Reduction Act language is included in this appendix. Please refer to the Mail Only, and Mixed Mode sections, for specific letter guidelines.